

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Trinity Woods, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 4134 East 31st Street Tulsa, OK 74135	
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 observation, interview, facility policy review, and Centers for Disease Control and Prevention (CDC) and the National Institute for Occupational Safety and Health (NIOSH) guidance, the facility failed to ensure staff were fit tested for N95 respirator masks annually. Additionally, the facility failed to maintain sanitary technique and prevent contamination of medication for 4 (Resident #10, #26, #38, and #44) of 5 sampled residents observed for medication administration, when the nurse touched the medications with bare hands, and the facility failed to ensure equipment used for vital sign readings (measurements including body temperature, heart rate, respiratory rate, and blood pressure that indicate the status of the body's vital functions) among multiple residents was disinfected between residents' uses for 3 (Resident #10, #38 and #42) of 3 sampled residents observed for vital sign readings. Findings included: 1. A facility policy titled, COVID [coronavirus disease of 2019, COVID-19] Guidelines, dated 09/30/2024, in the section Personal Protective Equipment indicated, Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard. An undated publication by the Centers for Disease Control and Prevention (CDC) and the National Institute for Occupational Safety and Health (NIOSH) titled, Filtering Out Confusion: Frequently Asked Questions about Respiratory Protection, in the section How Often Must Fit Testing Be Conducted? indicated, In addition to fit testing upon initially selecting a model of respirator, OSHA requires that fit testing be conducted annually, and repeated ?whenever an employee reports, or the employer or the physician or other licensed health care professional makes visual observations of changes in the employee's physical condition that could affect respirator fit.' During an interview on 06/03/2026 at 10:51 AM, the Infection Preventionist (IP) stated she had been at the facility approximately 22 months, fit testing for N95 masks was done before she started her position, but she had not done fit testing for any of the staff. The IP stated the person certified to fit test staff for N95 masks was no longer with the facility. During an interview on 06/03/2026 at 11:07 AM, the Administrator (ADM) stated the facility had not fit tested for N95 masks since the current IP had been in the role. During an interview on 06/03/2026 at 2:02 PM, Licensed Practical Nurse (LPN) #5 stated she had been with the facility since October 2025, and she had not been fit tested for an N95 mask. During an interview on 06/03/2026 at 2:08 PM, Certified Medication Aide (CMA) #7 stated she had been with the facility for a year and a half, and she had not been fit tested for an N95 mask with the facility. During an interview on 06/03/2026 at 2:10 PM, Certified Nursing Assistant (CNA) #8 stated she had been with the facility 11 years, she thought she was last fit tested for an N95 mask three years ago, and she was certain she had not been fit tested for an N95 mask within the past year. During an interview on 06/03/2026 at 1:50 PM, the ADM stated they could not find a list of staff who had been fit tested for N95 masks. 2. A facility policy titled, Administering Medications, revised 01/2016, revealed, 14. Staff shall follow (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 375454	Facility ID: 375454 If continuation sheet Page 1 of 8

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	established facility infection control procedures (e.g. [exempli gratia, for example], hand washing, aseptic technique, gloves, isolation precautions, etc. [et cetera, and other similar things]) when these apply to administering medications. A. An admission Record revealed the facility admitted Resident #44 on 10/16/2023. According to the admission Record, the resident had a medical history that included diagnoses of major depressive disorder, overactive bladder, foot drop of the right foot, and osteoarthritis of the knee. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/10/2026, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. A Medication Administration Record [MAR], dated 06/2026, revealed Household Manager (HM) #6 administered Resident #44's morning medications on 06/03/2026, which included the following medications:- aspirin (a platelet aggregation inhibitor), one 325 milligrams (mg) tablet by mouth for deep vein thrombosis (DVT);- Lasix (furosemide, a diuretic), one 40 mg tablet by mouth for edema (swelling from excess fluid); - potassium chloride (a mineral, electrolyte), one Extended Release (ER) 10 milliequivalent tablet by mouth for the prevention of hypokalemia (low potassium) due to diuretics;- sertraline hydrochloride (Zoloft, an antidepressant), one 50 mg tablet for major depressive disorder;- Colace (docusate, a stool softener), one 100 mg capsule by mouth; and- Neurontin (gabapentin, an anticonvulsant for nerve pain), one 100 mg capsule by mouth. An observation of medication administration, on 06/03/2026 at 10:37 AM, revealed HM #6 prepared and administered medications to Resident #44. The observation revealed HM #6 removed Resident #44's oral medications from individual medication bottles and placed the medications into HM #6's ungloved left hand before putting the medications