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	07/11/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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	07/11/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 07/08/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to have a system in place to ensure residents were monitored for the safe use of electronic vaping devices. Resident #1, 6, and Resident #11 were observed to use supplemental oxygen. The latest cognition assessments showed all three residents were intact in their cognition. Their care plans showed the three residents smoked, vaped, or both. The care plan showed the residents were not to use smoking or vaping materials while in the possession of or near any type of oxygen.On 07/08/25 at 3:43 p.m., Resident #11 was observed sitting in their motorized wheelchair in their room, vaping. The two O2 concentrators present in their room were running for the resident and their roommate. Resident #11's oxygen concentrator was approximately six inches from Resident #11 as they vaped.On 07/08/25 at 3:50 p.m., Resident #1 was observed lying in bed and vaping. The resident was observed to wear oxygen at 2 liters per nasal cannula. On 07/08/25 at 4:35 p.m., Resident #6 was observed vaping in their room while lying in bed with oxygen on per nasal cannula.On 07/08/25 at 4:52 p.m., Resident #6 was observed sitting in their motorized scooter in the dining room, at the dining table, vaping with Resident #12 at the head of the table. Resident #12 was observed to wear oxygen at 2 liters per minute via nasal cannula. The residents were observed to be less than five feet apart from each other.Interviews with direct care staff showed they were unaware or uncertain of the use of oxygen while vaping.On 07/08/25 at 6:25 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.On 07/08/25 at 6:57 p.m., the administrator, DON, and regional administrator were notified of the IJ situation and was provided a copy of the template.On 07/09/25 at 9:20 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Ambassador Skilled Nursing and Therapy Plan of Removal 7/8/25 1. Inservice on facility smoking procedures/designated locations. What to do if someone is smoking outside of those areas or in the presence of oxygen. 2. Re-assess all residents who vape for safety and understanding of the agreement and policy. 3. Re-issue the smoking agreement to these residents. 4. Any of the residents who have been reported to smoke freely around o2, be it theirs or their roommates, must have privileges revoked and put on supervised vaping. 5. Initiate a supervised smoking schedule and ensure each resident who is supervised has this information. 6. All of this to be completed by midnight 7/8/25.The IJ was lifted, effective 07/08/25 at 10:46 p.m., when all components of the plan of removal had been verified as completed. Direct care staff from all three shifts were interviewed about inservice/education and showed the staff were knowledgeable of the facility's policy regarding vaping and the risks involved if residents vaped while utilizing supplemental oxygen. Review of clinical records showed residents who vaped had been assessed for safety related to vaping and had signed a smoking/vaping agreement. The supervised smoking schedule showed what type of supervision residents required for vaping. The deficient practice remained at a pattern level with the potential for more than minimal harm.Based on observation, record review, and interview, the facility failed to ensure residents were monitored for the safe use of electronic vaping devices for 6 (#1, 2, 6, 11, 12, and #13) of 6 sampled residents who were reviewed for the use of electronic vaping devices.The alphabetical room roster identified 131 residents resided in the facility.Findings:1. On 07/08/25 at 3:33 p.m., Resident #1 was observed in their motorized wheelchair wheeling down the 100 hall with an electronic vape in their lap.On 07/08/25 at 3:48 p.m., Resident #1 was observed laying in bed, vaping, and had oxygen on at 2.5L via nasal canula. Resident #1 and Resident #11 were observed to be roommates. A physician order, dated 12/03/24, showed Resident #1 was ordered oxygen at two to five liters per minute via nasal cannula as needed.A policy titled Smoking/Vaping, dated 02/24/20, read in part, Oxygen equipment is not permitted in smoking areas. Smoking is not permitted while in possession of or in the presence of oxygen equipment .To offer the resident the ability to smoke/vape free of danger to self or others. The term smoking/vaping referenced herein includes the use of any type of cigarette, pipe, electronic device, battery powered device or any other object/device that produces smoke/vape.A policy titled Smoking, signed by Resident #1 on 01/18/24, read in part, The resident may choose to utilize an electronic cigarette. Electronic cigarettes may be utilized in approved smoking areas, in resident rooms when neither resident utilizes O2, and in non-public areas to prevent offending others.An annual assessment, dated 04/28/25, showed Resident #1 had a BIMS score of 13, which indicated the resident was cognitively intact for daily decision making and had a diagnosis of multiple sclerosis.A care plan, updated 05/22/25, showed Resident #1 was independent with vaping.A Smoking/Vaping Supervision Checklist, dated 06/10/25, showed Resident #1 utilized vaping products, was

