STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375460	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montereau, Inc.	6800 South Granite Avenue Tulsa, OK 74136

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 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 record review and interview, the facility failed to ensure appointments were scheduled for a resident for 1 (#1) of 3 sampled residents reviewed for appointments.The DON identified 46 residents resided in the facility.Findings:An admission assessment, dated 08/10/25, showed Resident #1 had a diagnosis of heart failure and a BIMS score of 15 which indicated the resident was cognitively intact for daily decision making.A progress note, dated 08/13/25 at 11:13 p.m., showed Resident #1 had a nosebleed and was sent to the emergency room for evaluation and treatment.Hospital discharge paperwork, dated 08/13/25, showed Resident #1 was evaluated in the emergency room for a nosebleed. The hospital discharge paperwork, read in part, Follow-up with ENT for further evaluation of your recurrent nosebleeds. The hospital discharge paperwork showed Resident #1 was to follow-up with an ENT physician within five to seven days. A progress note, dated 08/14/25 at 2:47 a.m., showed Resident #1 had returned to the facility from the hospital.Review of the clinical record for Resident #1 and the facility appointment log, dated 08/01/25 through 08/29/25, did not show a follow-up appointment with an ENT physician had been scheduled for Resident #1. On 10/29/25 at 12:34 p.m., Resident #1 stated they had not been notified they had been scheduled or attended an ENT physician appointment during their stay at the facility. Resident #1 stated they had discharged from the facility on 08/26/25.On 10/29/25 at 1:12 p.m., ADON #1 stated they were responsible to schedule appointments for the residents. They stated they reviewed hospital records to obtain the appointments/referrals needed. ADON #1 stated Resident #1 had attended a cardiology appointment during their stay at the facility and upon discharge was scheduled an appointment with their primary care physician. They stated they would review the clinical record regarding other appointments/referrals for Resident #1.On 10/30/25 at 1:23 p.m., ADON #1 stated they had reviewed the clinical record and the hospital record for Resident #1. ADON #1 stated they had not identified at the time of readmission to the facility, from the emergency room visit on 08/13/25, Resident #1 required an appointment/referral for a follow-up appointment with an ENT physician. On 10/31/25 at 3:30 p.m., the DON stated ADON #1 was responsible to schedule appointments for the residents. The DON stated they did not know if monitoring was in place to ensure appointments and referrals were scheduled for the residents. The DON stated they did not know why Resident #1 had not been scheduled a follow-up appointment with an ENT physician.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 record review and interview, the facility failed to ensure nutritional supplements were implemented for the treatment of pressure ulcers for 1 (#3) of 2 sampled residents reviewed for nutritional supplements. The DON identified 20 residents received nutritional supplements. Findings:An admission assessment, dated 10/11/25, showed Resident #3 had a BIMS of 03, which indicated they were severely cognitively impaired for daily decision making. The assessment showed Resident #3 had diagnoses which included coronary artery disease, hypertension, and Alzheimer's disease.A Comprehensive Nutrition Assessment, dated 10/13/25, showed Resident #3 had an increased protein need related to physiological changes as evidenced by the presence of a stage three pressure ulcer to the coccyx. The assessment showed an intervention to add liquid protein twice a day to optimize protein intake.A physician's order for Resident #3, dated 10/13/25, showed to give one packet of active liquid protein by mouth two times a day for wound, in order to optimize protein intake for wound healing. An October 2025 medication/treatment administration record for Resident #3 showed the active liquid protein was not administered eight out of 30 opportunities. The active liquid protein was not administered on 10/15/25 and 10/16/25 at 7:00 a.m., 10/18/25 at 7:00 a.m. and 7:00 p.m., 10/19/25 at 7:00 a.m., 10/20/25 at 7:00 a.m. and 7:00 p.m., and 10/22/25 at 7:00 a.m. An Orders - Administration Note, dated 10/15/25 at 8:08 a.m., showed no reason for the