

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER The Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 1165 South Brenner Road Sapulpa, OK 74066	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview, document review, and facility policy review, the facility failed to implement the interdisciplinary water management process described in their policy and failed to conduct a facility-specific risk assessment of its water system to identify vulnerabilities to water-borne pathogens. These deficient practices had the potential to affect all 65 residents who currently resided in the facility. Findings included: A facility policy titled, Legionella Water Management Program revised 07/2017, indicated, 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 2. The water management team will consist of at least the following personnel: a. The infection preventionist; b. The administrator; c. The medical director (or designee); d. The director of maintenance; and e. The director of environmental services. The policy specified, 5. The water management program included the following elements: a. An interdisciplinary water management team; b. Reviewing the areas of potential risk for Legionella including the following: 1) Receiving; 2) Cold water distribution; 3) Heating; 4) Hot water distribution; and 5) Waste. c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: 1) Storage tanks; 2) Water heaters; 3) Filters; 4) Aerators; 5) Showerheads and hoses; 6) Misters, atomizers, air washers and humidifiers; 7) Hot tubs; 8) Fountains; and 9) Medical devices such as CPAP [continuous positive airway pressure] machines, hydrotherapy equipment; etc. [et cetera, and the rest] d. The identification of situations that can lead to Legionella growth, such as: 1) Construction; 2) Water main breaks; 3) Changes in municipal water quality; 4) The presence of biofilm, scale or sediment; 5) Water temperature fluctuations; 6) Water pressure changes; 7) Waters stagnation and; 8) Inadequate disinfection. The facility Water Safety Audit dated 06/02/2026, revealed a general checklist of items to include water temperatures, flushing activities, plumbing review, aerosol-generating devices, and construction considerations. The audit did not identify facility-specific water system components, facility-specific risk areas, or vulnerabilities within the facility water system that could encourage the growth and spread of Legionella and other waterborne pathogens. The audit further did not describe the facility's water distribution system to include the receipt of incoming water, cold water distribution, heating, hot water distribution, or waste systems as identified in the facility policy. The facility Monthly Flushing of Inactive Plumbing Fixtures revealed a checklist of monthly flushes for Hall 100, Hall 200, Hall 300, Hall 400, the kitchen, outside faucets, common areas, drinking fountains, and flushed water heaters. The checklist indicated the staff conducted flushes but provided no other details for how the facility had identified where its water system was vulnerable to Legionella or other waterborne pathogens. During an interview on 07/17/2026 at 9:07 AM, the Environmental Services Director (ESD) stated every Tuesday she tested and flushed taps in the facility and inspected every hot water tank and every line, but did not document the weekly flushes. The ESD stated there was no documentation that she identified areas (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in the water system that could encourage the growth and spread of Legionella or other waterborne pathogens. The ESD stated she not able to explain how the facility water system worked. During an interview on 07/17/2026 at 9:43 AM, the ESD stated she could not verify the facility did anything to prevent Legionella or waterborne pathogens beyond flushing. During an interview on 07/17/2026 at 10:32 AM, the Infection Preventionist stated she had no involvement in the water management plan. During an interview on 07/17/2026 at 11:32 AM, the Director of Nursing stated she had no involvement in the water management plan, did not know about a facility-specific water system assessment, and did not know who was supposed to be on the water management team. During an interview on 07/17/2026 at 1:38 PM, the Administrator stated she could not speak to whether the facility had a risk assessment of its water system. Per the Administrator, her role in the water management team was to check the county report to see if there were any concerns in the municipal water supply.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) for 3 (Residents #9, #46, and #57) of 5 sampled residents reviewed for unnecessary medications. Findings included: A facility policy titled, Resident Assessment Instrument, revised 09/2010, indicated A comprehensive assessment of a resident's needs shall be made within fourteen days of the resident's admission. The policy specified, 7. All persons who have completed any portion of the MDS Resident Assessment Form MUST sign such document attesting to the accuracy of such information. 1. An admission Record revealed the facility admitted Resident #46 on 08/02/2024. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/17/2026, revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident received an antipsychotic medication during the last seven days of the assessment period. Resident #46's Order Recap Report for the timeframe 01/01/2026 - 07/31/2026, revealed no evidence of an order for an antipsychotic medication. During an interview on 07/17/2026 at 2:15 PM, the Director of Nursing (DON) stated she had been made aware of the MDS issue. The DON stated her expectation was that MDS assessments were completed accurately. 2. An admission Record revealed the facility admitted Resident #9 on 09/11/2017. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/30/2026, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident received an antipsychotic medication during the last seven days of the assessment period. Resident #9's Order Recap Report for the timeframe 01/01/2026 - 07/31/2026, revealed no evidence of an order for an antipsychotic medication. During an interview on 07/16/2026 at 3:07 PM, the Nurse Assessment Coordinator (NAC) reviewed Resident #9's physician orders and confirmed that Resident #9 did not receive an antipsychotic medication during the last seven days of the assessment period for the quarterly MDS, with an ARD of 04/30/2026. The NAC stated the coding of an antipsychotic medication for Resident #9 was a mistake. During an interview on 07/17/2026 at 1:46 PM, the Administrator stated she would expect MDS staff to code a resident's MDS assessments correctly. 3. An admission Record revealed the facility admitted Resident #57 on 10/01/2025. According to the admission Record, the resident had a medical history that included diagnoses of generalized anxiety disorder, cognitive communication deficit, and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/15/2026, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident received an antipsychotic medication during the last seven days of the assessment period. Resident #57's Order Recap Report for the timeframe 01/01/2026 - 07/31/2026, revealed no evidence of an order for an antipsychotic medication. During an interview on 07/16/2026 at 3:07 PM, the Nurse Assessment Coordinator (NAC) stated regarding Resident #57, she coded the use of the medication memantine (a medication used to treat dementia linked to Alzheimer's disease) as an antipsychotic medication on the resident's quarterly MDS, with an ARD of 04/15/2026. The NAC that was an error on her part as memantine was not an antipsychotic medication. During an interview on 07/16/2026 at 11:32 AM, the Director of Nursing stated memantine was not an antipsychotic and should not be coded as such on a resident's MDS. During an interview on 07/17/2026 at 1:46 PM, the Administrator stated she would expect MDS staff to code a resident's MDS assessments correctly.		

