STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375465	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor Nursing Home	1815 East Skelly Drive Tulsa, OK 74105

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30267 Based on observation, record review, and interview, the facility failed to protect a resident from abuse for one (#1) of six sampled residents whose clinical records were reviewed for abuse. The Resident Listing Report, dated 10/24/24, documented 54 residents. Findings: Resident #1 had diagnoses which included dementia, psychotic disturbance, mood disturbance, and anxiety. The quarterly assessment, dated 07/17/24, documented the resident was cognitively intact, exhibited no behaviors, required supervision or touch assistance for activities of daily living, and required supervision or touch assistance for ambulation. The care plan, revised 10/08/24, documented the resident had the potential to demonstrate verbally abusive behaviors related to poor impulse control. The care plan, read in part, when I become agitated, intervene before verbal agitation escalates. Guide me away from [the] source of distress. Engage [me] calmly in conversation. If response is aggressive walk away, [sic] and approach later. A hand written statement from CMA #1, dated 10/18/24, documented on 10/18/24 at around 7:00 p.m., they attempted to administer the Resident #1's evening medications. The resident asked for them to return later because the evening meal was served late and they were still eating. The CMA documented the resident complained the food was served late and did not taste good. The CMA documented at about 7:30 p.m., Resident #1 came to them and requested their evening medications. The CMA documented the resident was already angry, so to minimize interrupting the resident's evening, they brought the snack cart as well as the resident's medications to the resident's room. The CMA documented by the time they returned to the resident's room the resident was aggressively shouting and cursing at them. The CMA documented they attempted to plead with the resident, but the resident stood, and while yelling and cursing, pointed to their face. The CMA documented they attempted to leave the resident's room, but the resident pulled them back and hit them in the face, knocking their glasses from their face. The CMA documented while trying to get away from the resident the resident lost their balance and fell . (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A witness statement from CNA #1, dated 10/18/24 at 8:40 p.m., documented they had just returned from break and assisted a resident in the hallway and observed Resident #1 had their call light on. The CNA documented they heard a verbal argument and turned to look. The CNA documented they observed CMA #1 place something in the resident's room. The CNA documented Resident #1 was leaning over the snack cart and with their finger was pushing into the CMAs right shoulder. The CNA documented the CMA #1 attempted to leave with the snack cart, but the resident held onto the cart and again pushed their finger into CMA #1's chest/shoulder. The CNA documented CMA #1 pushed the resident and when the resident began to fall CMA #1 attempted to catch the resident. The CNA documented both the resident and CMA #1 disappeared into the room, and when they went to the room, there was a pool of blood on the floor. The CNA documented Resident #1 stated they themselves started the altercation and did not want CMA #1 to get in trouble or be terminated. An undated handwritten statement from LPN #1 documented they were alerted Resident #1 was on the floor. The LPN documented when they entered the room, the resident was laying on the floor with blood under their head. The LPN documented they addressed the laceration above the resident's left eyebrow and sent the resident to the hospital for further evaluation. A city citation, dated 10/18/24, documented CMA #1 committed the offense of assault and battery. On 10/19/24 at 11:30 a.m., Resident #1 gave a verbal accounting of the incident to the DON. The DON documented the resident walked to the medication room to wake CMA #1 because the CMA had not given them their evening medications. The resident stated the CMA brought them their pills and placed them on the table in their room. The resident stated they were standing near the door to their room. The resident pointed their finger and said they just touched the CMAs chest and the CMA grabbed their neck and slammed them down. The resident stated they fell with the left side of their face to the floor. The resident stated a new staff member stayed with them while CMA #1 was out in the hall and went to get help. The resident stated staff entered their room to help them, but they were on the floor for nearly an hour before the ambulance arrived to take them to the hospital. On 10/24/24 at 4:05 p.m., the door to Resident #1's room was closed. The resident was heard yelling and berating RN #1 for their inability to perform their duties to the resident's satisfaction. RN #1 was overheard to remain calm and quietly attempted to redirect the resident and left the room shortly after. On 10/24/24 at 4:10 p.m., RN #1 stated Resident #1 was never happy with their care and addressed everyone rudely and with condescension. RN #1 stated Resident #1 even structured complements in a negative connotation and