STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375389	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tulsa Nursing Center	10912 East 14th Street Tulsa, OK 74128

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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 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. 41809 Based on record review and interview, the facility failed to ensure the physician was notified of a significant weight loss for 1 (#18) of 4 sampled residents who were reviewed for nutrition/weight loss. The administrator and corporate nurse consultant identified seven residents who had weight loss. Findings: Resident #18 had diagnoses which included altered nutritional status. A nutrition assessment, dated 10/24/24, showed Resident #18 weighed 188.4 pounds. Review of the vital signs for Resident #18 showed their admit weight on 10/16/24 was 185 pounds and a weight on 03/03/25 was 166.6 pounds, which was greater than 10% in five months. A quarterly assessment, dated 01/21/25, showed no concern for nutrition and showed no weight loss in the past six months. A follow up nutrition note, dated 02/20/25, showed the resident weighed 159.9 pounds with no recommendations. A care plan, dated 03/12/25, showed a concern for diet which included a goal Resident #18 would maintain their weight over the next 90 days. The care plan showed interventions which included dietitian referral as indicated, assist with eating, encourage self-performance, monitor oral intake of food, and to monitor weight per policy. There were no physician visit notes or documentation the physician had been notified of the weight loss. On 03/12/25 at 1:48 p.m., Resident #18 stated their weight loss was not intentional, but they had been ill and was not eating. They stated no one had come to speak to them about their weight loss that they could remember. Resident #18 stated they weighed 157 pounds a couple of days ago. (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/25 at 2:14 p.m., the DON was asked how the weight loss was addressed. They reviewed their notes, checked in a binder, and stated nothing was in their notes. The DON was asked why the weight loss was not addressed. They stated they did not have an answer. They stated they were made aware of weights by reviewing a report after the weights were entered and go reviewed them monthly in a meeting with dietary present. The DON stated Resident #18 was weighed monthly and did show up on the weight report. They stated they should have known Resident #18 had a significant weight loss. On 03/12/25 at 2:24 p.m., the dietitian stated they received the weights from the facility's electronic clinical record. They stated there were no recommendations probably because they had requested a re-weigh.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 35474 Based on record review and interview, the facility failed to ensure a significant change assessment was completed within 14 days of electing the hospice benefit for 1 (#16) of 1 sampled resident who was reviewed for hospice services. The corporate regional nurse consultant and administrator identified 12 residents who received hospice services. Findings: Resident #16 had diagnoses which included dementia. The physician telephone order, dated 07/29/24, read in part, Admit to Hospice to eval and treat. The significant change assessment, dated 08/21/24, showed the resident had a condition or chronic disease that may result in a life expectancy of less than six months. On 03/12/25 at 1:38 p.m., corporate MDS coordinator #1 stated when a resident was admitted to hospice services a significant change assessment was to be completed within 14 days. They stated they would need to check on the significant change assessment for Resident #16. On 03/12/25 at 2:07 p.m., the DON reviewed the order for hospice services and the significant change assessment and stated the previous MDS coordinator had completed the assessment late.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on record review and interview, the facility failed to ensure assessments were accurate for 2 (#5 and #18) of 21 sampled residents whose assessments were reviewed. The administrator identified 96 residents who resided in the facility. Findings: 1. Resident #5 had diagnoses which included chronic obstructive pulmonary disease. The quarterly assessment, dated 01/21/25, showed the resident received an anticoagulant medication. Review of the medication administration record, dated January 2025, did not show the resident received an anticoagulant medication. On 03/06/25 at 3:48 p.m., the DON reviewed the January 2025 medication administration record and the quarterly assessment dated [DATE] and stated Resident #5 had not received an anticoagulant medication. The DON stated they did not know why the assessment was coded incorrectly. The DON stated the MDS coordinator who completed the assessment no longer worked at the facility. 41809 2. Resident #18 had diagnoses which included hypertension. Review of the clinical record showed on 10/16/24, Resident #18 weighed 185 pounds and on 01/03/25 the resident weighed 166.2 pounds, which was a 10.16% weight loss. The quarterly assessment, dated 01/21/25, did not show the resident had experienced a weight loss of 10% or more in the last 6 months. The assessment showed the resident's current weight was 166 pounds. On 03/12/25 at 2:30 p.m., corporate MDS coordinator #1 stated they did not know why the quarterly assessment had not been completed accurately to indicate the weight loss for Resident #18.