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	03/20/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the physician of suspected illegal drug paraphernalia found in a resident's possession for 1 (#7) of 9 sampled residents reviewed for notification of the physician.The administrator identified 124 residents who resided in the facility.Findings:A facility policy titled Notification of Change, dated 06/2025, read in part, The facility will notify the resident, the resident's physician, and the resident's representative (if applicable) promptly when there is: .An accident involving the resident that results in injury or has the potential for requiring physician intervention.All notifications should be documented in the medical record.An admission assessment, dated 03/21/25, showed Resident #7 was admitted on [DATE] with diagnoses which included alcohol abuse with withdrawal, cannabis use, other stimulant dependence, and other psychoactive substance abuse.A quarterly assessment, dated 02/17/26, showed a BIMS score of 15 which indicated Resident #7 was cognitively intact.A nurse's note for Resident #7, dated 02/17/26, read in part, Care plan team and administrator met with resident. Resident in-serviced regarding his revocation of self sign out privileges due to [their] non-compliance in the matter of smoking devices and paraphernalia. Resident signed that [they] are understanding of this.A nurses' note for Resident #7, dated 02/24/26, showed on 02/17/26, Resident #7 received in-service education over revocation of self-sign out privileges due to ongoing illicit substance use and possession of smoking devices/paraphernalia violating the facility rules. The note showed Resident #7 continued to use illicit substances in and was reported to provide substances to other residents despite prior education. There was no documentation the physician was notified of the illicit paraphernalia found in Resident #7's possession on 02/17/26.On 03/18/26 at 11:35 a.m., Resident #7 stated the facility found a methamphetamine pipe in their room in February. They stated the facility confiscated the pipe and threw it in the trash. Resident #7 stated they used illegal drugs including methamphetamine, cocaine, and marijuana. On 03/19/26 at 9:41 a.m., the medical director stated they were not notified of the suspected drug paraphernalia found in Resident #7's possession on 02/17/26. The medical director stated it was important to notify them of suspected drug abuse by residents because the illicit drugs may interact with prescribed medications. On 03/20/26 at 8:58 a.m., the HK supervisor stated on 02/17/26, housekeeping saw Resident #7 put a small glass pipe with residue in a box. They stated the administrator was notified and they went with the administrator to discuss with Resident #7 the concern. They stated Resident #7 gave the suspected drug paraphernalia to the administrator and they disposed of it in the trash. On 03/20/26 at 11:07 a.m., the DON stated it was not documented the physician was notified of the incident.On 03/20/26 at 11:21 a.m., the administrator stated the physician was not notified.

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify law enforcement and Oklahoma State Department of Health of suspected criminal activity for 1 (#7) of 9 sampled residents reviewed for notifying law enforcement and Oklahoma State Department of Health of suspected criminal activity.The administrator identified 124 residents who resided in the facility.Findings:A facility policy titled Resident Abuse, Neglect and Misappropriation of Property, revised 11/01/22, read in part, Crime; Section 1150B(b)(1) of the Social Security Act (42 U.S.C &1320b-25) provides that a crime is defined by law of the applicable political subdivision where the facility is located. A political subdivision would be a city, county, township, or village, or any local unit of Government created by or pursuant to State law. Crime is defined by Oklahoma state law as an act or omission forbidden by law. 21 O.S. &3.The facility will also file reports with agencies in accordance with state regulations. If there is a suspicion of a crime against a resident has occurred, the facility shall report the incident to the Department and law enforcement. Title 63 of the (name of state withheld) Statute S 2-405, (2025), read in part, No person shall deliver, sell, possess or manufacture drug paraphernalia knowing, or under circumstances where one reasonably should know, that it will be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale