STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375230	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Village Health Care Center	2154 South 85th East Avenue Tulsa, OK 74129

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, and interview, the facility failed to ensure comfortable water temperatures were maintained for 5 of 5 shower rooms. The DON identified 79 residents received showers. Finding:On 01/27/26 at 3:23 p.m., an observation of the large South shower showed an initial temperature of the water flow out of the shower head to be 100.4 degrees F. Within 11 minutes the water temperature was observed to be 77.4 degrees F.On 01/28/26 at 8:42 a.m., an observation of the small East shower showed an initial temperature of the water flow out of the shower head to be 107.4 degrees F. Within eight minutes the water temperature was observed to be 85.2 degrees F.On 01/28/26 at 9:01 a.m., an observation of the large East shower showed an initial temperature of the water flow out of the shower head to be 97.6. degrees F. Within one minute the water temperature was observed to be 98.4 degrees F.On 01/28/26 at 9:15 a.m., an observation of the North shower showed an initial temperature of the water flow out of the shower head to be 81.3 degrees F. Within two minutes the water temperature was observed to be 70.5 degrees F. On 01/28/26 at 1:18 p.m., an observation of the small South shower showed an initial temperature of the water flow out of the shower head to be 104.6 degrees F. Within five minutes the water temperature was observed to be 85.8 degrees F.A facility policy titled ADL [activity of daily living] CARE BATHING, dated 07/21/22, read in part, ENSURE BATHING AREA is at a comfortable temperature.A facility maintenance document titled Direct Supply Tels, dated 11/17/25, read in part, Hot water not working on north hall.On 01/22/26 at 8:58 a.m., Res #2 stated they had a problem with the water being cold. They stated last week they took a shower and it was warm for about two minutes and then the water became ice cold. They stated they did not take many showers now because the water in the shower got ice cold.On 01/27/26 at 3:41p.m., CNA #3 stated when they started the showers for the residents the water turns very cold within three minutes. They stated they had to hurry and get the soap washed off the residents. CNA #3 stated residents felt their showers were cut short. They stated residents would refuse showers because they knew the water got cold fast.On 01/27/26 at 3:45 p.m., CNA #5 stated residents told them the water got cold too fast. They stated they noticed the water got cold fast. CNA #5 stated they reported the cold water in the shower rooms to the maintenance supervisor several times.On 01/27/26 at 4:00 p.m., Res #8 stated within five minutes the water was freezing in the shower. They stated it was very difficult to take a shower when it was ice cold, and they hated that it was just frigid.On 01/27/26 at 4:20 p.m., Res #9 stated the water was freezing within a minute on the North hall shower.On 01/28/26 at 10:47 a.m., the maintenance supervisor stated they did not perform routine checks on water temperatures, and they had no logs of temperature checks. On 01/28/26 at 2:01 p.m., the administrator stated after feeling the water coming out of the shower head on the North hall, they would not take a shower in that water because it was too cold.

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
	375230	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Village Health Care Center	2154 South 85th East Avenue Tulsa, OK 74129

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation and interview, the facility failed to ensure there were qualified dietary staff to meet the needs of the residents for 2 of 3 dietary staff reviewed for qualifications. The DON identified 81 residents received nutrition from the kitchen. The DM identified 11 staff members who worked in the dietary department. Findings:On 01/27/26 at 1:35 p.m., dietary aide #1 and dietary aide #2 were observed washing dishes in the low temperature dish machine and dietary aide #2 stopped the dish machine during the wash cycle and walked away.On 01/27/26 at 1:38 a.m., dietary aide #2 stated there were suds in the side tank and that was how they knew the water was not hot enough. They stated they waited awhile and tried running the dishwasher again. Dietary Aide #2 stated they had not been shown how to check the temperature with the gauge or use test strips on the machine. Dietary Aide #2 stated they had worked at the facility for about a month and were trained by another staff member but had not learned anything about testing the dish machine, even though they used it several times a day.On 01/27/26 at 1:40 p.m., dietary aide #1 stated they looked at the temperature gauge and mad sure it was between the two green lines. They stated they knew there were strips to check the machine with, but they did not know where they were. Dietary Aide #1 stated they did not usually worry about testing or documentation. They stated they just watched for suds to know if the water was too cold.On 01/28/26 at 9:56 a.m., the DM stated they were unable to locate the quarterly training documents, 90-day nutrition services, training or annual competencies for the dietary staff. The DM stated they reviewed the process for checking temperatures and sanitation strips in orientation and were not sure why the staff were not following the process or did not have an understanding for the need or frequency for the dish machine testing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375230	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Village Health Care Center	2154 South 85th East Avenue Tulsa, OK 74129

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure staff performed their duties in a manner that would ensure clean and proper sanitation of dishes during 2 of 2 kitchen observations.The DON identified 81 residents received nutrition from the kitchen. Findings:On 01/27/26 at 1:30 p.m., the low temperature dishwasher was observed being stopped mid-cycle by dietary aide #2. The dishwasher reservoir water was observed to have suds. The temperature gauge was observed and showed the dial between the green arrows marked on the gauge and water temperature was measured to be 140 degrees F.A facility policy titled Warewashing, dated 08/25/25, read in part, dishware shall be washed in (3) sink unit with sanitizer or disposable dishware shall be used if dish machine is not working or reaching regulatory requirements.test strips shall be available for the pot sink and low temp dish machine sanitizer. Results shall be checked and recorded daily.A facility log sheet titled Warewashing Log - Dishmachine, dated January 2026, showed lines marked through 01/21/26 with a note hot water being installed. The log sheet did not show documentation was recorded for 01/21/26 through 01/28/26. On 01/22/26 at 8:30 a.m., cook #2 stated hot water had been an issue and the facility was getting a new hot water tank installed. [NAME] #2 stated they were washing dishes in the tubs since the dishwasher was out of service due to the availability of hot water. They stated they were heating water on the stove to wash pots and pans and other cooking utensils and used paper plates and paper containers for serving food to the residents.On 01/22/26 at 9:00 a.m., the DM stated they were using paper products for residents and washing cooking utensils in three plastic tubs. The DM stated they did not know they needed to check the temperature of the water or the sanitizer solution in the tubs, but they were using the sanitizer. The DM stated they were heating the water on the stove.On 01/27/26 at 1:30 p.m., dietary aide #1 stated they looked at the temperature gauge and made sure it was between the two green lines. Dietary Aide #1 stated they knew there were strips to check the machine, but they did not know where they were. Dietary Aide #1 stated they did not usually worry about testing or documentation. They stated they just watched for suds in the side reservoir to know if the water was too cold.On 01/27/26 at 1:35 p.m., dietary aide #2 stated they had not been shown how to check the water temperature with the gauge or use test strips. Dietary aide #2 stated they had worked at the facility for about a month and they were trained by another staff member. Dietary Aide #2 stated they washed dishes when they worked but had not learned anything about testing the machine.On 01/27/26 at 2:16 p.m., the administrator stated they were unsure of training of staff or that they were completing the process for dish machine testing since there was no documentation to show it had been completed. The administrator stated the testing of the dishwasher should be done daily per facility policy. On 01/28/26 at 10:30 a.m., the DM stated they were at the facility and worked over the weekend but had not realized the dish machine had not been tested for temperature or sanitation, or that documentation was not completed from 01/21/26 through 01/28/26. They stated they felt like there was some miscommunication between the staff. The DM stated the temperature, and sanitizer should be checked daily and that it was not documented.