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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 interview, record review, document review, and facility policy review, the facility failed to timely report an allegation of abuse to the state agency for 1 (Resident #77) of 2 sampled residents reviewed for abuse. Findings included: A facility policy titled, Abuse Investigation and Reporting revised 07/2017, indicated, 2. An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury. An admission Record revealed the facility admitted Resident #77 on 09/01/2024. According to the admission Record, the resident had a medical history that included a diagnosis of dementia. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/24/2025, revealed Resident #77 had a Brief Interview for Mental Status score of 3, which indicated the resident had severe cognitive impairment. Resident #77's Progress Note authored by Licensed Practical Nurse (LPN) #1 and dated 12/16/2025 at 8:42 AM, indicated LPN #1 recorded that she would notify the resident's family of the statement made by the resident. An undated incident report form revealed on 12/16/2025 the facility reported to the state survey agency an allegation of abuse/mistreatment. Per the incident report form, a charge nurse was informed by a day shift certified nursing assistant (CNA) and hospice aide that resident stated they was raped. The incident report form further indicated, On 12/16/25 [Resident #77] informed day shift 6-2 CNA and Hospice Aide that [he/she] raped, Aides informed charge nurse. Nurse verified statement with [Resident #77]. Nurse contacted [name] PA-C [physician assistant-certified] to make aware of the statement, nurse was giving new orders for U.A. [urinalysis] and for psychiatrist to eval [evaluate] and treat. [Resident #77's] POA [power of attorney] was called and notified. According to the facsimile result report, the facility reported the allegation of abuse to the state survey agency on 12/16/2025 at 3:07 PM. During an interview on 07/15/2026 at 10:26 AM, the Administrator stated the facility reported allegations of abuse to the state survey agency within two hours. The Administrator stated she did not remember when she reported the allegation of abuse to the state survey agency regarding Resident #77. During an interview on 07/15/2026 at 10:54 AM, the Infection Preventionist stated the facility became aware of Resident #77's allegation of abuse on 12/16/2025 at approximately 9:00 AM. During an interview on 07/15/2026 at 11:32 AM, the Director of Nursing (DON) the facility should report allegations of the abuse to the state survey agency within two hours of becoming aware of the allegation. The DON states she was unsure why Resident #77's abuse allegation was reported late.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview, record review, and facility policy review, the facility failed to implement wound treatment when a resident was assessed to have shearing on their coccyx for 1 (Resident #76) of 2 sampled residents reviewed for pressure ulcer/injury. Findings included: A facility policy titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol revised 03/2014, revealed, 3. The staff will examine the skin of a new admission for ulcerations or alterations in skin. 4. The physician will assist the staff to determine etiology and characteristics of the skin alteration. The policy specified, 1. The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings, and application of topical agents if indicated for type of skin alteration. An admission Record revealed the facility admitted Resident #76 on 07/01/2024. According to the admission Record, the resident had a medical history that included diagnoses of obesity and hypertension. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (AR) of 06/25/2025, revealed Resident #76 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident was at risk of developed pressure ulcers/injuries, had moisture associated skin damage (MASD), but no unhealed pressure ulcers. Resident #76's Care Plan Report included a focus area initiated 08/01/2025 that indicated the resident had a pressure injury to their skin or a potential for pressure injury. Interventions directed staff to administer treatment as ordered and monitor effectiveness (initiated 08/01/2025). Resident #76's Skin/Wound Note dated 05/29/2025 at 12:35 PM, indicated the resident had no skin tears and no opened areas. Resident #76's admission Summary dated 06/19/2025, revealed Resident #76 returned from the hospital and had no opened areas, but shearing was noted on their coccyx that was red in color. Resident #76's Skin/Wound Note dated 06/26/2025 at 12:02 PM, indicated the resident had an opened area on their right buttock that measured 8 centimeters (cm) by 6 cm and connected to the left buttocks wound which measured 5.5 cm by 4.5 cm, and an opened area on the left center of their buttocks that measured 1 cm by 1 cm. The Skin/Wound Note indicated a treatment of zinc oxide was applied as ordered. Resident #76's medical record revealed no evidence of a wound treatment order for shearing noted on the