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	02/06/2026

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to ensure family and the physician was notified of a resident's refusal of care for 1 (#8) of 14 sampled residents reviewed for notification of refusal of care.The administrator identified 120 residents resided in the facility. Findings:A facility policy titled Refusal of Care and Treatment, dated 02/16/23, read in part, When a resident refuses treatment/procedure ordered by the physician, staff shall notify the physician.Staff will notify the resident's responsible party unless the resident chooses not to allow.Physician orders for Resident #8, dated 10/08/25, showed the resident had the following orders:a. weekly weights for 4 weeks,b. 60 milliliters of milk/soy protein supplement twice a day, andc. sodium bicarbonate (an antacid) 650 milligrams tablet twice a day.An admission assessment for Resident #8, dated 10/14/25, showed the resident's cognition was severely impaired with a BIMS score of 3. The assessment showed Resident #8 was admitted with a diagnoses of obstructive uropathy and non-Alzheimer dementia. The assessment showed Resident #8 did not reject care during the seven days look back period.Nurses' notes for Resident #8, dated 10/2025 through 11/2025, showed the resident refused care on the following dates:a. on 10/12/25, refused protein supplement health shake,b. on 10/18/25, refused protein supplement health shake,c. on 10/19/25, refused protein supplement health shake, d. on 10/25/25, refused to be weighed,e. on 10/26/25, refused protein supplement health shake, f. on 11/01/25, refused protein supplement health shake and sodium bicarbonate,g. on 11/02/25, refused protein supplement health shake and sodium bicarbonate, andh. on 11/08/25, refused protein supplement health shake and sodium bicarbonate.On 02/03/26 at 9:35 a.m., resident representative #1 stated they were not notified Resident #8 refused care. On 02/04/26 at 2:44 p.m., CNA #4 stated when a resident refused care, they should notify a nurse who charted the refusal and notified the family and physician.On 02/06/26 at 9:36 a.m., LPN #6 stated when a resident refused care, medications, and/or supplements, they made a nurses note documenting the refusal, notification of the family, and notification of the physician. On 02/06/26 at 10:49 a.m., the DON was shown Resident #8's nurses' notes. The DON stated the nurses should have notified the family and physician of any refusals of care and documented the notification in the nurses' notes. The DON stated there was a problem with no documentation to show the family and physician were notified of the refusals. The DON stated the notification of family, and the physician was important to ensure the residents received the care they required. The DON stated there was no documentation showing Resident #8's family and physician were notified of the refusals of care.

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 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 record review and interview, the facility failed to ensure a comprehensive care plan was developed for 1 (#8) of 14 sampled residents reviewed for comprehensive care plans.The administrator identified 120 residents resided in the facility. Findings:A facility policy titled Comprehensive care plans, dated 04/17/23, read in part, It is the policy of this facility to develop and implementation a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.The comprehensive care plan will be developed within seven (7) days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.An admission assessment for Resident #8, dated 10/08/25, did not show the resident had a catheter upon admission.Physician orders for Resident #8, dated 10/08/25, showed the resident had physician orders to:a. change suprapubic catheter as needed,b. monitor the output on every shift, andc. suprapubic catheter care every shift.A treatment administration record for Resident #8, dated 10/08/25 through 10/31/25, showed the resident received care for a suprapubic catheter.A comprehensive care plan for Resident #8, initiated on 10/09/25, did not show a focus or interventions for catheter care. The care plan had a focus for activities dated 10/09/25. There were no other areas of focus on the care plan. An admission assessment for Resident #8, dated 10/14/25, showed the resident's cognition was severely impaired with a BIMS score of 3. The assessment showed Resident #8 was admitted with a diagnoses of obstructive uropathy and non-Alzheimer dementia. The assessment showed Resident #8's urinary continence was not rated due to Resident #8 had a catheter at the time of the assessment. The assessment showed Resident #8 required supervision to touching assistance for eating, substantial to maximum assistance for showers/baths and dressing and was dependent for bed transfers. On 02/03/26 at 9:35 a.m., resident representative #1 stated Resident #8 had a catheter upon admission and throughout their stay at the facility.On 02/06/25 at 9:23 a.m., CNA #3 stated they did not have any documentation to direct them to provide catheter care. CNA #3 stated they checked and provided care for all catheters every two hours. On 02/06/26 at 10:49 a.m., the DON reviewed Resident #8's comprehensive care plan dated 10/09/25. The DON stated the care plan only had a focus for activities and did not document the resident's catheter care and ADL's. The DON stated the comprehensive care plan was not created and it was the responsibility of the MDS coordinator. On 02/06/26 at 11:53 a.m., MDS coordinator #1 stated comprehensive care plans should be completed after admission by day twenty-one after admission. They stated Resident #8's care plan only had activities for a focus. They stated Resident #8's comprehensive care plan was not completed because it got missed.

