STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375241	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Care Center	801 North 193 East Avenue 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure assessments were accurate for 1 (#26) of 2 sampled residents reviewed for indwelling urinary catheters.LPN #1 identified four residents had indwelling urinary catheters.Findings: Based on record review and interview, the facility failed to ensure assessments were accurate for 1 (#26) of 2 sampled residents who were reviewed for indwelling urinary catheters. LPN #1 identified four residents who had indwelling urinary catheters. Findings: On 12/03/25 at 9:38 a.m., Resident #26 was observed in their room. An indwelling urinary catheter bag was observed to hang from their chair. On 12/09/25 at 11:30 a.m., LPN #1 and CNA #1 were observed to provide care to the resident's suprapubic catheter. A policy titled, MDS Assessment Coordinator, dated November 2019, read in part, Each individual who completes a portion of the assessment [MDS] must certify the accuracy of that portion of the assessment by: a. Dating and signing the assessment [MDS]; and b. Identifying each section completed. A physician order, dated 08/02/25, showed Resident #26 was to receive catheter care for indwelling urinary catheter every shift. A medication administration/treatment administration record, dated November 2025, showed Resident #26 had received care for their indwelling urinary catheter. A quarterly assessment, dated 11/12/25, showed Resident #26 had an indwelling urinary catheter and was always incontinent of urine. A care plan, dated 11/13/25, showed Resident #26 had an indwelling urinary catheter. On 12/09/25 at 11:59 a.m., the DON stated Resident #26 was admitted with an indwelling urinary catheter and they were responsible to complete assessments. They reviewed the quarterly assessment, dated 11/12/25, and stated they should have coded the assessment as 'not rated' rather than always incontinent of urine.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review, and interview, the facility failed to ensure 1 (treatment cart #1) of 3 treatment carts observed were locked.The DON reported 50 residents resided in the facility.On 12/02/25 at 10:57 a.m., treatment cart #1 was observed to be South of the nurse's station, unlocked and unattended. On 12/02/25 at 10:58 a.m., LPN #1 was observed sitting on the North side of the nurse's station with their back to treatment cart #1. The cart was observed to be unlocked and unattended. On 12/02/25 at 3:03 p.m., treatment cart #1 was observed to be unlocked and unattended on the South side of the nurse's station. On 12/02/25 at 3:04 p.m., LPN #2 was observed to walk out the of the storage closet on Hall A, toward treatment cart #1 located on the South side of the nurse's station. Treatment cart #1 was observed to be unlocked and unattended. On 12/02/25 at 3:06 p.m., RN #1 was observed to stand in room A1 on Hall A. Treatment cart #1 was observed to be unlocked and unattended. On 12/08/25 at 12:51 p.m., treatment cart #1 was observed to be unlocked and unattended located on the South side of the nurse's station. On 12/08/25 at 12:52 p.m., LPN #1 was observed to walk away from treatment cart #1, the cart remained unlocked. A facility policy titled Security of Medication Cart, revised 04/2007, read in part, 1. The nurse must secure the medication cart during pass to prevent unauthorized entry .4. Medication carts must be securely locked at all times when out of the nurse's view .5. When the medication cart is not being used, it must be locked and parked.On 12/02/25 at 11:00 a.m., LPN #1 stated treatment carts were to be supervised and locked. They stated, they could not see the treatment cart while facing the opposite direction of the cart.On 12/02/25 at 12:13 p.m., the DON stated they used the medication cart policy for their treatment carts procedures. On 12/02/25 at 12:14 p. m., the DON stated treatments carts were to be secured and supervised. On 12/02/25 at 3:07 p.m., LPN # 2 stated treatment cart #1 was out of their sight while they were in the storage closet. On 12/02/25 at 3:07 p.m. , RN #1 stated they had gotten a bandage from the treatment cart and had left the treatment cart unlocked. They stated all nursing staff were responsible to lock the treatment carts. On 12/02/25 at 3:08 p.m., RN #1 stated nursing staff were to lock the treatment cart after every use. RN #1 stated they could not see the treatment cart from the resident's room. On 12/08/25 at 12:53 p.m., LPN #1 stated they had left treatment cart #1 unlocked and unattended.