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	03/05/2026

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review and interview, the facility failed to complete a quarterly assessment for 1 (#2) of 3 sampled residents reviewed for quarterly assessments.The administrator identified 52 residents resided in the facility. Findings:An undated policy titled MDS 3.0 Completion showed the facility was to complete quarterly comprehensive assessments no greater than 92 days from the resident's last quarterly assessment.A quarterly assessment for Resident #2, dated 11/18/25, showed the resident had diagnoses which included parkinsonism and diabetes mellitus. A comprehensive assessment list for Resident #2 showed a quarterly assessment was to be completed by 02/18/26 and was in progress.On 03/05/26 at 7:55 a.m., the MDS coordinator stated Resident #2's quarterly assessment was due on 02/18/26 and should have been completed.

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: 375465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 person-centered care plan for a contracture was developed for 1 (#1) of 3 sampled residents reviewed for care plans.The DON identified two residents with contractures resided in the facility. Findings:On 03/04/26 at 9:53 a.m., Resident #1's left leg was observed to be contracted. Their left leg was bent at the knee, and their left ankle was under their right knee.An undated policy titled Comprehensive Care Plans, read in part, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident.The comprehensive care plan will describe, at a minimum, the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.A care plan for Resident #1, dated 02/23/26, showed the resident had diagnoses which included osteoarthritis of unspecified hip, cerebral infarction (a stroke), and aseptic necrosis of the left femur. The care plan showed the the resident required assistance for lower body dressing and a total lift for transfers. The care plan did not address Resident #1's left leg contracture.On 03/04/26 at 9:53 a.m., Resident #1 stated their leg became contracted at another nursing facility due to a stroke. They stated they wore a compression sleeve on their left leg for comfort and required pain medication to help manage the pain.On 03/05/26 at 7:25 a.m., certified nurse aide #1 stated they utilized care plans as a guide to care for the residents in the facility. They stated Resident #1's care plan did not address their left leg contracture.On 03/05/26 at 7:30 a.m., registered nurse #1 stated Resident #1's left leg contracture was not listed on their care plan.On 03/05/25 at 7:57 a.m., the MDS coordinator stated Resident #1's left leg contracture was not but, should have been included in their care plan.On 03/05/26 at 8:06 a.m., the DON stated Resident #1's left leg contracture should have been included in their care plan.