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	375536	A. Building B. Wing	02/06/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were bathed for 2 (#1 and #2) of 14 sampled residents reviewed for bathing.The administrator identified 120 residents resided in the facility. Findings: 1.A facility policy titled Bathing (Not Partial or Complete Bed Bath), revised 02/12/20, read in part, Staff will provide bathing services for residents with standard practice guidelines.If the resident refuses to independently or allow staff to assist with bathing, document the refusal in the record. A CNA flow sheet, dated 01/14/26 through 01/27/26, showed Resident #1 received a shower on 01/18/26 and 01/25/26. Interdisciplinary progress notes for Resident #1, dated 01/14/26 through 01/27/26, showed no documented refusals of showers. An admission assessment for Resident #1, dated 01/21/26, showed the resident's cognition was severely impaired, and had a BIMS score of 07. The assessment showed the resident was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease and had not exhibited any rejection of care behaviors. A care plan for Resident #1, dated 01/23/26, showed the resident required the assistance of one staff member for activities of daily living. On 02/03/26 at 10:07 a.m., family member #2 stated Resident #1 was scheduled for showers on Tuesdays and Fridays. Family Member #2 stated the resident only received a shower on Sunday, 01/18/26 and Sunday, 01/25/26 after they complained to staff. On 02/03/26 at 1:53 p.m., CNA #5 stated there was not enough time and help to get all scheduled showers done daily. 2. On 02/06/26 at 1:36 p.m., Resident #2 was observed in bed. Resident #2's hair was not brushed. An annual assessment for Resident #2, dated 09/18/25, showed the resident's cognition was intact with a BIMS score of 14. The assessment showed Resident #2 was admitted with diagnoses which included polyneuropathy, anxiety disorder, and depression. The assessment showed Resident #2 had impairments on both sides of their upper and lower extremities. The assessment showed Resident #2 required substantial to maximum assistance with showers/baths and personal hygiene. The assessment showed Resident #2 was dependent for tub/shower transfers and did not ambulate. A care plan for Resident #2, initiated 04/10/25, showed a focus for activities of daily living. The care plan showed an intervention for ADL assistance/ADL assistance as needed. Physician orders for Resident #2, dated 08/15/25, showed the resident's bath days were weekly on Mondays and Thursdays on the first shift. A TAR for Resident #2, dated 12/01/25 through 12/31/25, showed the resident did not receive a bath (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 12/29/25. A MAR for Resident #2, dated 12/01/25 through 12/31/25, showed the resident received a bath on 12/29/25. The MAR showed LPN #3 initialed the MAR on 12/29/25 that Resident #2 received a bath. Nurses' notes for Resident #2, dated 12/29/25, showed no documentation the resident refused a shower/ bath on 12/29/25. On 02/03/26 at 1:53 p.m., CNA #5 stated the showers were not getting done for all residents. CNA #5 stated Resident #2 reported to them they had not had a shower for two weeks. CNA #5 stated they tried to ensure residents were showered once a week. They stated when a resident did not get showers/baths, the residents and resident representatives got frustrated. CNA #5 stated they had reported the residents not getting showers to the DON. On 02/04/26 at 9:16 a.m., LPN #3 was shown the MAR and TAR for Resident #2 dated 12/01/25 through 12/31/25. LPN #3 stated they signed the MAR on 12/29/25 because Resident #2 was scheduled for a shower. They stated the MAR initial on 12/29/25 was not to indicate Resident #2 received a shower/bath, but only initialed because it was Resident #2's scheduled bath day. LPN #3 stated Resident #2's bath days were on Mondays and Thursdays. LPN #3 stated when a resident refused a shower/bath, the CNA should have reported to them, they should have contacted the family and physician and put a note in the EHR documenting the refusal and notification. LPN #3 stated they were never notified Resident #2 refused showers on 12/29/25 and there was no documentation Resident #2 received a shower on 12/29/25. LPN #3 stated bath sheets were given to the MDS coordinator to file after all baths. On 02/04/26 at 9:36 a.m., MDS coordinator #1 stated the DON reviewed all bath sheets and checked the EHR to ensure the family and physician were notified. They stated there were no bath sheets for Resident #2 from 12/26/25 through 12/31/25. On 02/04/26 at 10:08 a.m., resident representative #2 stated Resident #2 was not getting their baths and assistance with hygiene. On 02/04/26 at 2:44 p.m., CNA #4 stated when a resident refused a shower/bath, they notified the nurse who charted the refusal and notified the family and physician. They stated when a resident refused a shower/bath, the nurse would try and offer it. CNA #4 stated they charted yes or refused in the EHR. On 02/04/26 at 2:55 p.m., LPN #7 stated when a resident reused a shower/bath, the CNA would have notified the nurse who would go speak with the resident and try and offer the shower/bath. They stated if the resident continued to refuse, they would have notified the family and physician, and a note should have been entered into the EHR documenting the family and physician were notified. On 02/04/26 at 3:09 p.m., the ADON stated when a resident refused a shower, the aide should have notified the charge nurse. They stated the charge nurse should have notified the family and physician of the refusal and placed a note in the EHR the family and physician were notified. The ADON was asked to review Resident #2's TAR and progress notes dated 12/01/25/ through 12/31/25. The ADON stated there was no documentation the shower was refused or received. They stated there was no documentation family and physician were notified. They stated it did not look like the policy and procedure was followed. They stated Resident #2 did not usually refuse showers. (continued on next page)

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	375536	A. Building B. Wing	02/06/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/26 at 10:54 a.m., the DON reviewed Resident #2's progress/nurses notes, MAR, and TAR dated 12/01/25 through 12/31/25. The DON stated the MAR initial on 12/29/25 should have been initialed to indicate Resident #2 received a bath. The DON stated they needed to educate the nurse who initialed the bath was given on 12/29/25. The DON stated there was no documentation Resident #2 received or refused a bath on 12/29/25. On 02/06/25 at 1:36 p.m., Resident #2 stated they did not receive a bath from 12/26/25 through 12/31/25. They stated the aides told them there was not enough staff to bathe all the residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a physician ordered dressing change as ordered for 1 (#12) of 4 sampled residents reviewed for wound care.The DON identified 23 residents required wound care.Findings:A physician's order for Resident #12, dated 07/09/25, showed IV-Midline (access device inserted into upper arm veins) dressing change on the day shift weekly on Friday, or when it becomes damp, loose, soiled, or if the patient develops problems at the site that require further inspection.A medication administration record for Resident #12, dated 07/11/25, showed the IV-Midline dressing change was missed. The record showed no reason the dressing change was missed.An admission assessment for Resident #12, dated 07/12/25, showed the resident was admitted to the facility on [DATE] and their cognition was severely impaired. The assessment showed the resident's BIMS score was 07, required assistance for activities of daily living, and had IV access while a resident. The assessment showed the resident had diagnoses which included septicemia and renal failure.A grievance form for Resident #12, dated 07/16/25, showed Resident #12's family reported the resident's IV dressing had not been changed since being admitted to the facility. The grievance form showed the dressing would be changed that day.A nurse progress note for Resident #12, dated 07/18/25, showed the resident's IV dressing change was not performed due to it being changed on 07/16/25.A care plan for Resident #12, dated 07/28/25, showed the resident was on IV therapy for infection. The care plan showed medications and treatments were to be administered as ordered.On 02/04/26 at 9:49 a.m., family member #1 stated on 07/16/25 Resident #12's IV dressing was dated 07/03/25. Family Member #1 stated they asked the nurse why it had not been changed and were told the resident was at dialysis when the dressing change was scheduled. They stated they were told the dressing would be changed that day.On 02/06/26 at 11:13 a.m., the DON stated Resident #12 was out of the facility for an appointment and the dressing change should have been done upon return.On 02/06/26 at 1:30 p.m., the regional nurse consultant stated there was no documentation the IV dressing change was performed before 07/16/25.