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	04/02/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41318 Based on observation, record review, and interview, the facility failed to ensure staff did not use disinfectant wipes to clean residents' skin for 2 (#23 and #70) of 2 sampled residents observed during a finger stick for blood sugar and insulin observation. The corporate nurse identified 39 diabetic residents resided in the facility. Findings: On 04/01/25 at 7:41 a.m., LPN #2 was observed to gather supplies to obtain a blood sugar. They were observed to go to Resident #70 and clean the resident's finger with a disinfectant wipe prior to obtaining the blood sugar. On 04/01/25 at 7:49 a.m., the disinfectant wipe container was observed to show Not for use on skin. On 04/01/25 at 7:51 a.m., LPN #2 was observed to gather supplies to obtain another blood sugar. They were observed to go to Resident #23 and clean the resident's finger with a disinfectant wipe prior to obtaining the blood sugar. On 04/01/25 at 8:02 a.m., LPN #2 was observed to clean Resident #23's skin on their abdomen with a disinfectant wipe and administer insulin. A Safety Data Sheet for the disinfectant wipes, dated 06/29/22, showed to avoid contact with skin. A policy titled Bedside Blood Glucose Monitoring, dated 04/26/24, showed to cleanse the finger with alcohol. On 04/01/25 at 10:36 a.m., LPN #2 stated they were suppose to use alcohol swabs when obtaining blood glucose and administering insulin. They were asked if the disinfectant wipes were safe to use on skin. LPN #2 stated they did not think so.

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 35749 Based on observation, record review, and interview, the facility failed to ensure staff were competent with the facility's EMR for 3 (CMA #1, LPN #2, and AD) of 3 staff observed for competent staff. The DON identified 111 residents resided in the facility. Findings: On 04/01/25 at 8:05 a.m., during a medication observation pass with CMA #1, a medication for a Resident #70 was observed not to be administered. In-service sheets for the new EMR, dated 03/05/25, 03/06/25, 03/10/25, and 03/12/25, did not show CMA #1, LPN #2, or the AD attended the in-services. On 04/01/25 at 8:08 a.m., CMA #1 stated the medication was not in the facility. They were asked how medications were ordered. CMA #1 stated as far as they knew, it was on the new EMR system. CMA #1 was asked if they could look at the new EMR and tell if the medication had been ordered. They stated they had not been trained on the new EMR and did not know how to tell if the medication had been ordered. CMA #1 stated they came into work one morning and the new EMR was in place. On 04/02/25 at 10:35 a.m., LPN #2 stated they did not know how to order medication on the new EMR system. On 04/02/25 at 11:56 a.m., the corporate nurse was asked how they ensured staff were competent with the new EMR. They stated corporate staff had conducted a two day training with key staff and nursing administration. The corporate nurse stated those staff members then trained the rest of the staff. On 04/02/25, at 12:01 p.m., during the interview with the corporate nurse, the AD entered and asked the corporate nurse how to get to care plans in the new system. The corporate nurse stated there should be in-service sheets. On 04/02/25 at 1:37 p.m., the corporate nurse stated they could not find any other in-service sheets. They stated without the inservice sheets, they could not say everyone had been in-serviced. 41318

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35749 Based on observation, record review, and interview, the facility failed to ensure medications were administered as ordered for 5 (#70, 71, 77, 106, and #226) of 10 sampled residents reviewed for medications. The DON identified 111 residents resided in the facility. Findings: 1. On 04/01/25 at 7:17 a.m., CMA #2 was observed to administer medications to Resident #71. Resident #71 had an order for hydrocodone/acetaminophen (an opiate medication) 7.5/325 mg every six hours that was not administered. 2. On 04/01/25 at 7:25 a.m., CMA #2 was observed to administer medications to Resident #226. Resident #226 was administered Vitamin B12 10 mcg without an order. Resident #226 had physician's orders to administer thiamine (a vitamin) 100 mg daily at 9:00 a.m. and ferrous sulfate (a iron supplement) 325 mg daily at 9:00 a.m. that were not observed to be administered. 3. On 04/01/25 at 7:46 a.m., CMA #2 was observed to administer medications to Resident #106. Resident #106 had an order for lisinopril (an ACE inhibitor)10 mg daily at 9:00 a.m. that was not observed to be administered. 4. On 04/01/25 at 8:05 a.m., CMA #1 was observed to administer medications to Resident #70. Resident #70 had orders for amlodipine (a calcium channel blocker) 5 mg daily at 9:00 a.m. and clindamycin (an antibiotic) 150 mg every six hours that were not observed to be administered. 5. On 04/02/25, at 8:17 a.m., LPN #2 was observed to prepare medication for Resident #77. Resident #77 had orders for two capsules of gabapentin (an anticonvulsant)100 mg twice daily and one tablet of potassium (electrolyte supplement)10 meq daily. LPN #2 was observed to administer one capsule of gabapentin and was not observed to administer potassium. A Medication Administration policy, dated 01/2024, read in part, Medications are administered in accordance with written orders of the prescriber. On 04/01/25 at 8:08 a.m., CMA #1 stated the clindamycin for Resident #70 was not in the facility. They stated it had been ordered yesterday and they did not know how quickly the pharmacy delivered new orders. On 04/01/25 at 10:35 a.m., LPN #2 stated they only administered one capsule of gabapentin and should have administered two capsules for Resident #77. They stated they did not administer the potassium tablet because the card of medication was empty. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/02/25 at 11:56 a.m., the corporate nurse was asked how they ensured medications were administered per physician orders. They stated they would get physician orders, order the medication from the pharmacy, make sure the medications were on the carts, and follow the MAR. They stated they purchased over the counter medications. The corporate nurse was asked what the policy was for ordering new medications. They stated their EMR interfaces with the pharmacy. The corporate nurse stated they would fax a new order if the EMR was not working. They stated staff would follow up with the pharmacy to ensure they received the orders. The corporate nurse was made aware of the above observations for #70, 71, 77, 106, and #226. Surveyor: Green, [NAME] 41318

