STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375556	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Manor Nursing Home	2416 West 51stsouth Tulsa, OK 74107

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41220 On 04/01/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to protect Resident #1 from verbal and physical abuse. During breakfast pass on 03/22/25, CNA #1 was involved in a verbal and physical altercation with Resident #1. CNA #1 was in the hallway passing drinks and Resident #1 was also in the hallway. CNA #1 was witnessed to yell, threaten and throw a glass of milk and a 2/3 full gallon of milk at Resident #1. The altercation was witnessed by CMA #1 and LPN #1 who unsuccessfully attempted to intervene and de-escalate the situation. On 04/01/25 at 5:29 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation. On 04/01/25 at 5:49 p.m., the administrator and DON were notified of the immediate jeopardy situation and provided the IJ template. On 04/03/25 at 9:10 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The facility plan of removal, read in part, IJ Plan of Removal [NAME] Manor Nursing Home Submitted by: [name withheld], Administrator Re-submitted 4/2/2025 with corrections 4/1/25 - 5:49pm - IJ received from OSDH LTC Enforcement 4/1/25 - 10:15pm DON, ADON & Administrator contacted all staff via text to in-service & educate regarding procedure when a resident is involved in a verbal and/or physical altercation (to include staff, residents & visitors) Procedure when a resident is involved in a verbal/physical abuse situation (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	'If there is a situation where there is a potential for verbal or physical abuse with a resident, please remove the resident to a safe place away from the altercation. Our residents must remain free from abuse and neglect, and it is our responsibility and obligation to follow that policy and procedure. If you ever witness or hear of abuse or neglect you are to report to your supervisor immediately. It is the supervisor's responsibility to report to administration immediately'. 4/2/25 - 3:37pm Resident safe surveys completed Total = 64 complete / 4 unable to communicate Current Census = 68 4/2/25 4 Residents unable to communicate: full skin assessments done -[Resident #9]-time completed 5:11pm -[Resident #8]-time completed 5:01pm -[Resident #11]-time completed 4:58pm -[Resident #12]-time completed 5:01pm 4/2/25 - 5:13pm Plan of Removal completed -Employee CNA #1 was separated from resident #1 immediately, wrote [their] statement. [They] was interviewed by police and then escorted out of the building by ADON and was terminated by DON. -All staff have abuse training on hire. -All staff will be educated regarding abuse and dealing with behaviors at minimum semi-annually and as needed. -Nursing Administration and/or Administrator will continue abuse training at every scheduled in-service for 90 days, and more often as needed. QAPI will review monthly x 90 days to ensure compliance. The IJ was lifted, effective 04/03/25 at 11:51 a.m., when all components of the plan of removal had been verified as completed. Thirteen staff members in all departments from all shifts were interviewed regarding abuse as indicated in the plan of removal. Documentation for safe surveys and skin assessments of residents were reviewed. The deficient practice remained at an isolated level with potential for more than minimal harm. