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	04/07/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview, the facility failed to ensure a care plan was developed to address immediate needs of residents for 2 (#1 and #48) of 8 sampled residents reviewed for care plans.The administrator identified 56 residents resided in the facility.Findings:1.On 03/30/26 at 2:20 p.m., Resident #1 was observed in a wheelchair in their room with a urinary catheter in place.A physician order for Resident #1, dated 02/27/26, showed to admit the resident to the SNF.A physician order for Resident #1, dated 02/27/26, showed the resident had an order for apixiban (an anticoagulant) 5 mg every morning and at bedtime.An admission assessment for Resident #1, dated 03/05/26, showed the resident had medical diagnoses including atrial fibrillation and heart failure. The assessment showed Resident #1 had an indwelling urinary catheter and they were on anticoagulant therapy.A care plan for Resident #1, revised 03/15/26, showed focus areas for anticoagulant therapy and catheter use, but did not show interventions for those areas.On 04/02/26 at 2:10 p.m., the ADON stated the care plan for Resident #1 should have interventions for anticoagulant therapy and urinary catheter care, including EBP.2. A physician order for Resident #48, dated 03/11/26, showed to admit the resident to the SNF.A physician order for Resident #48, dated 03/11/26, showed to obtain weights daily.A physician order for Resident #48, dated 03/13/26, showed Lasix (a diuretic) 20 mg every 48 hours as needed for shortness of breath.An admission assessment for Resident #48, dated 03/15/26, showed the resident had medical diagnoses including pneumonia, atrial fibrillation, heart failure, and urinary tract infection in last 30 days.A physician order for Resident #48, dated 03/17/26, showed EBP for multidrug-resistant organisms of the urine.A medication administration record for Resident #48, dated 03/2026, showed Lasix was administered, in addition to regular doses, on 03/15/26, 03/22/26, 03/26/26, and 03/31/26 for shortness of breath.A care plan for Resident #48, dated 03/12/26, showed focus areas for malnutrition and potential impairment to skin integrity.On 04/02/26 at 2:15 p.m., the ADON stated the care plan for Resident #48 should have goals and interventions, including the admission diagnosis of pneumonia and EBP.

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
	375460	A. Building B. Wing	04/07/2026

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

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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 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 according to physician orders for 1 (#56) of 1 sampled resident reviewed for timely administration of medications. The administrator identified 56 residents resided in the facility. Findings: An admission record for Resident #56, dated 08/07/24, showed the resident had diagnoses which included dementia, restless leg syndrome, and anxiety.Physician orders for Resident #56, dated 08/09/24, showed to administer the following: a. ropinirole (dopamine agonist) 2 mg, give one tablet by mouth at bedtime andb. ropinirole 1 mg, give one tablet by mouth two times a day. A policy titled Medication Reordering, revised 2025, read in part, each time a nurse is administering medications and observes a seven day supply or less, that nurse will reorder the medication, time permitting.A Medication Record for Resident #56, dated December 2025, showed missed doses for the following:a. ropinirole 1 mg on 12/17/25 at 3:00 p.m., because the medication was on order and awaiting delivery andb. ropinirole 1 mg on 12/25/25 at 7:00 a.m., because the medication was on order and awaiting delivery. A quarterly assessment for Resident #56, dated 02/06/26, showed the resident had a brief interview for mental status score of 10 which indicated the resident was moderately impaired in cognition. On 04/07/26 at 10:23 a.m., CMA #1 stated medication should be reordered when seven doses of medication were left. CMA #1 stated if the medication was not delivered when expected the pharmacy should be called. On 04/07/26 at 10:45 a.m., LPN #2 stated they should order medication when there was a one-week supply left. LPN #2 stated If the mediation did not arrive when expected they called the pharmacy and they would deliver it the same day. On 04/07/26 at 11:10 a.m., the ADON stated medications should be reordered when there is a one-week supply left. The ADON stated If it was ordered by 4:00 p.m., the medication would be delivered the same day. The ADON stated if the medication was ordered after 4:00 p.m., it would arrive with the morning delivery the next day. They stated If the medication did not arrive when expected the CMA or the nurse should call the pharmacy.