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 35749 Based on observation, record review, and interview, the facility failed to ensure a medication error rate was less than 5 percent for 5 (#70, 71 77, 106, and #226) of 10 sampled residents reviewed for medication administration. The medication error rate was 23.68 percent. The DON identified 111 residents resided in the facility. Findings: 1. On 04/01/25 at 7:17 a.m., CMA #2 was observed to administer medications to Resident #71. Resident #71 had an order for hydrocodone/acetaminophen (an opiate medication) 7.5/325 mg every six hours that was not administered. 2. On 04/01/25 at 7:25 a.m., CMA #2 was observed to administer medications to Resident #226. Resident #226 was administered Vitamin B12 10 mcg without an order. Resident #226 had physician's orders to administer thiamine (a vitamin) 100 mg daily at 9:00 a.m. and ferrous sulfate (a iron supplement) 325 mg daily at 9:00 a.m. that were not observed to be administered. 3. On 04/01/25 at 7:46 a.m., CMA #2 was observed to administer medications to Resident #106. Resident #106 had an order for lisinopril (an ACE inhibitor)10 mg daily at 9:00 a.m. that was not observed to be administered. 4. On 04/01/25 at 8:05 a.m., CMA #1 was observed to administer medications to Resident #70. Resident #70 had orders for amlodipine (a calcium channel blocker) 5 mg daily at 9:00 a.m. and clindamycin (an antibiotic) 150 mg every six hours that were not observed to be administered. 5. On 04/02/25, at 8:17 a.m., LPN #2 was observed to prepare medication for Resident #77. Resident #77 had orders for two capsules of gabapentin (an anticonvulsant)100 mg twice daily and one tablet of potassium (electrolyte supplement)10 meq daily. LPN #2 was observed to administer one capsule of gabapentin and was not observed to administer potassium. A Medication Administration policy, dated 01/2024, read in part, Medications are administered in accordance with written orders of the prescriber. On 04/01/25 at 8:08 a.m., CMA #1 stated the clindamycin for Resident #70 was not in the facility. On 04/01/25 at 10:35 a.m., LPN #2 stated they only administered one capsule of gabapentin and should have administered two capsules for Resident #77. They stated they did not administer the potassium tablet. On 04/02/25 at 11:56 a.m., the corporate nurse was asked how they ensured medications were administered per physician orders. They stated they would get physician orders, order the medication from the pharmacy, make sure the medications were on the carts, and follow the MAR. The corporate nurse was made aware of the above observations for #70, 71, 77, 106, and #226.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45583 Based on observation, record review, and interview, the facility failed to ensure infection control practices were maintained for handling soiled linen and hand hygiene during incontinent care for 1 (#52) of 23 sampled residents reviewed for infection control. The DON identified 111 residents resided in the facility. Findings: On 03/25/25 at 9:18 a.m., LPN #1 was observed exiting a resident's room while holding a soiled incontinent pad and took it into the soiled utility room. On 03/31/25 at 5:46 a.m., CNA #1 was observed to provide incontinent care to Resident #52 whose brief was soiled with urine and feces. CNA #1 did not change their gloves after cleaning the resident. CNA #1 used soiled gloves to put a clean brief on Resident #52 and placed a clean incontinent pad and a clean draw sheet under the resident. CNA #1 placed the soiled linen and soiled wipes onto the floor and not into a plastic bag. On 03/31/25 at 6:01 a.m., CNA #1 was observed to place soiled items from the floor into a plastic bag. CNA #1 used soiled gloves to place a clean sheet on top of Resident #52. CNA #1 was not observed to perform hand hygiene during the observation. A policy titled Hand Hygiene for Staff and Residents, revised 02/2025, read in part, Hand hygiene is done . Before .resident contact .After .contact with soiled or contaminated articles, that are contaminated with body fluids .toileting or assisting others with toileting. A policy titled Linen and Laundry Services, revised 03/2025, read in part, Contaminated laundry is bagged or contained at the point of collection (location where it was used) .Linen is not placed on the floor. On 03/25/25 at 9:19 a.m., LPN #1 stated they should have placed the soiled incontinent pad in a bag prior to transporting them to the soiled utility room. On 03/31/25 at 6:02 a.m., CNA #1 stated staff were to place soiled items in the trash, change their gloves, and wash their hands during incontinent care. On 03/31/25 at 6:14 a.m., the DON stated staff were to change their gloves between soiled and clean items when they were providing incontinent care to the residents. The DON stated soiled items went into bags and not on the floor.