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 35474 Based on record review and interview, the facility failed to ensure care plans were reviewed and revised after each assessment for 2 (#5 and #18) of 21 sampled residents whose care plans were reviewed. The administrator identified 96 residents who resided in the facility. Findings: 1. Resident #5 had diagnoses which included chronic obstructive pulmonary disease. The care plan showed the last review was completed on 09/11/24. Review of the clinical record showed a quarterly assessment had been completed on 01/21/25. On 03/12/25 at 2:05 p.m., corporate MDS coordinator #1 stated Resident #5's care plan was currently being reviewed and revised. They stated the last review was completed on 09/11/24. Corporate MDS Coordinator #1 stated care plans were to be reviewed after each assessment and as needed. They stated they did not know why Resident #5's care plan had not been reviewed since 09/11/24. 41809 2. Resident #18 had diagnoses which included depression. The care plan showed the last review was completed on 12/04/24. Review of the clinical record showed a quarterly assessment had been completed on 01/21/25. On 03/12/25 at 3:03 p.m., the MDS nurse stated the last care plan was reviewed 03/12/25. They stated the last one prior was 10/23/24. They stated a care plan review was not done in January and they could not answer to why.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35474 Based on record review and interview, the facility failed to ensure a physician order was obtained for an indwelling urinary catheter for 1 (#100) of 3 sampled residents who were reviewed for an indwelling urinary catheter. The corporate regional nurse consultant and the administrator identified five residents who had an indwelling urinary catheter. Findings: Resident #100 had diagnoses which included acute kidney failure. An admission assessment, dated 12/12/24, showed the resident had an indwelling urinary catheter. Review of the electronic clinical record showed the resident had received catheter care but did not show a physician order for the use of the indwelling urinary catheter. On 03/12/25 at 4:26 p.m., the DON stated Resident #100 was in the facility for approximately 10 days. They stated the admissions nurse, assistant director of nursing, or themselves entered physician orders upon admission and did not know why the order for the use of an indwelling urinary catheter had not been put into the electronic clinical record.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41809 Based on record review and interview, the facility failed to ensure significant weight loss was addressed for 1 (#18) of 2 sampled residents who were reviewed for nutrition. The administrator and corporate nurse consultant identified seven residents who had weight loss. Findings: Resident #18 had diagnoses which included depression, gastro-esophageal reflux disease, and altered nutritional status. A nutrition assessment, dated 10/24/24, showed Resident #18 weighed 188.4 pounds. Review of the vital signs for Resident #18 showed their admit weight on 10/16/24 was 185 pounds and a weight on 03/03/25 was 166.6 pounds, which was greater than 10% in five months. A quarterly assessment, dated 01/21/25, showed no concern for nutrition and showed no weight loss in the past six months. A follow up nutrition note, dated 02/20/25, showed Resident #18 weighed 159.9 pounds with no recommendations. A care plan, dated 03/12/25, showed a concern for diet which included a goal Resident #18 would maintain their weight over the next 90 days. The care plan showed interventions which included dietitian referral as indicated, assist with eating, encourage self-performance, monitor oral intake of food, and to monitor weight per policy. On 03/12/25 at 1:48 p.m., Resident #18 stated their weight loss was not intentional, but they had been ill and was not eating. They stated no one had come to speak to them about their weight loss that they could remember. Resident #18 stated they weighed 157 pounds a couple of days ago. On 03/12/25 at 2:14 p.m., the DON was asked how the weight loss was addressed. They reviewed their notes, checked in a binder, and stated nothing was in their notes. The DON was asked why the weight loss was not addressed. They stated they did not have an answer. They stated they were made aware of weights by reviewing a report after the weights were entered and reviewed them monthly in a meeting with dietary present. The DON stated Resident #18 was weighed monthly and did show up on the weight report. They stated they should have known Resident #18 had a significant weight loss. On 03/12/25 at 2:24 p.m., the dietitian stated there were no recommendations was probably because they had requested a re-weigh. They stated they received the weights from the facility's electronic clinical record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41809 Based on record review and interview, the facility failed to ensure monthly medication reviews were completed for 4 (#2, 16, 66, and #69)of 5 sampled residents who were reviewed for