

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  02/06/2025
NAME OF PROVIDER OR SUPPLIER  Colonial Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>30267</p> <p>Based on observation and interview, the facility failed to maintain a clean ice machine.</p> <p>The roster matrix documented 53 residents who utilize ice from the ice machine.</p> <p>Findings:</p> <p>On 02/05/25 at 2:50 p.m., an observation of the ice machine was performed with the maintenance supervisor. There was a slimy black substance observed on the top and interior of the plastic cover, along each side of the water reservoir, and near the water pump which hung above and in the water reservoir.</p> <p>On 02/05/25 at 2:53 p.m., the maintenance supervisor stated the ice machine was dirty. The maintenance supervisor stated they did not know who was responsible for cleaning the ice machine.</p> <p>On 02/05/25 at 3:15 p.m., the administrator stated they were made aware of the dirty ice machine. They did not know who was responsible for cleaning the ice machine. They stated they would coordinate with the dietary manager and maintenance supervisor and work out a routine schedule for cleaning the ice machine.</p>

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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