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	06/20/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure responsible parties were notified:a) for a change in condition, and b) an order for a new medication for 1 (#2) of 3 sampled residents who were reviewed for notification of change.LPN #2 identified 120 residents resided in the facility.Findings:A policy titled Change of Condition, dated 02/13/23, read in part, Patient families, guardians, or other appropriate people are to be contacted when there is a significant change in a patients condition or health status.An undated face sheet for Resident #2's showed diagnoses which included hemiplegia and hemiparesis following cerebral infarction affection left non-dominant side, muscle weakness and cerebral infarction, and bipolar disorder. The face sheet showed HealthCare Contact to be Resident #2's daughter. The resident's spouse/roommate was listed as the primary contact.Resident #2's significant change MDS, dated [DATE], showed cognitively intact cognition with BIMS of 15. An Interdisciplinary Progress Notes, dated 04/07/25 at 2:42 p.m., showed a new order from the physician to send the resident to the emergency room for vomiting and not being able to keep food, water and medication down, and with increased confusion and hallucinations. An SBAR Communication Form, showed the husband, the residents' roommate, was notified on 04/07/25 at 1:00 p.m. There was no documentation the HealthCare contact was notified. A physicians order, dated 04/23/25, showed alprazolam (a benzodiazepine) 0.5 mg tablet was to be administered by mouth twice a day for anxiety. An Interdisciplinary Progress Notes, dated 04/23/25, showed a new physicians order for alprazolam 0.5 mg twice a day. The note showed the resident, and the hospice company were notified. There was no documentation the HealthCare contact was notified. On 06/19/25 at 2:13 p.m., the IP, working as the charge nurse on the hall stated, to determine who was notified for a residents change in condition, they would look on the face sheet for the power of attorney or next of kin and notify them and the physician. The IP stated the representative for Resident #2, when they went to the hospital on [DATE], was the guarantor/emergency, [the resident's daughter]. The IP stated the husband was notified on 04/07/25 at 1:00 p.m. The IP stated the previous electronic record used had switched and had Resident #2's daughter as the HealthCare contact. On 06/19/25 at 2:30 p.m., the IP stated there were no notes for notification.On 06/19/25 at 2:42 p.m., the IP stated Resident #2's daughter probably should have been contacted.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to accurately code a significant change MDS assessment for 1 (#2) of 3 sampled residents reviewed for accuracy of assessments.LPN #2 identified 120 residents resided at the facility.Findings:An undated face sheet for Resident #2's, showed diagnoses which included hemiplegia and hemiparesis following cerebral infarction affection left non-dominant side, muscle weakness, cerebral infarction, and bipolar disorder. Resident #2's significant change assessment, dated 05/01/25, showed cognitively intact cognition with a BIMS of 15. The assessment showed the Special treatments, procedures, and programs section, O0100 Z1 was coded as none of the above. Hospice care while a resident at K1 was not marked. A hospice certification document, dated 04/17/25, showed the certification date range of 04/17/25 to 07/15/25. The document was signed by an RN. A physician's order, dated 04/18/25, showed admit to hospice.On 06/19/25 at 12:56 p.m., MDS coordinator #1 stated the significant change assessment, dated 05/01/25, for Resident #2 was related to going on hospice. The MDS coordinator stated the resident went on hospice services on 04/17/25. MDS coordinator #1 reviewed the MDS and stated the MDS did not have hospice coded and was not accurately coded to reflect the resident's status at that time.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to assess, monitor and intervene in a timely manner for 1 (#3) of 3 sampled residents reviewed for care and treatment.LPN #2 identified 120 residents resided in the facility.Findings: An Interdisciplinary Team Notes, dated 04/09/25 at 9:17 p.m., showed family member #1 called the facility requesting their family member be sent to the emergency room to be tested for C-Diff since their other family member that was a roommate was hospitalized and positive for it. A Medication Administration Record, dated 04/01/25 through 04/30/25, showed Zofran (medication for nausea and vomiting) ordered PRN, was administered on:a. 04/07/25 at 10:40 p.m. b. 04/08/25 at 12:05 p.m.c. 04/09/25 at 8:37 p.m.A facility policy Medication Administration, dated 01/2024, read in part, If two consecutive doses of a vital medication are withheld or refused, the physician is notified.An Interdisciplinary Progress Notes, dated 04/02/25 through 04/11/25 showed the following:On 04/08/25 at 10:45 a.m., CMA#1 documented all morning medications were refused, and the charge nurse was notified of the refusal.On 04/08/25 at 4:49 p.m. , CMA #2 documented rabeprazole sodium (a medication for gastro esophageal reflux disease) was held due to refusal.On 04/08/25 at 10:44 p.m., CMA #2 documented