or otherwise introduce into the human body a controlled dangerous substance in violation of the Uniform Controlled Dangerous Substances Act. An admission assessment, dated 03/21/25, showed Resident #7 was admitted on [DATE] with diagnoses which included alcohol abuse with withdrawal, cannabis use, other stimulant dependence, and other psychoactive substance abuse.A quarterly assessment, dated 02/17/26, showed a BIMS score of 15 which indicated Resident #7 was cognitively intact.A nurse's note for Resident #7 dated 02/17/26, read in part, Care plan team and administrator met with resident. Resident in-serviced regarding his revocation of self sign out privileges due to [their] non-compliance in the matter of smoking devices and paraphernalia. Resident signed that [they] are understanding of this.A nurses' note for Resident #7, dated 02/24/26, showed on 02/17/26, Resident #7 received in-service education over revocation of self-sign out privileges due to ongoing illicit substance use and possession of smoking devices/paraphernalia violating the facility rules. The note showed Resident #7 continued to use illicit substances in and was reported to provide substances to other residents despite prior education. There was no documentation a report of suspected illegal activity was made to the police or Oklahoma State Department of Health of the illicit paraphernalia found in Resident #7's possession on 02/17/26.On 03/18/26 at 11:35 a.m., Resident #7 stated the facility found a methamphetamine pipe in their room in February. They stated the facility confiscated the pipe and threw it in the trash. Resident #7 stated they used illegal drugs including methamphetamine, cocaine, and marijuana. On 03/20/26 at 8:58 a.m., the HK supervisor stated on 02/17/26, housekeeping saw Resident #7 put a small glass pipe with residue in a box. They stated the administrator was notified and they went with the administrator to discuss with Resident #7 the concern. They stated Resident #7 gave the suspected drug paraphernalia to the administrator and they disposed of it in the trash. On 03/20/26 at 11:07 a.m., the DON was asked about the suspected drug paraphernalia found in Resident #7's possession on 02/17/26. The DON stated they followed the abuse policy and was not aware the suspected drug paraphernalia was a crime, so it was not reported to the police. They stated the incident on 02/17/26 should have been reported to the Oklahoma State Department of Health and it was not reported. On 03/20/26 at 11:21 a.m., the administrator the police and Oklahoma State Department of Health were not notified of the incident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to assess, monitor and intervene for 2 (#1 and #3) of 5 sampled residents reviewed for administration of medication and following physician orders. The administrator identified 124 residents who resided in the facility.Findings:Resident #1 had a physician order dated 03/09/26 for Insulin Aspart injection solution 100 units/mL (Insulin Aspart) (a medication for diabetes), which read in part, .FSBS 351- 400 =10 units Recheck in 2 hours. If still 400, Notify MD. FSBS 401 - 450 = 12 units Recheck in 2 hours, if till greater than 400 notify MD. Resident #1 had the following readings:On 03/09/26 at 9:00 p.m. FSBS 383, 03/10/26 at 4:00 p.m. FSBS 401, 03/10/26 at 9:00 p.m. FSBS 399, 03/11/26 at 07:30 a.m. FSBS 390, 03/11/26 at 11:00 a.m. FSBS 360, 03/11/26 at 4:00 p.m. 384, 03/12/26 at 07:30 a.m. 370, 03/12/26 at 11:00 a.m. FSBS 366, and 03/12/26 at 4:00 p.m. FSBS 383. No documentation of repeat FSBS or physician notification was provided.Resident #11 had a physician order dated 12/08/25 for Insulin Aspart injection solution 100 units/mL (Insulin Aspart) (a medication for diabetes), which read in part, .FSBS 401 - 450 = 12 units Recheck in 2 hours, if till greater than 400 notify MD, FSBS 451-500 = 15 units Recheck in 2 hours and if still greater than 400 notify MD. Resident #11 had the following readings: 03/01/26 at 4:00 p.m. FSBS 411, 03/02/26 at 11:00 FSBS 460, 03/02/26 at 4:00 p.m. FSBS 481, 03/08/26 st 4:00 p.m. FSBS 411, 03/11/26 at 4:00 p.m. FSBS 429. 