active liquid protein to not be administered.An Orders - Administration Note, dated 10/16/25 at 9:57 a.m., showed the reason for active liquid protein to not be administered as awaiting dose from pharmacy and not available.An Orders - Administration Note, dated 10/18/25 at 9:05 a.m., showed the active liquid protein was not administered because they had asked the nurse and the nurse did not know what it was.An Orders - Administration Note, dated 10/18/25 at 7:32 p.m., showed the active liquid protein was not administered due to being on order.An Orders - Administration Note, dated 10/19/25 at 9:48 a.m., showed the active liquid protein was not administered due to on hold, medication reorder.An Orders - Administration Note, dated 10/20/25 at 12:19 p.m., showed the active liquid protein was not administered due to drug on order.An Orders - Administration Note, dated 10/20/25 at 7:28 p.m., showed the active liquid protein was not administered due to waiting on pharmacy.An Orders - Administration Note, dated 10/22/25 at 7:46 a.m., showed the active liquid protein was not administered but did not provide a reason.On 10/31/25 at 10:55 a.m., LPN #5 stated medications were ordered through the electronic clinical record. They stated once the medication was ordered they would receive a message with when to expect delivery. LPN #5 showed the electronic record which displayed the medication was received on 10/21/25, but also showed the medication was re-ordered the same day. They stated if a medication was not available to administer, they were to notify the physician. LPN #5 stated if a medication was ordered one time a day the medication would be administered when it arrived, but if it were ordered more than one time a day, the first dose may be held due to not being available.On 10/31/25 at 4:34 p.m., ADON #1 stated the dietician ordered the liquid protein and it should be house stock. They stated they did not know why the active liquid protein was not administered. ADON #1 stated the nurse was responsible to ensure medication was ordered and administered.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide sufficient staff to answer call lights in a timely manner for 1 (#1) of 3 sampled residents reviewed for call light response.The DON identified 46 residents resided at the facility. Findings:Review of the Alarms by Room report, dated 08/07/25 through 08/25/25, for Resident #1, showed:a. on 08/07/25 at 4:11 p.m., call light initiated on bed for 1 hour 19 minutes 18 seconds;b. on 08/07/25 at 4:33 p.m., call light initiated on bath for 30 minutes 46 seconds; c. on 08/07/25 at 5:06 p.m., bath call light initiated on for 27 minutes 8 seconds;d. on 08/08/25 at 5:11 a.m., call light initiated on bed for 1 hour 6 minutes 12 seconds; e. on 08/12/25 at 12:35 a.m., bed call light initiated on for 59 minutes 54 seconds; f. on 08/15/25 at 8:09 a.m., bed call light initiated on for 38 minutes 30 seconds; g. on 08/20/25 at 5:24 p.m., bed call light initiated on for 45 minutes 6 seconds; h. 08/21/25 call log until 6:00 p.m., showed call light times up to 23 minutes;i. 08/22/25 at 5:50 p.m., bed call light initiated on 27 minutes 13 seconds; andj. 08/25/25 at 3:16 p.m., bed call light initiated on for 3 hour 15 minutes 17 seconds.A progress note, dated 08/08/25 at 12:38 p.m., showed Resident #1 called out for help from their room. The note showed Resident #1 was observed on the floor in the bathroom, on their knees, with their pants around their ankles. The note showed Resident #1 stated, I pulled the call bell for 45 minutes; I've been calling, and no one came; I did not fall; I slid down off the toilet. The note showed Resident #1 was assessed for injury and assisted to their wheelchair with two staff, vitals checked, the medical doctor, DON, and family notified. The note showed neurological checks were initiated. An admission assessment, dated 08/10/25, showed Resident #1 admitted on [DATE] with a BIMS of 15 which indicated they were cognitively intact for daily decision making. The assessment showed diagnoses which included heart failure, hypertension, and renal insufficiency. The assessment showed Resident #1 required setup assistance for eating, partial to moderate assistance with oral care, substantial to maximum assistance with shower/bath, transfers, hygiene, and lower body dressing. The assessment showed Resident #1 was dependent for bed to chair transfers and walking. A progress note, dated 08/21/25, showed Resident #1 had complained their call light was not answered