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and interview, the facility failed to:a. assess, monitor, and intervene for urine changes for 1 (#9) of 4 sampled residents; andb. failed to ensure a resident with a catheter had a physician order specifying the type of catheter for 1 (#8) of 4 sampled residents reviewed for catheter care. The corporate nurse identified 11 residents had catheters. Findings: A Care and Removal of an Indwelling Catheter policy, revised 01/12/20, read in part, Evaluate the need for catheter removal by validating the record and physician's order.Staff will provide care and removal of an indwelling catheter in accordance with standard practice guidelines.Observe urinary output and urine characteristics; evaluate for discharge, redness, bleeding, or presence of tissue trauma around the urethral meatus. 1.An admission assessment for Resident #8, dated 10/08/25, did not show the resident had a catheter upon admission. Physician orders for Resident #8, dated 10/08/25, showed the resident had physician orders to: a. change suprapubic catheter as needed, b. monitor the output on every shift, and c. suprapubic catheter care every shift. Resident #8's physician orders did not show an order specifying the type of catheter and supporting diagnosis. A treatment administration record for Resident #8, dated 10/08/25 through 10/31/25, showed the resident received care for a suprapubic catheter. A comprehensive care plan for Resident #8, initiated on 10/09/25, did not show a focus or interventions for catheter care. An annual assessment for Resident #8, dated 10/14/25, showed the resident's cognition was severely impaired with a BIMS score of 3. The assessment showed Resident #8 was admitted with a diagnoses of obstructive uropathy and non-Alzheimer dementia. The assessment showed Resident #8's urinary continence was not rated due to Resident #8 had a catheter at the time of the assessment. On 02/03/26 at 9:35 a.m., resident representative #1 stated Resident #8 had a catheter upon admission and throughout their stay at the facility. On 02/06/25 at 9:23 a.m., CNA #3 stated they did not have any documentation to direct them to provide catheter care. CNA #3 stated they checked and provided care to all catheters every two hours. On 02/06/26 at 9:36 a.m., LPN #6 stated when a resident was admitted to the facility with a catheter, they should look for the size and type from the admitting orders. They stated every resident with a catheter should have an order specifying the type of catheter. LPN #6 stated Resident #8 had a catheter upon admission. LPN #6 reviewed Resident #8's physician orders and stated there was not a (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician order for a catheter. On 02/06/26 at 10:49 p.m., the DON stated Resident #8 had a catheter upon admission. The DON stated Resident #8 had orders for suprapubic catheter care and did not have a physician order for a catheter. The DON stated it was important to have physician orders for the correct type of catheter because staff would not be able to provide the care for the catheter. The DON stated the catheter was not on the baseline care plan or comprehensive care plan. 2. On 02/04/26 at 11:57 a.m., Resident # 9's indwelling catheter was observed to have a thick off-white substance filling almost the entire visible tubing. A physician order, dated 11/26/25, showed Resident #9 was to have the catheter changed as needed or clinically indicated. A comprehensive assessment for Resident #9, dated 11/29/25, showed the resident had a BIMS score of 00 indicating severe problems with memory and thinking. The assessment showed Resident #9 had a diagnoses of cerebral palsy and traumatic brain injury and was dependent on staff for all of their needs. On 02/04/26 at 11:58 a.m., LPN #1 stated the indwelling catheter should be changed if there were signs of an infection, and Resident #9 did not have a fever. LPN #1 stated if they noticed a difference with the catheter they would be keyed into potentially call the physician. LPN #1 stated the indwelling catheter had a thick off-white substance in it from Resident # 9's body all the way down into the bag. LPN #1 stated it was sometimes normal for the contents inside the tubing to look like that. On 02/04/26 at 12:31 p.m., the DON stated LPN #1 was about to change the catheter because the orders were to change the indwelling catheter as needed. The DON stated the catheter tubing was stained and very cloudy with sediment in the drainage tubing. The DON stated they were unsure if it was normal for Resident #9's catheter to look like that. The DON stated the catheter tubing was not secured to Resident #9's leg and it was advised to have the catheter secured to keep it from pulling against the bladder wall.