docusate sodium (a medication for constipation) was held due to refusal:On 04/09/25 at 9:51 a.m., CMA #3 documented the following medications were held due to refusal:a. furosemide (medication for edema),b. Linzess (medication for irritable bowel syndrome),c. rabeprazole sodium (medication for gastro esophageal reflux disease),d. vitamin c (a supplement), e. calcium carbonate/vitamin d (a supplement), andf. potassium chloride (a supplement).On 04/09/25 at 9:51 a. m., CMA #3 documented the charge nurse was notified of medication refusal.On 04/09/25 at 7:52 p.m., CMA #2 documented the following medications were held due to refused:a. gabapentin (medication for pain),b. rabeprazole sodium, andc. docusate sodium.On 04/10/25 at 9:40 a.m., CMA #1 documented the following medications were held due to refusal and charge nurse was notified:a. rabeprazole sodium,b. furosemide,c. Linzess,d. morphine sulfate (medication for pain),e. vitamin c, andf. calcium carbonate/vitamin d.On 04/10/25 at 9:40 a.m., CMA#1 documented the charge nurse was notified of medication refusal.On 4/10/25 at 10:23 p. m., CMA #2 documented docusate sodium was held due to refusal.On 04/11/25 at 10:40 a.m., CMA#1 documented all morning medications were refused, and the charge nurse was notified of the refusal.An Interdisciplinary Team Notes, dated 04/11/25 at 3:03 p.m., read in part, Physician in the building and ordered C-diff lab test per resident family request. Order in place with lab. There was no documentation in the EHR to show the c-diff test was completed or other attempts were made to obtain it. An Interdisciplinary Team Notes, dated 04/11/25 at 06:07 p.m., showed Resident #3 had an altered mental status and was sent to the emergency room for evaluation.On 06/18/25 at 1:40 p.m., documentation of intake and output for Resident #3 was requested. The DON stated there were not any intake and output records past 02/02/25 due to change in the EMR systems. The DON was asked how they knew if a resident had consistent intake and output. The DON stated they monitored weights for weight loss.A review of Resident Weight Record for Resident #3, showed monthly weights from 10/03/24 through 03/04/25 as refused. There was no weight documentation after 03/04/25.On 06/20/25 at 9:20 a.m., NP #1 was asked about the documentation of a phone conversation from the facility nurse on 04/09/2. The NP stated they were on call the evening of 04/09/25. NP #1 was asked about a phone conversation with facility regarding Resident #3. The NP stated they did remember part of the conversation and the reason for the call, but they did not recall all of the conversation. NP #1 stated they did remember a facility nurse had called them regarding a family member requesting a C-diff test. The NP stated they reviewed the symptoms the resident was having with the facility nurse, specifically regarding diarrhea or abnormal vital signs. The NP stated his vitals were within normal limits and the resident did not have loose stools or diarrhea, other gastrointestinal symptoms or abnormal vital signs, so they did not order the C-diff test since they had lab facilities decline test samples if there were not any loose stool. NP #1 was asked if they were aware the resident had refused some of his routine medications that morning, as well as the previous two days, and had required PRN medications for nausea the two days prior. The NP stated they were not aware of that assessment. NP #1 stated they instructed the facility nurse to have physician #1 follow up and to call if there were any changes in condition. NP #1 was asked about nurses' documentation regarding the family requesting the resident to be sent to emergency room. The NP stated they did not remember that conversation and they were usually supportive of family requests and feels like they would have told them to send the resident to emergency room if they had been aware of the family request. On 04/20/25 at 1:15 p.m., the DON was asked about the process for

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure activities of daily living documentation was completed for 1 (#2) of 3 sampled residents reviewed for ADL's.LPN #2 identified 120 residents resided at the facility.Findings:An undated face sheet for Resident #2, showed diagnoses which included hemiplegia and hemiparesis following cerebral infarction affection left non-dominant side, muscle weakness, cerebral infarction, and bipolar disorder. Resident #2's significant change assessment, dated 05/01/25, showed cognitively intact cognition with a BIMS of 15.A policy titled ADL Dysphagia and Dining, dated 01/23/23, read in part, 17. Document percentage consumed in EHR. Review of the ADL documentation for March and April 2025, did not show any documentation of intake and output or meal percentages for 04/01/25 through 04/07/25, the days leading up to the 04/07/25 hospital stay.On 06/18/25 at 3:49 p.m., the regional nurse consultant stated via an email response, they had provided all the ADL documentation they had for March and April 2025.On 06/20/25 at 9:33 a.m., the regional nurse consultant stated they did not have a generalized policy for ADLs, but had it broken down into subgroups that talk about documentation. The regional nurse consultant stated they did not find one for eating or intake or output.