03/11/26 at 9:00 p.m. FSBS 461, 03/17/26 at 9:00 p.m. FSBS 455. No documentation of repeat FSBS or physician notification was provided.On 03/19/26 at 11:06 a.m. LPN #1 stated that sliding scale between 351-400 that stated to recheck in 2 hours should have a recheck in 2 hours - if over 400 would call the physician and document repeat FSBS and physician contact in progress notes and under vital signs.On 03/19/26 at 2:25 p.m. RN#1 stated the TAR for Resident #1 showed if a blood sugar was 351-400 to administer 10 units of insulin and re-check FSBS in 2 hours. RN #1 stated they document in the nurses notes under progress notes when the FSBS is rechecked but does not see where it was done for Resident #1.On 3/19/26 at 2:35 p.m. the DON stated they did not find documentation that there were repeat FSBS performed when blood sugars were over 351 for Resident #1 or over 400 for Resident #11.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on record review and interview, the facility failed to accurately transcribe admission orders and ensure medications were administered for one (#1) of three sampled residents reviewed for medication administration.The administrator identified 124 residents who resided in the facility. Findings:A medical diagnoses record showed Resident #1 had diagnoses which included encounter for orthopedic aftercare following surgical amputation, acquired absence of other right toes, diabetes mellitus due to underlying condition with diabetic amyotrophy, acute kidney failure, unspecified, chronic obstructive pulmonary disease, unspecified, and hyperkalemia. Clinical discharge instructions for Resident #1, dated 03/09/25 at 1:12 p.m., showed to administer insulin Glargine (a diabetes medication), 30 units subcutaneous every 24 hours.An Order Summary Report showed an active physician order to start on 03/10/26 for Insulin Glargine Subcutaneous 100 unit/mL, (a diabetes medication), Inject 30 units subcutaneously one time a day for DMII.A review of the Medication Administration Record showed a start date of 03/10/26 for Insulin Glargine Subcutaneous solution 100 units/mL, (a diabetes medication), inject 30 units subcutaneous one time a day for DMII.Entries made on the MAR for 03/10/26, 03/11/26, 03/12/26 and 03/13/26 showed a code 9 with initials. Per the code legend on the MAR, Code 9 is a chart code indicating charting in nurses notes.On 03/10/26 at 08:05 a.m., progress notes showed CMA #2 Documented Note Text: Insulin Glargine subcutaneous Solution 100Units/mL Inject 30 units subcutaneously one time a day for DMII, Notified Nurse.On 03/11/26 at 07:35 a.m., progress notes showed CMA #2 Documented Note Text: Insulin Glargine subcutaneous Solution 100Units/mL Inject 30 units subcutaneously one time a day for DMII, Notified Nurse. 03/12/26 at 07:40 a.m., progress notes showed CMA #2 Documented Note Text: Insulin Glargine subcutaneous Solution 100Units/mL Inject 30 units subcutaneously one time a day for DMII, Notified Nurse. On 03/13/26 at 07:45 a.m., progress notes showed CMA #2 Documented Note Text: Insulin Glargine subcutaneous Solution 100Units/mL Inject 30 units subcutaneously one time a day for DMII, Notified Nurse.A Medication Orders policy, dated January 2022, read in part, the nurse who transcribes the orders to the physician order sheet/electronic medical record and MAR documents on the admission form the date, the time and by whom the orders were noted.On 03/18/26 at 3:14 p.m., CMA #2 stated when a medication was on the MAR, such as inhalers and insulins, they informed the nurse in charge for the day and documented it on the MAR and in the progress notes. CMA #2 stated they did not give any insulins, only nurses do, so they inform them when it was on the MAR and not the TAR. CMA #2 stated Resident #1 did have insulin on their MAR for several days and they told the nurse. CMA #1 stated they did not tell anyone else and does not think Resident#1 received the medication.On 03/18/26 at 3:25 p.m., LPN #2 stated they administered medications that were on the TAR and the CMA's administered the medications on the MAR. They stated they understood how the medication got missed as they did not look at the MAR when administering medications, only the TAR, and the Glargine insulin was listed on the MAR when it should have been listed on the TAR. LPN #2 stated the resident did not receive the doses of insulin that were not on the TAR.On 03/18/26 3:35 p.m., the ADON stated they realized there was a medication error when the hospital called for a list of medications the resident had received. They stated when reviewing orders the Glargine insulin was listed on the MAR and not the TAR and had been missed. A facility Quality report showed the problem was identified on 03/13/26. The facility Quality report showed an audit of all insulin orders was completed to ensure the correct tab was selected and staff training was completed on 03/17/26.