into a medication cup for administration. The observation revealed the medications that HM #6 administered to Resident #44 on 06/03/2026 at 10:37 AM included gabapentin, potassium chloride, furosemide, sertraline, aspirin, and docusate. B. An admission Record revealed the facility admitted Resident #26 on 04/02/2026. According to the admission Record, the resident had a medical history that included diagnoses of metabolic encephalopathy, traumatic subarachnoid hemorrhage with loss of consciousness, and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/20/2026, revealed Resident #26 had moderate impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a staff assessment of mental status (SAMS). A Medication Administration Record [MAR], dated 06/2026, revealed on 06/03/2026 Household Manager (HM) #6 administered Resident #26 one amantadine (an antiviral, antiparkinsonian agent) tablet orally for tremors. An observation of medication administration, on 06/03/2026 at 10:48 AM, revealed HM #6 prepared and administered amantadine to Resident #26. The observation revealed HM #6 removed Resident #26's amantadine tablet from a multi-dose medication packaging card into HM #6's ungloved left hand before placing the medication into a medication cup for administration. The observation revealed HM #6 then administered the amantadine to Resident #26. C. An admission Record revealed the facility admitted Resident #38 on 12/15/2025. According to the admission Record, the resident had a medical history that included diagnoses of vitamin deficiency and essential hypertension. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2026, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. A Medication Administration Record [MAR], dated 06/2026, revealed Household Manager (HM) #6 administered Resident #38's morning medications on 06/03/2026, which included one 5 milligram (mg) tablet of Norvasc (amlodipine, a calcium channel blocker to lower blood pressure) and a multivitamin/mineral tablet. An observation of medication administration, on 06/03/2026 at 11:00 AM, revealed HM #6 prepared and administered medication to Resident #38. The observation revealed HM #6 removed (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record, the resident had a medical history that included diagnoses of syncope and collapse, hypokalemia, atrial fibrillation, gastroesophageal reflux disease, vitamin deficiency, depression, anxiety disorder, essential hypertension, esophageal obstruction, constipation, age related osteoporosis, pain, unspecified dementia, and zygomatic (cheekbone) fracture right side. A discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/19/2026, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Resident #42's Order Summary Report, dated 06/04/2026, revealed an order that indicated vital signs were to be taken weekly on Sundays, started 06/03/2026. An observation, on 06/03/2026 at 9:37 AM, revealed Household Manager (HM) #6 obtained Resident #42's blood pressure, pulse, oxygen saturation, and temperature readings with a device used for multiple residents. The observation revealed HM #6 did not clean the multiuse device either before or after use. B. An admission Record revealed the facility admitted Resident #38 on 12/15/2025. According to the admission Record, the resident had a medical history that included diagnoses of vitamin deficiency and essential hypertension. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2026, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Resident #38's Order Summary Report, dated 06/04/2026, revealed an order that indicated vital signs were to be taken every shift, started 12/15/2026. An observation, on 06/03/2026 at 10:00 AM, revealed Household Manager (HM) #6 obtained Resident #38's blood pressure, pulse, oxygen saturation, and temperature reading with a device used for multiple residents. The observation revealed HM #6 did not clean the equipment either before or after use. C. An admission Record revealed the facility admitted Resident #10 on 02/27/2026. According to the admission Record, the resident had a medical history that included diagnoses of acute respiratory with hypoxia, acute bronchitis, constipation, vitamin deficiency, acute on chronic combined systolic and diastolic heart failure, other seasonal allergies, atrial fibrillation, and chronic kidney disease. A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/27/2026, revealed Resident #10 had severe impairment in cognitive skills for daily decision making and had a short-term and long-term memory problem per a staff assessment for mental status (SAMS). Resident #10's Order Summary Report, dated 06/04/2026, revealed an order that indicated vital signs were to be taken every shift, started 02/28/2026. During an observation, on 06/03/2026 at 10:20 AM, Household Manager (HM) #6 was observed to obtain Resident #10's blood pressure, pulse, oxygen saturation, and temperature readings with a device used for multiple residents. The observation revealed HM #6 was not observed to clean the equipment either before or after use. During an interview on 06/03/2026 at 12:46 PM, HM #6 stated she had been trained to disinfect the vital sign equipment between residents. HM #6 stated she should have disinfected the vital-sign equipment between each resident but did not think about it at the time. During an interview on 06/04/2026 at 1:12 PM, the Infection Preventionist (IP) stated staff were educated to disinfect vital sign equipment between each resident use, and HM #6 should have disinfected the equipment between residents. During an interview on 06/04/2026 at 10:34 AM, the Director of Nursing (DON) stated HM #6 should have disinfected the vital sign equipment between each resident.