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on record review and interview, the facility failed to ensure residents were free from abuse for 1 (#1) of 3 sampled residents reviewed for abuse. The administrator identified 76 residents resided in the facility. Findings: 1. Resident #1 was admitted with diagnoses which included unspecified dementia and schizoaffective disorder, bipolar type. An abuse and neglect policy, revised April 2021, read in part, Abuse of any kind against residents is strictly prohibited. A final incident report to the Oklahoma State Department of Health, dated 03/26/25, showed CNA #1 and Resident #1 had a verbal and physical disagreement. The report showed CNA #1 threw a glass of milk and a gallon jug of milk at Resident #1. The report showed Resident #1 was noted to have a scratch on their forehead. The report showed CNA #1 was immediately escorted out of the building and Resident #1 was sent to a hospital for evaluation. On 03/31/25 at 4:28 p.m., the administrator showed this surveyor a facility closed circuit video, dated 03/22/25, of the West/South hall of the facility. The video of the incident occurred from 8:52 a.m. to 8:55 a.m. The video showed CNA #1 pouring drinks and taking them into rooms and Resident #1 was walking in the hall. The video showed CNA #1 and Resident #1 talking next to a drink cart at the end of the hall. The video showed CNA #1 waved their hands and arms around wildly, pointing at Resident #1, stepping towards the resident, and shaking a finger in Resident #1's face. The video showed LPN #1 and CMA #1 were observed to enter the frame of the video and LPN #1 stood next to Resident #1 and CMA #1 stood next to CNA #1. The video showed CMA #1 and LPN #1 appeared to talk to both Resident #1 and CNA #1 and CNA #1 continued to make wild arm and hand gestures and did not back away from Resident #1. The video showed CNA #1 continued to point and shake a finger at Resident #1's face and gesture wildly. The video showed CNA #1 was observed to pick up a glass of milk and throw it at Resident #1. The video showed CMA #1 reached across CNA #1's chest and CNA #1 pushed CMA #1 away. The video showed CNA #1 then picked up a jug of milk from the cart and threw it at the resident. The video showed CNA #1 was observed to slip, fall to their knees, and when CNA #1 stood they were observed to swing at the resident. On 03/31/25 at 3:55 p.m., LPN #1 stated they witnessed CNA #1 and Resident #1 in a heated argument. LPN #1 stated they saw CNA #1 throw a cup of milk and a 90% full gallon jug of milk at Resident #1. LPN #1 stated they and CMA #1 tried to get CNA #1 to walk away, but instead were shoved away by CNA #1. LPN #1 stated they called the DON and another staff member called the police. LPN #1 stated they observed Resident #1 with an abrasion on their forehead after the incident. On 04/01/25 at 1:29 p.m., the DON stated in response to the incident, CNA #1 was escorted out of the facility and Resident #1 was sent to the hospital for evaluation. The DON stated they did not provide education on abuse afterwards. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/01/25 at 2:07 p.m., the administrator stated they did not come to the facility the day of the incident, but did watch the video surveillance of the incident when they returned to the facility. The administrator stated they did discuss providing abuse education to the staff. The administrator stated they discussed the incident at their morning staff meeting and with the facility's physician. On 04/01/25 at 3:29 p.m., CMA #1 stated they witnessed CNA #1 and Resident #1 in an argument. CMA #1 stated they and LPN #1 tried to de-escalate the situation, but CNA #1 was yelling at Resident #1 and was not backing out of the argument. CMA #1 stated they and LPN #1 were trying to stop the argument. CMA #1 stated LPN #1 was trying to keep Resident #1 safe and they were trying to get CNA #1 to walk away. CMA #1 stated CNA #1 was yelling, threw a glass of milk at Resident #1, then picked up a gallon jug of milk, and threw it at Resident #1. CMA #1 stated after CNA #1 walked away they observed Resident #1 with an abrasion on their forehead. CMA #1 stated the nose piece to Resident #1's glasses was stuck in the hair on their forehead and their glasses were on the floor across the room. CMA #1 stated CNA #1 was still very angry and they assisted Resident #1 to a safe area and stayed with the resident.