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on record review and interview, the facility failed to obtain a physician's order for suctioning of a tracheostomy for 1 (#1) of 3 sampled residents reviewed for tracheostomy care.The DON stated three residents had a tracheostomies. Findings:A facility Tracheostomy Care policy, dated 03/02/23, showed staff would provide care for residents with a tracheostomy (an opening in the neck into the windpipe) in accordance with standard practice guidelines and provide suctioning per practice guidelines.A baseline care plan for Resident #1, dated 01/14/26, showed the resident required suctioning and had a tracheostomy.Physician orders for Resident #1, dated 01/14/26 through 01/27/26, showed no order for tracheostomy suctioning.An admission assessment for Resident #1, dated 01/21/26, showed the resident's cognition was severely impaired and had a BIMS score of 07. The assessment showed the resident required suctioning and tracheostomy care and had a diagnosis of chronic obstructive pulmonary disease.On 02/03/26 at 3:26 p.m., the DON stated Resident #1 should have had a physician order for tracheostomy suctioning. The DON stated the resident's physician orders showed no order for tracheostomy suctioning.On 02/03/26 at 9:37 p.m., LPN #2 stated on 01/26/26 Resident #1's family reported the resident needed to be suctioned. LPN #2 stated the resident was not in distress and was suctioned via the resident's tracheostomy after the resident finished eating and the family left the facility. LPN #2 stated the resident's tracheostomy was suctioned regularly.

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	375536	A. Building B. Wing	02/06/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 a residents physician orders were accurate for 1 (#8) of 14 sampled residents reviewed for accurate physician orders.The administrator identified 120 residents resided in the facility. Findings:A facility policy titled Care and Removal of an Indwelling Catheter, dated 01/12/20, read in part, Evaluate the need for catheter removal by validating the record and physician's order.Physician orders for Resident #8, dated 10/08/25, showed the resident had physician orders to:a. change suprapubic catheter as needed,b. monitor the output on every shift, c. suprapubic catheter care every shift, andd. enteral tube feeding twice a day. A treatment administration record for Resident #8, dated 10/08/25 through 10/31/25, showed the resident received care for a suprapubic catheter.An annual assessment for Resident #8, dated 10/14/25, showed the resident's cognition was severely impaired with a BIMS score of 3. The assessment showed Resident #8 was admitted with a diagnoses of obstructive uropathy and non-Alzheimer dementia. The assessment showed Resident #8's urinary continence was not rated due to the resident had a catheter at the time of the assessment. The assessment showed Resident #8 did not have a tube feeding device and ate with supervision or touching assistance by staff.A discharge assessment for Resident #8, dated 11/13/25, showed the resident had a planned discharged for a short-term hospital stay.On 02/03/26 at 9:35 a.m., resident representative #1 stated Resident #8 had a catheter upon admission and throughout their stay at the facility and was not receiving enteral tube feeding.On 02/06/26 at 9:36 a.m., LPN #6 stated when a resident was admitted to the facility with a catheter, they should look for the size and type from the admitting orders. They stated every resident with a catheter should have an order specifying the type of catheter. LPN #6 stated Resident #8 had a catheter upon admission. LPN #6 reviewed Resident #8's physician orders and stated there was not a physician order for a catheter. LPN #6 stated the orders were not accurate due to Resident #8's orders showed they had an order for suprapubic catheter care when Resident #8 had a catheter. LPN #6 stated Resident #8 had a regular diet and was not an enteral tube feed. LPN #6 was asked to review the orders. They stated the orders were not accurate. On 02/06/26 at 10:49 p.m., the DON stated Resident #8 had a catheter upon admission. The DON stated Resident #8 had orders for suprapubic catheter care and did not have a physician order for a catheter. The DON stated it was important to have physician orders for the correct type of catheter because staff would not be able to provide the care for the catheter. The DON stated the catheter care orders were not correct due to the orders specifying the wrong type of catheter care. On 02/06/26 at 3:30 p.m., the DON stated Resident #8 was not nothing by mouth and received a regular diet. The DON stated the orders for enteral tube feeding dated 10/08/25 was an error.