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview, record review, and facility policy review, the facility failed to notify a physician when a resident's vital signs were outside physician-ordered parameters for 1 (Resident #13) of 17 sampled residents. Specifically, a Physician wrote an order to be notified when Resident #13's systolic blood pressure (SBP) was above 160 millimeters of mercury (mm/Hg). The facility measured 35 blood pressure readings from 05/10/2026 through 05/31/2026 that were above 160 mm/Hg for Resident #13 that were not reported to the Physician. Findings included: A facility policy titled, Blood Pressure, Measuring, revised 01/2016, indicated, 4. Hypertension is defined as blood pressure over 140/90 mm/Hg (although the elderly often have persistent systolic readings from 140 to 160 mm/Hg [sic]. 5. Hypertension should be reported to the physician. An admission Record revealed the facility admitted Resident #13 on 05/04/2026. According to the admission Record, the resident had a medical history that included a diagnosis of essential hypertension. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/10/2026, revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Resident #13's Care Plan Report, included a problem statement dated 05/14/2026, that indicated the resident had hypertension. Interventions directed staff to notify the doctor if the SBP was over 160 mm/Hg. Resident #13's Order Summary Report, for active orders as of 06/02/2026, included an order dated 05/04/2026 to notify the physician if systolic blood pressure was above 160 mm/Hg. Resident #13's Weights and Vitals Summary for the timeframe from 05/04/2026 through 06/04/2026 included the following blood pressures: 162/68 mm/Hg on 05/10/2026 at 08:09 PM 173/68 mm/Hg on 05/14/2026 at 8:24 AM 166/72 mm/Hg on 05/14/2026 at 10:41 PM 168/64 mm/Hg on 05/15/2026 at 8:09 AM 168/64 mm/Hg on 05/15/2026 at 3:36 PM 165/74 mm/Hg on 05/16/2026 at 8:09 AM 165/74 mm/Hg on 05/16/2026 at 8:10 AM 165/74 mm/Hg on 05/16/2026 at 6:16 PM 162/68 mm/Hg on 05/16/2026 at 8:37 PM 170/68 mm/Hg on 05/17/2026 at 8:44 AM 170/68 mm/Hg on 05/17/2026 at 8:45 AM 170/68 mm/Hg on 05/17/2026 at 11:42 AM 163/71 mm/Hg on 05/17/2026 at 9:07 PM 169/68 mm/Hg on 05/18/2026 at 9:56 AM 169/68 mm/Hg on 05/18/2026 at 9:57 AM 169/68 mm/Hg on 05/18/2026 at 9:58 AM 167/67 mm/Hg on 05/20/2026 at 7:55 AM 167/61 mm/Hg on 05/21/2026 at 8:10 AM 197/84 mm/Hg on 05/22/2026 at 8:08 AM 163/72 mm/Hg on 05/23/2026 at 9:37 PM 174/70 mm/Hg on 05/24/2026 at 9:08 PM 174/70 mm/Hg on 05/24/2026 at 9:09 PM 162/79 mm/Hg on 05/24/2026 at 9:48 PM 169/69 mm/Hg on 05/25/2026 at 11:33 AM 169/69 mm/Hg on 05/25/2026 at 11:34 AM 169/79 mm/Hg on 05/26/2026 at 8:44 AM 169/79 mm/Hg on 05/26/2026 at 8:45 AM 169/79 mm/Hg on 05/26/2026 at 8:46 AM 166/64 mm/Hg on 05/29/2026 at 7:57 AM 166/64 mm/Hg on 05/29/2026 at 5:10 PM 185/82 mm/Hg on 05/30/2026 at 8:13 AM 185/82 mm/Hg on 05/30/2026 at 1:57 PM 162/74 mm/Hg on 05/30/2026 at 9:47 PM 162/74 mm/Hg on 05/31/2026 at 8:50 AM 162/74 mm/Hg on 05/31/2026 at 8:51 AM During an interview on 06/02/2026 at 2:24 PM, Certified Medication Aide (CMA) #2 stated CMAs gathered vital signs and verbally told the nurse if they were elevated, but that was not documented. She stated that she had collected Resident #13's vital signs, which had been high, but not high enough to report to the nurse. She stated that if there was a threshold for reporting Resident #13's elevated blood pressure, it had not been communicated to the CMAs. During a telephone interview on 06/02/2026 at 3:31 PM, Registered Nurse (RN) #3 stated that nurses notified the physician when Resident #13's SBP was above 160 mm/Hg. RN #3 stated that they also documented the notification, but she was not sure if she had documented her notifications to the physician. During an interview on 06/03/2026 at 8:54 AM, Licensed Practicing Nurse (LPN) #4 stated the medication administration record (MAR) indicated if a vital sign needed to be reported to the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician and staff notified the physician via an encrypted messaging application. LPN #4 stated that the CMAs took the resident's vital signs before administering medications. LPN #4 stated the reporting thresholds were in the MAR. She stated that CMAs should report anything out of clinical range. During an interview on 06/03/2026 at 12:22 PM, the Medical Director stated that the nurses used a Health Insurance Portability and Accountability Act (HIPAA) compliant communication system to report elevated vital signs. He stated that he reviewed his communications for Resident #13 and found no indication of elevated blood pressures. He stated he was not aware of the abnormal blood pressures, and he would expect staff to notify him of blood pressures outside the physician-ordered parameters. During an interview on 06/04/2026 at 9:49 AM, the Director of Nursing (DON) stated that when vital signs were outside of physician-ordered parameters, they were reported via the facility's encrypted communication system to the physician. The DON stated that when a vital sign was outside the parameter, it created an alert. The DON stated that nursing staff used that alert to document the physician notification. During an interview on 06/04/2026 at 10:16 AM, the Administrator stated vital signs outside the physician-ordered parameters were communicated to the physician via the facility's encrypted communication system. The Administrator stated that if staff had to report to the physician, they should know what the thresholds were.