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 On 04/01/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure antipsychotic medications were available and residents were provided ordered medications for a serious mental illness. Resident #1 was admitted on [DATE] and had diagnoses which included schizoaffective disorder, bipolar type. The resident was ordered risperidone (an antipsychotic medication) 3mg twice daily and Seroquel (an antipsychotic medication) 25mg every evening. The resident did not receive 12 consecutive doses of risperidone, from the p.m. dose on 03/13/25 through the a.m. dose on 03/19/25. The first dose of risperidone was not administered until 03/19/25 for the p.m. dose. The resident did not receive five consecutive doses of Seroquel from 03/13/25 through 03/17/25. The first dose of Seroquel was not administered until 03/18/25. The physician was not made aware the medications were unavailable and not administered. Per interview with the DON the facility did not have a protocol in place to ensure medications were received and available for administration. Resident #1 was sent to the emergency roiagnom on [DATE] when they had threatened the nurse, had received olanzapine (an antipsychotic medication) 5mg intramuscularly (IM) while in the emergency room , and was readmitted to the facility. On 03/22/25, the resident was involved in a verbal and physical altercation with CNA #1. The resident was sent to the emergency room , was admitted for in-patient psychiatric treatment, and the resident would not return to the facility. On 04/01/25 at 5:47 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 04/01/25 at 5:49 p.m., the administrator and the DON were notified of the IJ situation and provided the IJ template. On 04/03/25 at 12:04 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, .4/1/25 - 5:49pm- IJ received from OSDH LTC Enforcement 4/1/25 - 6:30 pm List of residents on psychiatric medications was created and audit completed to ensure that all residents on psychiatric medications are receiving as ordered and meds [medications] are in the building 4/1/25 - 7:38pm -DON, ADON & Administrator contacted all nurses and CMA's (in person, via text and email) to in-service & educate regarding procedure when a resident medication is not available. - (See In-service procedure below) PROCEDURE WHEN PATIENT ORDERED MEDICATION IS NOT AVAILABLE/OUT 1. Certified Medication Aide must notify the nurse if a medication is not in building 2. Med Aide must document in EMAR [electronic medication administration record] progress note that they notified the nurse and document the name of the nurse. 3. The nurse needs to contact the pharmacy as to why medication is not available. 4. The nurse must then notify the Physician/Medical Director of the reason the medication is not available (ex [example]: to see if he wants to hold med or change med) 5. The nurse must write order per Doctor directive (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. The DON and/or designee must be notified if medication is not in the building. 7. The DON and/or designee will monitor daily that residents with psychiatric medication orders have their medications as ordered. **If it is a pre-auth [authorization] situation, the nurse will tell pharmacy to send 3-5-day supply at cost to the facility. Pharmacy will contact DON or Administrator for financial approval. **Any medication that is put on hold or waiting on pharmacy, the Nurse must notify the Physician/Medical Director, and an order must be written. DON must be notified by nurse as well. 4/1/25 - 10:08pm - Plan of Removal Completed Received last email to confirm all Nurse and CMA education done. Other staff working or came in to sign personally. (Total of 20) 4/3/25 - 10:15am Started inservice to speak to all nurses and cma's in person & over the phone to ensure proper understanding of the policy stated above. 4/3/25 12:00pm Plan of Removal completed Education and In-services will be on going per DON & Administrator The DON, and/or designee will check on [electronic health record name withheld] within 24 hours of a new admission to ensure that all medication to include psychiatric medications have been received. DON and/or designee will audit psychiatric medications daily to ensure that medications are in the building and if not, follow the above procedure. QAPI Committee will review monthly x 3 months to ensure compliance. The IJ was lifted, effective 04/03/25 at 11:51 a.m., when all components of the plan of removal had been verified as completed. Four CMAs, four charge nurses who work all shifts, and the DON were interviewed regarding the medication protocol to ensure availability and administration as indicated in the plan of removal. Documentation of medication audits and inservices were reviewed. The deficient practice remained at an isolated level with the potential for more than minimal harm. Based on record review and interview, the facility failed to ensure antipsychotic medications were available and a resident was provided ordered