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	07/11/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to maintain complete and accurate clinical records fortwo (#1 and #2) of three residents whose clinical records were reviewed for wound care documentation, andone (#6) of one resident whose clinical records were reviewed for medication administration. The alphabetical room roster showed there were 131 residents who resided in the facility.Findings: 1. The comprehensive assessment, dated 05/30/25, showed Resident #2 was severely impaired in daily decision making (BIMS = 5), had pressure ulcers and venous stasis ulcers, received pressure ulcer care, applications of ointments/medications, and the application of nonsurgical dressings. On 07/08/25 at 10:20 a.m., Resident #2 was observed in their room with long socks pulled to just below the knees bilaterally. A physician's order, dated 04/29/25, showed Resident #2 was to receive a daily dressing to right lateral calf and right posterior calf. A physician's order, dated 05/30/25, showed Resident #2 was to receive a daily dressing to the left heel. A treatment sheet, dated June 2025, did not show the daily dressings were performed on 06/07/25, 06/08/25, 06/21/25, 06/28/25, 06/29/25, or 06/30/25. A treatment sheet, dated July 2025, did not show the daily dressings were performed on 07/04/25, 07/06/25, or 07/07/25. On 07/08/25 at 10:20 a.m., Resident #2 stated the staff dressed their wounds but was not sure of the frequency of the wound care or the progression of the wounds. On 07/10/25 at 3:10 p.m., the DON stated the dressing changes to the left heel, the right posterior calf, and the right lateral calf were discontinued on 07/07/25 and would not be documented as performed for that date. The DON stated they were unable to find documentation the dressing changes were performed on any of the dates in June of 2025 or for July 4 and July 6, 2025. The DON stated they knew if the dressings were not documented they were not considered done. 2. On 07/08/25 at 10:31 a.m., LPN #2 was observed to provide wound care to Resident #1. The annual assessment, dated 04/28/25, showed Resident #1 had a BIMS score of 13, which indicated the resident was cognitively intact for daily decision making, had an ostomy, and had pressure ulcers. A physician order, dated 06/16/25, showed the resident was to have wound care to the sacrum every day shift on Monday, Tuesday, Wednesday, and Friday. A physician order, dated 06/17/25, showed the resident was to have wound care to the right posterior thigh every day shift. (continued on next page)

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	07/11/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 06/17/25, showed the resident was to have wound care to the right buttock every day shift. A physician order, dated 06/17/25, showed the resident was to receive wound care to their urostomy site every day shift. A physician order, dated 06/17/25, showed the resident was to have wound care to the left buttock every day shift. The treatment administration record, dated 07/01/25-07/31/25, showed the wound care to the left buttock, sacrum, right posterior thigh, right buttock, and the urostomy site for Resident #1 had not been documented for 07/04/25. On 07/08/25 at 10:53 a.m., Resident #1 stated staff performed wound care as ordered every day. On 07/10/25 at 3:40 p.m., the DON stated staff must have forgotten to document the wound care for Resident #1 on 07/04/25. They stated if the treatments were not documented they could not verify they had been completed. On 07/11/25 at 1:07 p.m., LPN #3 stated the wound care nurses had not worked on 07/04/25. LPN #1 stated they had performed wound care for Resident #1. They stated they should have documented the wound care on the treatment administration record but they had not documented for 07/04/25. 3. A physician order, dated 10/08/24, showed Resident #6 was to receive Insulin Glargine 28 units subcutaneously twice daily from 7:00 a.m. to 11:00 a.m. and 6:00 p.m.to 10:00 p.m. An annual assessment, dated 06/02/25, showed Resident #6 had a diagnosis of diabetes, had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and had received insulin for seven out of seven days during the look back period. The treatment administration record, dated 07/01/25-07/31/25, showed the insulin administration for Resident #6 had not been documented for the 6:00 p.m. to 10:00 p.m. dose on 07/04/25, 07/17/25, or 07/18/25. On 07/08/25 at 2:15 p.m., Resident #6 stated they received their insulin as ordered by the physician. On 07/10/25 at 5:42 p.m., the DON stated they did not have documentation insulin had been provided to Resident #6 on 07/40/25, 07/17/25, or 07/18/25 for the 6:00 p.m. to 10:00 p.m. dose.

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	07/11/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, record review, and interview, the facility failed to maintain an effective pest control program for the abatement of flies for 1 (center) of 4 halls observed for pests. A facility policy dated 10/24/08 and titled, Pest Control Policy, showed that an abundance of flies was often associated with an unhealthy environment. The policy showed that mechanical control measures such as window screens, screen doors that opened outwardly, the use of electric fans, and black light style traps were important interventions in the abatement of flies. On 07/08/25 at 11:35 a.m., during an observation of wound care, multiple flies were observed in the room of Resident #2. On 07/08/25 at 11:38 a.m., LPN #2 waved their gloved hand in front of their face and stated the flies were terrible due to the warm weather. On 07/08/25 at 11:39 a.m., LPN #2 asked Resident #2 how they were. The resident replied they had fought with flies all day long. On 07/08/25 at 11:42 a.m., Resident #2 continued to wave their hand about their face and asked LPN #2 if the room they were in was in fact the resident's own room. LPN #2 responded yes and commented the flies were particularly bad in this room. Resident #2 stated there were flies everywhere and asked to be removed from the fly room. The comprehensive assessment, dated 05/30/25, showed that Resident #2 was severely impaired in daily decision making (BIMS = 5), had unhealed pressure ulcers, and received hospice services. The exterminator's service report, dated 06/13/25, showed that light was visible around exterior doors which provided an entry point for pest. The report recommended to replace seals/door sweeps to prevent pest access to structure. On 07/11/25 at 8:50 a.m., the maintenance supervisor stated the facility pest control program for flies included lighted insect traps at main entrances and wind curtains above frequently used exterior doors. The maintenance supervisor stated they observed the exterior doors were held open for extended periods of time, allowing for flying insects to land on or follow residents as they re-entered the facility from outside. The maintenance supervisor stated they observed flies in the facility but did not witness a concentration of flies nor had a concentration of flies in any particular resident's room been reported to them. The maintenance supervisor stated they would ask housekeeping staff to inspect and clean the resident's room to determine what may be attracting the flies.