unnecessary medications. The administrator and corporate nurse consultant identified 96 residents who received medications. Findings: 1. Resident #2 had diagnoses which included depression. A Medication Monitoring Medication Regimen Review and Reporting policy, dated January 2024, read in part, The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated.The findings are communicated to the director of nursing or designee and the medical director. These findings are documented and filed with other consultant pharmacist recommendations in the resident's chart. The quarterly assessment, dated 02/28/25, showed the resident's cognition was moderately impaired with a BIMS of 11 and received an antipsychotic medication, an anticoagulant, and a hypoglycemic medication. Review of the electronic clinical record and pharmacist monthly medication regimen reviews for February 2024 through February 2025, provided by the DON, did not show a medication regimen review had been completed in April 2024 or December 2024. On 03/11/25 at 10:43 a.m., the April 2024 and December 2024 pharmacist medication regimen reviews, for Resident #2, were requested from the DON. 2. Resident #69 had diagnoses which included hypertension and diabetes. The annual assessment, dated 01/16/25, showed the resident's cognition was intact with a BIMS of 15 and received an antianxiety medication, an antidepressant medication, a potassium depleting diuretic, antihypertensives, and an antidiabetic medication. Review of the electronic record and pharmacist monthly medication regimen reviews from February 2024 through February 2025, provided by the DON, did not show a medication regimen review had been completed in February 2024, July 2024, November 2025, or February 2025. On 03/11/25 at 10:43 a.m., the missing medication regimen reviews, for Resident #69, were requested from the DON. 35474 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #16 had diagnoses which included dementia. The quarterly assessment, dated 02/21/25, showed the resident's cognition was severely impaired with a BIMS score of 00 and received an antianxiety medication, antidepressant medication, an opioid medication, an antiplatelet medication, and a hypoglycemic medication. Review of the electronic clinical record and pharmacist monthly medication regimen reviews from February 2024 through February 2025, provided by the DON, did not show a medication regimen review had been completed in April 2024 or August 2024. On 03/11/25 at 10:43 a.m., the April 2024 and August 2024 pharmacist medication regimen reviews, for Resident #16, were requested from the DON. 4. Resident #66 had diagnoses which included schizoaffective disorder. The annual assessment, dated 01/07/25, showed the resident received an antidepressant medication, hypnotic medication, anticoagulant medication, an antibiotic, a diuretic, an opioid, and a hypoglycemic medication. Review of the electronic clinical record and pharmacist monthly medication regimen reviews from February 2024 through February 2025, provided by the DON, did not show a medication regimen review had been completed in April 2024 or September 2024. On 03/11/25 at 10:43 a.m., the April 2024 and September 2024 pharmacist medication regimen reviews, for Resident #66, were requested from the DON. On 03/12/25 at 4:06 p.m., the consultant pharmacist stated they reviewed every residents medication regimen monthly and submitted them to the facility. On 03/12/25 at 4:29 p.m., the DON stated the consultant pharmacist reports were printed and addressed every month, including the medication regimen reviews. The DON stated they could not locate the requested medication regimen reviews.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 46703 Based on observation, record review, and interview, the facility failed to place call lights within reach for 1 (#36) of 1 sampled resident who was reviewed for call lights. The administrator reported 96 residents resided in the facility. Findings: On 03/05/25 at 9:04 a.m., the call light for Resident #36 was observed clipped to the fitted sheet and hanging down to the floor, out of the resident's reach. On 03/12/25 at 4:13 p.m., the call light for Resident #36 was observed clipped to the resident's blanket, hanging down to the floor, out of the resident's reach. A care plan, dated 12/04/25, showed a diagnosis of hemiplegia or hemiparesis. The care plan instructed staff to place the call light within the resident's reach. On 03/05/25 at 9:04 a.m., Resident #36 stated sometimes the call light was out of reach and they could not use it to get help when they needed to. They stated their roommate would use their call light. On 03/12/25 at 4:24 p.m., CNA #1 stated residents used their call light to get help from the staff and it was the responsibility of the staff to ensure the call light was within reach. They stated they did not know why it was not in the reach of Resident #36. On 03/12/25 at 4:29 p.m., LPN #2 stated residents used their call light to call for help and should be within reach. They stated it was the CNAs responsibility to ensure call lights were placed within reach of the resident. They stated it was ultimately the nurse's responsibility to ensure the resident could reach their call light. They stated the nurse should make rounds to determine if the call light was within reach.