promptly. The note showed Resident #1 stated the call light wait time was between 40 and 45 minutes. The note showed when the record of call light response times was reviewed, it was discovered response times were 45 seconds to 6 minutes. On 10/29/25 at 12:25 p.m., Resident #1 stated care by the CNAs was pretty good, but they had told the DON they should have gotten better care because several times at night, they had to call the security desk to get someone to answer their call light because it would take 15 to 30 minutes. They stated they were lucid and knew what was going on. Resident #1 stated they were on furosemide (diuretic) so when they had to go to the restroom, they had to go right away, but was a fall risk and was not supposed to go by themself to the bathroom. They stated staff would not come to help them get off the toilet. Resident #1 stated one time they slid down off the toilet and crawled toward the door after sitting on the toilet at least 30 minutes, maybe a little longer. They stated staff said they had fell, but they did not. They stated they had intentionally gotten on the floor.On 10/30/25 at 10:22 a.m., the DON stated most of the time call lights were responded to promptly. They stated residents did not hear the light in their room, it was silent, so time could get away from them. The DON stated is was not always accurate what their perception of time and the real time was. On 10/30/25 at 12:46 p.m., the DON stated they had reviewed the call light response time on 08/21/25. They stated Ack time was the time a call light was acknowledged on the iPad then staff have to click it off in the room. The DON reviewed the call light log for 08/21/25 and stated they were not sure what Resident #1 wanted, but there were a lot of call light punches. They stated they could not tell when the CNA came in or if they forgot to turn off the light and acknowledge the light. The DON stated Resident #1 was close to the nurses' station and they could hear Resident #1 if they were calling out. They stated they thought in the morning could have been a time when staff were rounding and busy with other things, they may have forgotten.On 10/30/25 at 2:09 p.m., LPN #1 stated Resident #1 stated they did not fall and they crawled to the door. LPN #1 stated they did not ask the CNAs if they had checked on Resident #1 or when Resident #1 was last checked on, it was during mealtime. They stated the expected call light response time was eight minutes. On 10/31/25 at 10:27 a.m., ADON #1 stated residents would complain about not answering the call lights timely. They stated they felt they were answered in a timely manner, during mealtime it could be longer, but 10 to 15 minutes was timely. On 10/31/25 at 10:58 a.m., CNA #1 stated two minutes was the expected call light response time. They stated the call lights showed if it is a bed cord or

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure medications were administered at the ordered time for 1 (#1) of 3 sampled residents reviewed for medication administration.The DON identified 46 residents received medications in the facility. Findings:An undated Medication Administration policy, read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.Ensure that the six rights of medication administration are followed .e. Right time .Example guidelines for Medication Administration (unless otherwise ordered by physician), this list is not all-inclusive .Medication timing .BID 7am-11am, 7pm-11pmAn admission assessment, dated 08/10/25, showed Resident #1 had a BIMS of 15 which indicated they were cognitively intact for daily decision making. The assessment showed diagnoses which included heart failure, hypertension, and renal insufficiency.A physician's order, dated 08/18/25, showed to administer Lasix (a diuretic medication) 60 mg BID at 7:00 a.m. and 2:00 p.m. for edema.A care plan, dated 08/19/25, showed a focus for diuretic therapy with interventions which included to administer diuretic medications as ordered by physician.A Medication Admin [administration] Audit Report, dated 08/01/25 to 08/31/25, showed on 08/19/25 Lasix 60 mg two times a day was to be administered at 7:00 a.m. and was administered at 7:35 a. m. A physician's order, dated 08/19/25, showed to administer Lasix 40 mg twice a day at 7:00 a.m. and 2:00 p.m. for edema.A Medication Admin Audit Report, dated 08/01/25 to 08/31/25, showed Lasix 40 mg was ordered to be administered at 7:00 a.m. The audit report showed four doses which were not administered