

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>375241                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>06/08/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Rolling Hills Care Center                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>801 North 193 East Avenue<br>Catoosa, OK 74015 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                                                 |
| F 0760<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Ensure that residents are free from significant medication errors.<br><br>Based on record review and interview, the facility failed to ensure medication was administered according to physician orders for 1 (#1) of 3 sampled residents reviewed for medication administration. The administrator identified 55 residents resided in the facility. A quarterly assessment for Resident #1, dated 03/27/26, showed the resident was severely cognitively impaired for daily decision making with a brief interview for mental status score of 0. An admission record for Resident #1, dated 04/18/26, showed the resident had diagnoses which included Alzheimer's disease, dementia, hypertension, and depression. A physician order for Resident #1, dated 05/14/26, read in part, Risperdal oral tablet 1mg. Give one tablet by mouth two times a day. A physician order for Resident #1, dated 05/14/26, read in part, metoprolol succinate extended-release oral tablet 24-hour 50 mg. Give one tablet by mouth one time a day. On 06/02/26 at 11:13 a.m., CMA #2 stated they did not crush medications for Resident #1 because they did not have an order to crush the medications. On 06/02/26 at 11:17 a.m., CMA #1 stated they crushed the medications for Resident #1 on two occasions because Resident #1 appeared to have a slight problem swallowing upon returning from the hospital. CMA #1 stated there was not an order for Resident #1 to have their medications crushed. On 06/02/26 at 2:00 p.m., the director of nursing stated medications should not be crushed without an order. On 06/05/26 at 3:30 p.m., Pharmacist #1 stated if Risperdal or metoprolol succinate were crushed, they would not cause clinical harm. |                                                                                             |                                                 |

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