STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375168	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Manor Nursing Center	1340 East 61st Street Tulsa, OK 74136

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review and interview, the facility failed to ensure residents' property was not misappropriated for 1 (#19) of 4 sampled residents reviewed for abuse. The administrator reported the facility census was 139. Findings: A facility policy titled Resident Abuse, Neglect and Misappropriation of Property, revised 11/01/22, read in part, The facility will not tolerate mistreatment, neglect, or abuse of residents, including verbal, mental, sexual, or physical abuse, misappropriation of property, corporal punishment or involuntary seclusion. A care plan, initiated 05/26/25, showed Res #19 had diagnoses which included anxiety disorder and major depressive disorder. An admission assessment, dated 05/29/25, showed Res #19 had a BIMS score (a test for cognition) of 11, which was indicative of moderate impairment for daily decision making. A physician order, dated 06/05/25, showed Res #19 was to receive alprazolam 0.5mg (an antianxiety medication) by mouth every eight hours as needed for anxiety for five days. An undated hand-written facility document provided by the DON showed on 06/11/25 CMA #1 reported a medication card with approximately 6 for Res #19's alprazolam were missing off the medication cart along with the corresponding narcotic sheet. On 06/23/25 at 12:05 p.m., CMA #1 stated on 06/11/25, they noted that a card containing approximately six of Res #19's alprazolam and the narcotic sheet for that medication were not on the medication cart. CMA #1 stated they looked for the narcotic sheet at the nurse's desk and were unable to locate it, so they reported the missing medication to the DON. On 06/23/25 at 2:45 p.m., the DON stated they were notified that Res #19's medications were missing. The DON also stated they were unable to determine what had happened to the medications.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report an allegation of misappropriation of property to local law enforcement and the OSDH for 1 (#19) of 4 sampled residents reviewed for abuse. The administrator reported the facility census was 139. Findings: A facility policy titled Resident Abuse, Neglect and Misappropriation of Property, revised 11/01/22, read in part, Upon receiving an allegation of resident abuse, neglect or misappropriation of resident property or a report of a facility incident as defined in this policy, the facility will begin an investigation of the incident. The facility will also file reports with agencies in accordance with state regulations. If there is a reasonable suspicion that a crime against a resident has occurred, the facility shall report the incident to the Department and law enforcement. A care plan, initiated 05/26/25, showed Res #19 had diagnoses which included anxiety disorder and major depressive disorder. An admission assessment, dated 05/29/25, showed Res #19 had a BIMS score (a test for cognition) of 11, which was indicative of moderate impairment for daily decision making. A physician order, dated 06/05/25, showed Res #19 was to receive alprazolam 0.5mg (an antianxiety medication) by mouth every eight hours as needed for anxiety for five days. An undated hand-written facility document provided by the DON, showed on 06/11/25, CMA #1 reported a medication card with approximately six of Res #19's alprazolam were missing off the medication cart along with the corresponding narcotic sheet. On 06/23/25 at 12:05 p.m., CMA #1 stated on 06/11/25 they noted a card containing approximately six of Res #19's alprazolam and the narcotic sheet for that medication were not on the medication cart. CMA #1 stated they looked for the narcotic sheet at the nurse's desk and were unable to locate it, so they reported the missing medications to the DON. On 06/23/25 at 2:45 p.m., the DON stated they were notified Res #19's medications were missing. The DON stated they did not report the missing narcotics to the OSDH or local law enforcement.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to thoroughly investigate an allegation of misappropriation of residents' property for 1 (#19) of 4 sampled residents reviewed for abuse. The administrator reported the facility census was 139. Findings: A facility policy titled Resident Abuse, Neglect and Misappropriation of Property, revised 11/01/22, read in part, Upon receiving an allegation of resident abuse, neglect or misappropriation of resident property or a report of a facility incident as defined in this policy, the facility will begin an investigation of the incident. A care plan, initiated 05/26/25, showed Res #19 had diagnoses which included anxiety disorder and major depressive disorder. An admission assessment, dated 05/29/25, showed Res #19 had a BIMS score (a test for cognition) of 11, which was indicative of moderate impairment for daily decision making. A physician order, dated 06/05/25, showed Res #19 was to receive alprazolam 0.5mg (an antianxiety medication) by mouth every eight hours as needed for anxiety for five days. An undated hand-written facility document, provided by the DON, showed on 06/11/25 CMA #1 reported a medication card with approximately six of Res #19's alprazolam were missing off the medication cart along with the corresponding narcotic sheet. On 06/23/25 at 12:05 p.m., CMA #1 stated on 06/11/25, they noted a card containing approximately six of Res #19's alprazolam and the narcotic sheet for that medication were not on the medication cart. CMA #1 stated they looked for the narcotic sheet at the nurse's desk and were unable to locate it, so they reported the missing medication to the DON. On 06/23/25 at 2:45 p.m., the DON stated they were notified Res #19's medications were missing. The DON stated they had investigated the missing medication, but they did not get any written statements from staff members, and they did not have any notes related to interviewing staff members. The DON also stated they did not determine what happened to the missing medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were secured for 1 of 2 medication carts on the South hall. The administrator identified 139 residents resided in the facility. Findings: On 06/18/25 at 3:05 p.m., the South hall medication cart located outside the DON's office was observed to be unlocked and unattended. On 06/18/25 at 3:20 p.m., CMA #1 walked up to the cart to lock it. On 06/18/25 at 3:21 p.m., CMA #1 stated the medication cart should have been locked. The CMA stated it was the facility's policy to keep medication carts locked when they were unattended.