at the ordered time:a. on 08/20/25 Lasix 40 mg was administered at 9:18 a.m.;b. on 08/21/25 Lasix 40 mg was administered at 11:35 a.m.;c. on 08/24/25 Lasix 40 mg was administered at 8:59 a.m.; and d. on 08/25/25 Lasix 40 mg was administered at 8:26 a.m. On 10/30/25 at 2:06 p.m., LPN #1 stated if the medication were ordered at a set time, they had an hour before and an hour after to administer the medication. They stated in the morning Resident #1 wanted their Lasix early, but one day they wanted it a little later. LPN #1 stated they might have charted later on some after they administered the Lasix. They stated they did not know why some were past the ordered time.On 10/31/25 at 3:34 p.m., the DON stated the protocol for the timeframe of administration if a medication was ordered at a specific time was an hour before and an hour after the ordered time. They stated the nurse should let them know if medications were administered late.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure medications were secured for 2 (first floor North treatment cart #2 and second floor South treatment cart #2) of 2 treatment carts observed to be unlocked and unattended.The DON identified six treatment carts and six medication carts in the facility. Findings: 1.On 10/27/25 at 1:57 p.m., in the chateau on the second floor, the South treatment cart #2 was observed to be unlocked next to the nursing station. Three staff were observed to be behind the nurses' station and one staff was observed to be in front of the nurses' station. On 10/27/25 at 1:59 p.m., two staff were observed to be behind the nurses' station and the one staff in the front of the nursing station left. One staff remained behind the nurses' station, talking with a contracted provider. On 10/27/25 at 2:01 p.m., LPN #2 was observed behind the nurses' station, talking to a nursing student then left the nurses' station. The unlocked cart was unattended. The cart contained the following: a. Hysept solution, read in part, keep out of reach of children (topical antiseptic);b. insulin;c. ipratropium nasal spray (used to treat runny noses);d. Narcan (an opioid antagonist);e. triad wound cleaner; f. lidocaine patches (used to relieve pain);g. iodine (an antiseptic);h. silver gel (an antimicrobial); [NAME]. Sani-cloths (disinfectant wipes). On 10/27/25 at 2:03 p.m., LPN #2 returned to the nurses' station. On 10/27/25 at 2:05 p.m., LPN #2 stated the cart was a treatment cart. They stated the key was kept under the trash bags in the open compartment on the side of the cart. LPN #2 stated medications were on the treatment cart. They stated the protocol for the cart was to ensure they were locked and did not have an answer for why the cart was unlocked and unattended. They stated they left the keys in the side compartment for easy access to the cart. LPN #2 did not lock cart and walked away from the cart, leaving out of eyesight.On 10/27/25 at 2:14 p.m., LPN #3 walked by the unlocked cart and locked the cart and stated to LPN #2 to Keep that cart locked.On 10/27/25 at 2:54 p.m., LPN #3 stated the carts were to be locked at all times and the keys kept on the nurse. On 10/27/25 at 2:25 p.m., the DON stated if the cart were out of sight, the cart should have been locked, and the keys should be kept out of sight. They stated it was best policy to keep the keys on them. The DON stated they monitored to ensure the carts were locked by completing rounds. 2. On 10/28/25 at 1:59 p.m., the first floor North treatment cart #2 was observed to be unlocked. The cart was around the corner from the nurses' desk with the lock facing away from the desk. On 10/28/25 at 2:05 p.m., the DON was observed to walk past the cart going down the hall and stopped to speak to the nurse at the desk. The DON did not acknowledge the unlocked cart. A CNA stopped at the cart and obtained some gloves off the top of the cart and entered into a resident's room. On 10/28/25 at 2:07 p.m. , LPN #4 was observed to leave the nurses' station and enter into the documentation room. On 10/28/25 at 2:07 p.m., LPN #1 was stopped and stated the cart was the first floor North treatment cart and should not be left unlocked and unattended. They stated they forgot to lock the cart.On 10/27/25 at 2:25 p.m., the DON stated if the cart were out of sight, the cart should have been locked, and the keys should be kept of sight. They stated it was best policy for the nurses to keep the keys on them. The DON stated they monitored to ensure the carts were locked by completing rounds.