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	07/21/2025

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record review and interview, the facility failed to ensure individual financial records were available through quarterly statements and upon request for 3 (#2, 4, and #6) of 3 sampled residents reviewed for personal funds. The administrator identified 27 residents with trust fund accounts. Findings:An undated policy titled Resident Personal Funds Accounting and Records, read in part, 3. The individual financial record must be available to the residents through quarterly statements and upon request.Review of resident records for Resident #2 from 01/01/25 to 07/17/25 showed no financial statements were available.Review of resident records for Resident #4 from 01/01/25 to 07/17/25 showed no financial statements were available. Review of resident records for Resident #6 from 01/01/25 to 07/17/25 showed no financial statements were available. On 07/17/25 at 1:34 p.m., the business office manager stated the residents could ask for their balance and it would be told to them, but they did not provide the residents with a quarterly statement. The business office manager stated they were not aware they should be providing a quarterly statement.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to revise a care plan for 2 (#7 and #8) of 8 residents sampled who were reviewed for care plans.The administrator identified 55 residents resided at the facility. Findings:1.An admission assessment for Resident #7, dated 01/03/25, showed a BIMS score of 00, which indicated Resident #7 was severely cognitively impaired for daily decision making. The assessment showed diagnoses which included cerebral vascular accident (CVA/stroke), transient ischemic attack (TIA/mini stroke or brief stroke-like attack caused by a blood clot that blocks blood flow to the brain), and Parkinson's disease. A care plan for Resident #7, dated 01/27/25, showed no concerns for CVA or TIA.A progress note, dated 07/12/25 at 12:55 p.m., showed Resident #7 was unable to sit up and eat at lunchtime. The note showed Resident #7 kept falling forward and putting their head on the table and were returned to their bed. The note was entered by RN #1.A progress note, dated 07/14/25 at 7:22 p.m., showed the representative of Resident #7 reported the resident had a stroke and required being sent to the emergency room. The note showed 911 was called and Resident #7 was taken to the emergency room. The note was entered by LPN #1.Hospital records for Resident #7, dated 07/14/25 at 11:10 p.m., showed results of a CT chest procedure. The results showed findings of a pulmonary emboli (a condition in which one or more arteries in the lungs become blocked by a blood clot) in the distal right pulmonary artery.On 07/16/25 at 2:59 p.m., the MDS coordinator stated concerns/focus for care plans were identified in multiple ways including weekly risk assessments and the care area assessment (CAAs) from the minimum data set assessment. They stated the diagnoses of CVA and TIA for Resident #7 were not included as they were not active diagnoses the resident was currently being treated for.2.A physician's order for Resident #8, dated 04/29/25, showed to administer a 24-hour transdermal nitroglycerin patch 0.1mg/hour in the morning related to angina pectoris.A care plan for Resident #8, dated 05/22/25, showed no concern for angina pectoris or heart failure.An annual assessment for Resident #8, dated 05/26/25, showed a BIMS of 15 which indicated Resident #8 was cognitively intact for daily decision making. The assessment showed diagnoses which included diabetes, heart failure, hypertension, angina pectoris and end stage renal disease.A CAA worksheet for Resident #8, dated 05/26/25, showed congestive heart failure and angina diseases of concern for the care plan. The worksheet was signed and dated by the MDS coordinator on 06/09/25.A progress note, dated 07/03/25 at 7:46 a.m., showed Resident #8 complained of chest pain to RN #1, vital signs were obtained and were shown to be within normal limits. The note showed Resident #8 stated it probably was indigestion.A progress note, dated 07/03/25 at 11:30 a.m., showed Resident #8 was found in their bed without pulse and respirations by RN #1. On 07/17/25 at 1:24 p.m., the MDS coordinator stated the diagnoses of angina pectoris, coronary artery disease and heart failure were not included in the care plan as Resident #8 was not actively being treated for them. The MDS coordinator stated the nitroglycerin patch had been overlooked and the diagnosis should have been included on the care plan.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On [DATE], an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to assess, monitor, and intervene for a change in condition for:1. Resident #8 who reported chest pain on [DATE] at 7:46 a.m. A progress note showed vital signs were taken, but no other action was documented, and2. Resident #7 who was reported by RN #1 to be slumped over the table in the dining room on [DATE] during the noon meal. The note showed Resident #7 was removed from the dining room and taken to their room. No other actions were documented.On [DATE] at 12:06 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation.On [DATE] at 12:45 p.m., the DON and administrator were notified of the IJ situation and provided the IJ template.On [DATE] at 11:41 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,Plan of Removal: IJ for Failure to Assess, Monitor [and] IntervenеCorrective Actions TakenImmediate Clinical Response:Nurse managers and charge nurses completing facility wide assessments of all residents to establish baselines. If concerns are found, notify DON, the party responsible and residents Physician immediately to get orders in place. The Medical Director was notified immediately and made aware of IJ status and action plan of interventions.All policies on change of condition, monitoring, and interventions reviewed and revised. Clinical systems revised to flag key indicators requiring escalation via E-interact and Change of Condition communication forms. E- Interact will populate to the Clinical Dashboard and 24-hour report. Staff Notification:All clinical staff were informed of the deficiency and advised of immediate changes in