tone. RN #1 stated the resident normally called them to enter their room two to three times a night to yell how everything was their fault. RN #1 stated they received an inservice on abuse and the management of agitated/aggressive residents on 10/19/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 4:35 p.m., CNA #1 stated they had witnessed the altercation between CMA #1 and Resident #1. The CNA stated Resident #1 was holding onto the snack cart while jabbing their finger into the shoulder of CMA #1. The CNA stated they thought the resident was taking a step closer to CMA#1 when CMA #1 placed their hands up about chest high with their palms outward toward the resident. The CNA stated it happened very quickly and could not say with certainty if CMA #1 pushed the resident or if the resident stepped into CMA #1 while CMA #1's hands were still between them. The CNA stated they observed CMA #1 attempt to catch the resident when the resident became off balanced, but was not able to catch the resident in time. The CNA stated CMA #1 was not yelling at the resident or otherwise appeared to be angry. CNA #1 stated they received an inservice on abuse and working with residents with behaviors when they returned to work on 10/21/24. On 10/25/24 at 4:05 p.m., Resident #1 returned to facility from a scheduled appointment. The skin around both of the resident's eyes were bruised and there were stitches above the left eyebrow. The area above the left eyebrow was swollen and raised. They did not feel like talking to anyone at the moment. On 10/25/24 at 4:50 p.m., Resident #1 was in their room seated in their recliner. The surveyor addressed the resident with name and surveyor identification. The resident immediately began yelling that CMA #1 had grabbed them by the neck, slammed them onto their back on the floor, and punched them repeatedly in the face while continuing to hold them down by their neck. The resident continued to yell and repeated the incident. On 10/25/24 at 5:05 p.m., the DON stated they were notified of the incident on 10/18/25 in the evening, and immediately returned to the facility to start the investigation. The DON stated they toured the facility to ensure everyone was safe and statements were gathered from residents and employees, including CMA #1. The DON stated CMA #1 stated they had not intended to push the resident, but only to maintain space between themselves and the resident. They stated CMA #1 never intended for the resident to fall or get hurt. The DON stated they suspended CMA #1 while they investigated the incident. The DON stated they attempted to contact family, notified the physician, local police, and OSDH. The DON stated they returned to the facility on [DATE] and again made rounds to ensure the residents were safe and collected their statements. The DON stated they developed an inservice on abuse and managing behaviors or aggressive residents and started inservicing the weekend staff. The DON stated they returned to the facility on [DATE] and again made rounds to ensure the residents were safe, collected statements from the residents, and inserviced staff. The DON stated on 10/21/24 they continued to inservice staff until all available staff were inserviced. The DON stated there were a few staff members they were unable to reach and those would be inserviced before their next shift started. The DON stated they continued to monitor staff/resident interactions daily as part of the QA process and continued to review and update the findings for their monthly QAPI meeting to review. The DON stated at the end of the investigation the allegation of abuse was substantiated and CMA #1 was terminated. On 10/25/24 at 5:20 p.m., the facility's policy and procedure for abuse was reviewed, in-service sheets for abuse training, in-service sheets for caring for residents with behaviors, the facility monitoring sheets, daily stand up/leadership team meetings, and the facility initial QA was reviewed. It was determined non-compliance started on 10/18/24 at 7:00 p.m. and ended on 10/22/24 at 4:50 p.m. when all active staff were in-serviced. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 5:30 p.m., the administrator stated when they received an allegation of abuse, they followed their abuse policy, ensured all residents were safe, and removed the alleged abuser from the facility pending the outcome of the investigation. The administrator stated they would begin the investigation by identifying and interviewing all persons involved, including the alleged abuser and any witnesses. The administrator stated they report the allegation to the SA, APS, and law enforcement, if indicated. The administrator stated they notify the resident's representative if the resident had one and their physician. The administrator stated they inservice/educate staff on abuse and neglect and monitor through observations of staff/resident interactions and resident statements which asked such questions as if the resident felt safe in the facility, did they know who to tell if something happened or if they had a problem, and other pertinent questions developed through the QA process/team. The administrator stated after completing the investigation the QA team discusses/reviews all state reportable incidents and grievances during daily meetings and at the monthly QA meeting to determine if their were any unidentified trends/patterns to add.