medications for a serious mental illness to maintain their highest practicable level of mental well-being for 1 (#1) of 3 sampled residents whose medications were reviewed. The DON identified 11 residents who were ordered antipsychotic medications and 11 residents who were diagnosed with a serious mental illness. Findings: Resident #1 was admitted on [DATE] with diagnoses which included schizoaffective disorder, bipolar type. A policy titled, Preparation and General Guidelines, dated April 2018, read in part, If 3 consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response. A policy titled, Behavioral Assessment, Intervention, and Monitoring, dated March 2019, read in part, The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A physician's order, dated 03/13/25, showed the resident was ordered risperdone 3mg po twice daily for schizoaffective disorder, bipolar type. A physician's order, dated 03/13/25, showed the resident was ordered Seroquel 25mg po after the evening meal for schizoaffective disorder, bipolar type. A Medication Administration Note, dated 03/13/25 at 10:20 p.m., read in part, waiting on pharmacy. The note was documented twice for the same date and time with no specific medication documented. A history and physical, dated 03/14/25, read in parts, With schizoaffective disorder.Quetiapine [Seroquel]. Risperidone. A Medication Administration Note, dated 03/14/25 at 8:09 p.m., read in part, waiting on pharmacy. A Medication Administration Note, dated 03/14/25 at 8:10 p.m., read in part, waiting on pharmacy. A Medication Administration Note, dated 03/15/25 at 10:52 a.m., read in part, risperiDONE Oral Tablet 3 MG Give 1 tablet by mouth two times a day related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE .On Order A Medication Administration Note, dated 03/15/25 at 9:20 p.m., read in part, risperiDONE Oral Tablet 3 MG Give 1 tablet by mouth two times a day related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE .On Order A Medication Administration Note, dated 03/15/25 at 9:20 p.m., read in part, QUEtiapine Fumarate [Seroquel] Oral Tablet 25 MG Give 1 tablet by mouth one time a day related to UNSPECIFIED DEMENTIA, MILD, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY .On Order A Medication Administration Note, dated 03/16/25 at 10:50 a.m., read in part, risperiDONE Oral Tablet 3 MG Give 1 tablet by mouth two times a day related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE .On Order A Medication Administration Note, dated 03/16/25 at 8:51 p.m., read in part, QUEtiapine Fumarate [Seroquel] Oral Tablet 25 MG Give 1 tablet by mouth one time a day related to UNSPECIFIED DEMENTIA, MILD, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY .On Order A Medication Administration Note, dated 03/16/25 at 8:52 p.m., read in part, risperiDONE Oral Tablet 3 MG Give 1 tablet by mouth two times a day related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE .On Order A Medication Administration Note, dated 03/18/25 at 11:48 a.m., showed the risperidone was on hold until 03/19/25. The reason for the hold, read in part, awaiting medication from pharmacy. A Medication Administration Note, dated 03/18/25 at 7:22 p.m., read in part, waiting on pharmacy. The specific medication was not indicated in the note. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A care plan, dated 03/18/25, read in part, .ANTI-PSYCHOTIC MEDICATION: I am at risk for adverse reactions, labile moods, and falls related to anti-psychotic medication I receive R/T [related to] Schizophrenia .Administer anti-psychotic medication per current orders. Refer to physician orders for details .I am exhibiting behaviors of using a razor to my nose .Administer behavior medications per current orders .Alert my charge nurse of unusual or ongoing behavioral or mood issues .Redirect as needed. A packing slip from the pharmacy, dated 03/18/25 at 11:00 p.m., showed the pharmacy had delivered seven tablets of Seroquel 25mg and 60 tablets of risperidone 3mg for Resident #1. A physician progress note, dated 03/20/25, read in part, Acute problem addressed: Patient is delusional and hallucinatory. [Resident #1] says this is better than usual. [Resident #1] has been to inpatient psychiatry multiple times. [Resident #1] has no hallucinations that tell [them] to hurt people or hurt others .Plan: I will get psychiatry to see the patient sooner rather than later. [Resident #1] is somewhat delusional and having hallucinations but this is [their] baseline. [Resident #1] actually may be better than usual. [Resident #1] does not seem to be agitated or to the point where [they are] having hallucinations that are telling [them] to harm people or harm [themselves]. A nurse note, dated 03/20/25 at 2:48 p.m., showed the nurse had noted the resident had a scratch to their nose. The note showed the resident had stated they were a doctor and had used a disposable razor to shave something off of their nose. The note showed a message was sent to the resident's guardian for approval for psychiatric services. A behavior