protocol. That includes the implementation of the E-Interact and the Change in Resident Status communication form.A mandatory in-service training was immediately scheduled and will be completed within 24 hours.Any staff that are not able to complete training within 24 hours will be required to complete training prior to working next scheduled shift. Education & TrainingEmergency Staff Education:Licensed nurses and CNAs received training on policy and procedure over Change in Resident Status or Conditions.Focus included documentation, escalation pathways, and timely physician notification.Educated and implemented use of E-Interact SBAR (Situation-Background-Assessment-Recommendation) and utilization of Change in Resident Status communication form. Competency Validation:Senior Director of Clinical Services trained Director of Nursing over processes of implementation of E- Interact SBAR (Situation-Background-Assessment-Recommendation) and utilization of Change in Resident Status communication form.Director of Nursing trained nurse management and charges nurses over processes and implementation of E- Interact SBAR (Situation-Background-Assessment-Recommendation) and utilization of Change in Resident Status communication form.Staff will verbalize understanding of training and observation of change in condition and assessment. RN Supervisor Role Expansion:DON will perform daily audits of residents with identified clinical risks.Shift Huddles Introduced:Begin and end-of-shift meetings instituted to identify potential high-risk residents starting [DATE]. Date of Compliance:Compliance Date: [DATE]The IJ was lifted, effective [DATE] at 12:25 p.m., when all components of the plan of removal had been verified as completed. Review of policy changes for change of conditions was conducted, clinical system changes were reviewed, review of the resident assessments for all 55 residents were completed, clinical staff were interviewed regarding changes in policy for change of condition, communication with facility staff and timely notification to physician of a change in condition. The DON was interviewed regarding in-service with the senior director of clinical services and daily audits of residents at risk. Review was completed of the Beginning and end of shift meetings documentation sheets. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the facility failed to assess, monitor, and intervene for a change in condition for 2 (#7 and #8) of 3 sampled residents reviewed for a change in condition.The administrator identified 55 residents resided in the facility. Findings:1.A physician's order for Resident #8, dated [DATE], showed to administer a 24-hour nitroglycerin patch 0. 1mg/hour transdermally in the morning related to angina pectoris and to take off after 24 hours.An annual assessment, dated [DATE], showed a BIMS of 15 which indicated Resident #8 was cognitive for daily decision making. The assessment showed diagnoses which included diabetes, heart failure, hypertension, angina pectoris, and end stage renal disease.The [DATE] MAR for Resident #8 showed the nitroglycerin patch was not administered on [DATE]. The MAR showed routine simethicone 80 mg for gas and as needed calcium carbonate (Tums an antacid) were not administered for indigestion on [DATE]. A progress note

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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 observation and interview, the facility failed to ensure medications were administered by the person preparing the medication for 1 of 1 observation.The administrator identified 55 residents received medications. Findings: On 07/16/25 at 10:30 a.m., CMA #5 was observed preparing an unknown resident's medication. After preparing the medication, CMA #5 gave CMA #6 the medication who took the medication down the hall and administered it to an unknown resident. On 07/16/25 at 11:00 a.m., CMA #5 stated it was not facility policy to prepare medication and allow another CMA to administer it. CMA #5 stated they had no explanation as to why they were administering medication in that manner. On 07/16/25 at 11:10 a.m., CMA #6 stated you should not administer medication you did not prepare. On 07/16/25 at 11:30 a.m., the DON stated it was not facility policy for one CMA to administer medication prepared by another CMA.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medications were administered as ordered by the physician for 1 (#8) of 1 sampled resident reviewed for medication administration.The administrator identified 55 residents received medications at the facility.Findings:A physician's order for Resident #8, dated [DATE], showed to administer a 24-hour transdermal nitroglycerin patch 0.1mg/hour every morning for angina pectoris.An annual assessment, dated [DATE], showed a BIMS of 15 which indicated Resident #8 was cognitively intact for daily decision making. The assessment showed diagnoses which included diabetes, heart failure, hypertension, angina pectoris, and end stage renal disease.A [DATE] MAR, showed on [DATE] Resident #8 did not receive the nitroglycerin patch as ordered.A progress note, dated [DATE] at 7:46 a.m., showed Resident #8 complained of chest pain to RN #1. The note showed RN #1 completed vital signs for Resident #8 and were within normal limits. The note showed Resident #8 stated the chest pain could be indigestion.A progress note, dated [DATE] at 11:30 a.m., showed Resident #8 was found by RN #1 to be without respiration and pulse. The note showed CPR was initiated and 911 was called.A progress note, dated [DATE] at 1:24 p.m., showed RN #1 notified the physician of the death of Resident #8 and received an order to release the body to the funeral home.On [DATE] at 12:15 p.m., the DON with the administrator present stated they would need to check as to why Resident #8 did not receive the ordered nitroglycerin patch on [DATE].On [DATE] at 9:00 a.m., the DON stated they had called the agency to obtain an answer as to why the nitroglycerin medication was not administered by the agency CMA, but they had not heard back. They stated they would follow up.On [DATE] at 10:30 a.m., the DON stated the agency CMA had given multiple different answers and they were unable to determine the reason. The DON stated they requested the CMA do not return to the facility.