resident's coccyx on 06/19/2025. During an interview on 07/16/2026 at 2:30 PM, Licensed Practical Nurse #1 stated she could not recall if the resident had a treatment in place for the shearing identified on 06/19/2025. During an interview on 07/17/2026 at 9:45 AM, the Infection Preventionist (IP) stated the facility would normally implement zinc oxide cream as a treatment for shearing, but the resident's physician should be notified of the skin concern because a physician's order would be needed for wound treatment. The IP reviewed Resident #76's medical record and confirmed that a wound treatment was not implemented when shearing was identified on the resident's coccyx on 06/19/2025. During an interview on 07/17/2026 at 10:32 AM, the Director of Nursing stated if skin conditions were identified, she would expect the nursing staff to contact the resident's physician because a wound treatment would require a physician's order. During an interview on 07/17/2026 at 11:33 AM, Nurse Practitioner #5 stated if a resident had shearing, there would normally be a treatment of zinc oxide or skin prep ordered. During an interview on 07/17/2026 at 1:49 PM, the Administrator stated she would expect the nursing staff to contact the resident's physician to obtain an order for treatment.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff cleaned and stored respiratory equipment after each use for 1 (Resident #28) of 21 sampled residents. Findings included: A facility policy titled, A1A6 Administering Medication through a Small Volume Nebulizer revised 10/2010, revealed, 27. Rinse and disinfect the nebulizer equipment according to facility protocol, or: a. Wash pieces with warm, soapy water; b. Rinse with hot water; c. OR may clean with disinfectant if rinsed afterward. e. Allow to air dry on a paper towel. 28. Wash and dry hands. 29. When equipment is completely dry, store it in a safe and sanitary manner. An admission Record revealed the facility admitted Resident #28 on 07/11/2025. According to the admission Record, the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/17/2026, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Resident #28's Order Summary Report with active orders as of 07/11/2025, revealed an order dated 07/11/2025, for levalbuterol hydrochloride inhalation nebulization solution 1.25 milligram per 0.5 milliliter, one vial inhale orally by way of a nebulizer three times a day for chronic obstructive pulmonary disease. During an observation on 07/13/2026 at 9:28 AM, Resident #28's nebulizer mask was noted not to be stored in a bag. During an interview on 07/14/2026 at 4:00 PM, Resident #28 stated the nurses had not cleaned their nebulizer. During a concurrent interview and observation on 07/14/2026 at 4:17 PM, the Director of Nursing (DON) confirmed Resident #28's nebulizer mask was not in a bag. The DON stated the nebulizer mask should have been cleaned, dried, and bagged after use. During an interview on 07/15/2026 at 11:50 AM, Licensed Practical Nurse #1 stated she administered Resident #28's nebulizer treatment and did not clean and bag the nebulizer mask after use. During an interview on 07/16/2026 at 4:00 PM, the Administrator stated she expected the nurse to clean the nebulizer after use and place it in a bag.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and facility policy review, the facility failed to post the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, post the total number and actual hours for registered nurses responsible for resident care per shift, and maintain a minimum of 18 months of nurse staffing data. These deficient practices had the potential to affect all 65 residents who currently resided in the facility. Findings included: A facility policy titled, Staffing revised 04/2007, indicated 5. Inquires or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee. During an observation on 07/16/2026 at 4:10 PM, the posted staffing information for the facility indicated the name of the facility, census, and the number of licensed nursing staff and certified nursing staff per shift directly responsible for resident care. The posted staffing information did not indicate the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift or the total number and actual hours for registered nurses responsible for resident care per shift. During an interview on 07/16/2026 at 4:16 PM, the Administrator stated the facility did not retain nurse staffing data. During an interview on 07/16/2026 at 4:24 PM, the Administrator stated she was responsible for posting the nurse staffing data and that she had never documented the actual hours worked by licensed and unlicensed staff on the form. During an interview on 07/16/2026 at 11:32 AM, the Director of Nursing stated she was not responsible for the posting of nurse staffing data and was not familiar with the expectation for the posting of nurse staffing data. During an interview on 07/16/2026 at 1:38 PM, the Administrator stated she was not aware of the requirement to post the actual hours worked by licensed and unlicensed staff or the requirement to maintain nurse staffing data for 18 months.		