note, dated 03/20/25 at 8:08 p.m., showed Resident #1 was sitting in the middle of the hallway rolling tobacco in paper. The note showed when the nurse asked the resident to not sit in the middle of the hallway the resident stated they were a fourth degree black belt and threatened the nurse. The note showed the resident's guardian, DON, and physician had been notified. An emergency department provider note, dated 03/20/25, showed Resident #1 presented with agitation and had made threats toward staff. The emergency department provider note showed the resident was administered olanzapine 5mg intramuscularly due to agitation on 03/20/25 at 8:57 p.m. and would be discharged back to the facility. A behavior note, dated 03/21/25 at 5:49 p.m., read in part, Resident pacing up and down the halls requesting the 'warden' and to also have [their] blood drawn. Educated resident about needing an order from the doctor before getting labs. Resident is asking for [their] wheel chair stating 'I walk over 20 miles a day I need my wheel chair' also went on to say things to me 'I need to speak to the charge nurse' When informed that I am the charge nurse, resident would respond 'Youre [sic] hard to look at'. Resident has found a wheel chair and now rolling around the facility. Will continue to monitor and redirect resident. A behavior note, dated 03/21/25 at 5:55 p.m., showed the resident was observed by the nurse to eat in the dining room and then as they walked to their room they notified the aides they had not received a tray for dinner. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A behavior note, dated 03/21/25 at 9:10 p.m., read in part, Resident has been pacing up and down the halls all shift, brushing [their] beard with [their] tooth brush, saying 'Im [sic] God, Im [sic] a Doctor, thank you Jesus, praying and speaking in a forgein [sic] language' Resident has come to the nurses desk asking for seroquel stating 'I cannot sleep without it and I will be up all night if the doctor wont give me seroquel' Doctor notified. A behavior note, dated 03/21/25 at 9:32 p.m., read in part, Resident going in and out room [ROOM NUMBER] turning the tv off and on. A behavior note, dated 03/22/25 at 8:40 a.m., read in part, Resident told [CNA #1] 'Dont [sic] touch my food you probably have aides [sic]'. An incident noted, dated 03/22/25 at 9:02 a.m., showed Resident #1 had been involved in a verbal and physical altercation with CNA #1. The note showed following the altercation the resident was taken to the emergency room for evaluation. A social services note, dated 03/28/25, showed the resident was receiving in-patient psychiatric treatment and would not return to the facility upon discharge. Review of the March 2025 medication administration record showed Resident #1 had not received Seroquel 25mg, ordered every evening, from 03/13/25 through 03/17/25. The medication administration record showed Resident #1 had received their first dose of Seroquel 25mg on 03/18/25 for the p.m. dose. The medication administration record showed Resident #1 had not received risperidone 3mg twice daily from the p.m. dose on 03/13/25 through the a.m. dose on 03/19/25. The medication administration records showed the p.m. dose on 03/18/25 and the a.m. dose on 03/19/25 of risperidone 3mg was held. The medication administration record showed Resident #1 had received their first dose of risperidone 3mg on 03/19/25 for the p.m. dose. On 04/01/25 at 10:46 a.m., CMA #2 stated if medications were not available for administration they notified the charge nurse and the pharmacy. They stated Resident #1 had requested their Seroquel several times but they did not think they had an order for Seroquel. CMA #1 stated they remembered having issues getting the risperidone from the pharmacy and not having it available to administer. They stated they thought they had notified the charge nurse but had not documented the notification. CMA #2 stated Resident #1 exhibited behaviors almost every day during their admission. On 04/01/25 at 11:02 a.m., LPN #2 stated they called the pharmacy if the CMA notified them a medication was not available for administration. They stated they did not remember orders for risperidone or Seroquel for Resident #1. They stated Resident #1 had requested 200mg of Seroquel, the physician was notified and stated they would review the resident's medications. LPN #2 stated on 03/20/25, Resident #1 was aggressive, threatened them, paced in the hallways, talked to themselves, verbalized delusions, and had been sent to the emergency room for a psychiatric evaluation. LPN #2 stated they were not aware Resident #1's Seroquel and risperidone had not been available for administration. On 04/01/25 at 11:47 a.m., the DON stated they were not sure what information they had regarding medication deliveries from the pharmacy for Resident #1. They stated once medications were delivered, everything was completed in the electronic clinical record, but they would look for delivery information. (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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/01/25 