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview, record review, facility document review, and facility policy review, the facility failed to implement a pharmacy recommendation for discontinuation of an antidepressant medication for 1 (Resident #5) of 5 residents reviewed for unnecessary medications. Specifically, the pharmacist recommended to review Resident #5's sertraline 12.5 milligrams (mg) via peg-tube once daily (QD) for depression. The Medical Director (MD) agreed with the recommendation to discontinue the medication, and the facility failed to follow the order to discontinue it. Findings included: A facility policy titled, Medication Utilization and Prescribing Clinical Protocol, reviewed January 2016, revealed, The Physician, Consultant Pharmacist and staff will adjust existing medications based on their efficacy and the continued presence of relevant conditions and risks. Resident #5's admission Record, indicated the facility admitted the resident on 05/22/2022. According to the admission Record, the resident had a medical history that included diagnoses of aphasia (loss of speech due to an injury to the brain), gastrostomy status (a surgical incision into the stomach to allow placement of a tube for food and nutrition), and other recurrent depressive disorders (at least two major depressive episodes with periods of no depression in between them). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/2026, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Per the MDS, Resident #5 received antidepressant medication during the assessment's seven-day lookback period. Resident #5's Care Plan Report included a focus area, revised 10/13/2025, that indicated the residents had prescribed antidepressant medication to treat depression. Interventions directed staff to monitor for medication side effects. The care plan further indicated that the last gradual dose reduction (GDR) for the antidepressant medications was on 05/01/2023. Resident #5's Order Summary Report for active orders as of 06/02/2026, included an order dated 09/02/2025, for sertraline (an antidepressant) 12.5 mg via peg-tube (percutaneous endoscopic gastrostomy tube - a tube inserted into the stomach to provide nutrition and medications for people who have trouble with swallowing) QD (quaque die, once daily), PO (per os, by mouth) for depression. Resident #5's Note to Attending Physician/Prescriber, dated 11/26/2025, indicated, Please review the following psychotropic medication for [Resident #5]: Sertraline 12.5 mg via peg-tube once daily for depression. Is the medication still needed at this time or is a trial of discontinuance an option? The physician agreed and indicated, ok to [discontinue] [after] [1 tablet] every other day (QOD) [quaque altera die, every other day] x 7 days, and signed it on 12/15/2025. Resident #5's May 2026 Treatment Administration Record (TAR) contained an order dated 09/02/2025 for sertraline 12.5 mg via peg-tube QD for depression. Resident #5 was administered the medication for 29 of the 31 days in the month. Resident #5's June 2026 TAR contained an order dated 09/02/2025 for sertraline 12.5 mg via peg-tube QD for depression. Resident #5 was administered the medication daily. During an interview on 06/03/2026 at 9:02 AM, the Pharmacy Consultant stated he reviewed all residents' medications monthly and gave recommendations to the facility. Per the Pharmacy Consultant, the Medical Director (MD) then gave orders based on his recommendations and was unsure why Resident #5's recommendation to discontinue the sertraline was not implemented. He stated there was no follow-up done to remove the order from the computer by the facility, thus the medication continued to be provided to the nursing staff for administration. During an interview on 06/03/2026 at 12:24 PM, the MD stated he received the pharmacy recommendations related to each resident's medication regimen monthly, responded to the recommendations, and returned them to the facility. The Physician further (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated if he wrote an order in his response to the recommendation, he expected the facility to follow that order. During an interview on 06/03/2026 at 2:50 PM, Household Manager (HM) #1 stated that the unit managers were responsible for updating the orders, and that the recommendation to discontinue Resident #5's sertraline should have been implemented and was unsure as to why it was not followed. During an interview on 06/04/2026 at 8:32 AM, the Director of Nursing (DON) stated that the pharmacy consultant made recommendations and the MD responded to them monthly. The DON further stated that based on the MD's responses, the HM's implemented any new orders, and the DON did not know why Resident #5's sertraline was not discontinued when the MD gave the order to discontinue it in December 2025. During an interview on 06/04/2026 at 10:22 AM, the Administrator stated she expected the pharmacy recommendations to be followed up on, and any new physician orders should be implemented when written.		