STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375536	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tuscany Village Nursing Center	2333 Tuscany Blvd Oklahoma City, OK 73120

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33097 Based on observation, record review, and interview, the facility failed to provide treatment and services to promote the healing of a pressure ulcer for one (#2) of three residents reviewed for pressure ulcers. The DON identified eight residents in the facility with pressure ulcers. Findings: A policy titled An Overview of Wound Care, dated July 2018, read in parts .The comprehensive assessment should provide the basis for defining approaches to address residents at risk of developing or already having a PU/PI .Effective prevention and treatment are based upon consistently providing routine and individualized interventions .Repositioning or relieving constant pressure is a common, effective intervention for an individual with a PU/PI or who is at risk of developing one . Resident #2 had diagnoses which included Parkinson's disease, cognitive communication deficit, and overactive bladder. A care plan, dated 08/09/23, documented at risk for/actual skin breakdown. The care plan documented staff where to assist the resident to turn and reposition frequently and inspect skin of the complete body head to toe every week and document. A nurse note, dated 03/12/24, documented the resident was seen by the wound physician and the wound to the buttock was resolved. A significant change assessment, dated 03/30/24, documented the resident was severely impaired cognitively and was dependent for most ADLs. The assessment documented the resident was always incontinent of bowel and bladder. A wound report, dated 04/15/24, documented the resident had a stage 3 pressure wound to the sacrum and measured 2cm X 2cm X 0.1cm. A wound report, dated 04/23/24, documented the resident had a stage 3 pressure wound to the sacrum and measured 4cm X 2cm X 0.2cm. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician orders, dated 04/23/24 documented the resident was to have wound care every Monday and Thursday in the morning to the sacrum. The staff were to apply medical honey, cover with a mepilex dressing, and change when needed. The ETAR for April 2024, documented from 04/23/24 to 04/30/24 the resident received one wound care treatment. The ETAR documented missed treatments. The ETAR for May 2024, documented from 05/01/24 to 05/08/24 the resident received one wound care treatment. The ETAR documented missed treatments. A coordination note, dated 05/12/24, documented the hospice service was in the facility to provide wound care. The note documented the wound measured 4cm X 4.5cm X 0.5cm. On 05/13/24 at 1:20 p.m., an observation of wound care was conducted for the resident. On 05/13/24 at 3:48 p.m., the DON stated the does not document turning or repositioning, they just know to make every two hour rounds. The DON stated the facility staff does not perform measurements of the wound, the hospice service does weekly wound measurements.