at 1:30 p.m., the DON stated they had not been made aware the risperidone and Seroquel had not been available for Resident #1. They stated they thought it was probably because the medications required a prior authorization, but they had a call in to the pharmacy for further information. On 04/01/25 at 1:42 p.m., the DON stated the only behavior they had observed for Resident #1 was pacing in the hallways. The DON stated on admission, on 03/13/25, the resident was observed to be calm, polite, and paced the hallways at times. They stated by 03/20/25 Resident #1 had threatened the nurse, was verbalizing delusions, and was sent to the emergency room for a psychiatric evaluation. The DON stated they did not know why the risperidone had been documented as on hold on 03/18/25 and 03/19/25. They stated when residents were admitted to the facility they relied on the CMAs and charge nurses to notify them if medications were not available but they had not been notified the risperidone and Seroquel were not available for Resident #1. The DON stated they reviewed the medication administration records once a month, reviewed the electronic health record to ensure newly admitted resident had physician orders, but did not review to ensure the ordered medications were available for administration. On 04/01/25 at 2:23 p.m., the administrator stated they had just noticed the risperidone and Seroquel were not available for administration for Resident #1. They stated the DON and physician should have been made aware the medications were not available for administration. The administrator stated Resident #1 had not initially exhibited behaviors, but a few days after admission they had noticed Resident #1 had began talking a little erratically. They stated at that time they had reviewed the physician orders and noted the resident was ordered antipsychotic medications but was unaware the medications were not being administered because they were unavailable. The administrator stated as days had passed they grew more concerned about Resident #1's mental health status and their vulnerable resident population. The administrator stated Resident #1 should have received their medications as ordered. The administrator stated This was avoidable. I wish myself or the team would have noticed the meds were not available. On 04/01/25 at 2:45 p.m., the consultant pharmacist stated the potential effects of Resident #1 not receiving 12 consecutive doses of risperidone would be worsening symptoms of the condition the medication was ordered to treat. They stated not receiving the dose of risperidone Resident #1 had been ordered increased the risk of symptoms returning. The consultant pharmacist stated they had informed the facility in the past to call the pharmacy if medications were not available for administration. On 04/01/25 at 2:53 p.m., physician #1 stated they had not provided the order to place risperidone on hold on 03/18/25 and 03/19/25. They stated they had not been notified the ordered risperidone and Seroquel had not been available or administered for Resident #1. They stated the potential effects of Resident #1 not receiving 12 consecutive doses of risperidone and five consecutive doses of Seroquel would be an increase in psychosis. On 04/01/25 at 3:57 p.m., the DON stated they had verified with the pharmacy that a prior authorization was needed for the risperidone and Seroquel for Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375556	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Manor Nursing Home	2416 West 51stsouth Tulsa, OK 74107

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 35474 Based on record review and interview, the facility failed to ensure labs were obtained as ordered by the physician for 1 (#1) of 3 sampled residents who were reviewed for labs. The DON identified 71 residents who had orders for labs. Findings: Resident #1 had diagnoses which included schizoaffective disorder, bipolar type. A physician order, dated 03/13/25 showed the resident was ordered lithium (mood stabilizer medication) 300mg twice daily. A physician progress note, dated 03/14/25, showed an order for admission labs which included a lithium level. Review of the labs for Resident #1 and the order summary report for the resident's stay, dated 03/13/25 through 03/22/25, did not show obtaining a lithium level had been requested from the lab company or completed. On 04/03/25 at 4:24 p.m., LPN #3 stated they had not seen an option to obtain a lithium level in the lab portal. On 04/03/25 at 4:52 p.m., the DON stated they did not know why the lithium level had not been entered into the lab portal. They stated they had asked LPN #1 why they had not ordered the lithium level and they stated they thought it would be included in the CBC (complete blood count). The DON stated they conducted random audits to ensure labs were obtained as ordered by the physician. They stated the last audit they had conducted was on 01/30/25. The DON stated, We have a problem with labs.