STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375094	A. Building B. Wing	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care Center Tulsa	2425 South Memorial Tulsa, OK 74129

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34270 Based on record review and interview, the facility failed to report an allegation of sexual abuse to the Oklahoma Stated Department of Health. A facility census report, dated 01/31/24, documented 66 residents resided in the facility. Findings: Resident #13 had diagnoses which included chronic obstructive pulmonary disease and Parkinson's disease. A facility policy, titled Abuse, Neglect, and Exploitation, dated November 2017, documented allegations of abuse were to be reported to the state survey agency within five working days of the alleged incident. A facility document, titled Concern Form, dated 06/28/26 [sic], documented a family member reported an alleged incident of sexual abuse to the director of nursing on 06/28/23. An Adult Protective Services investigation report, dated 11/06/23, documented an APS worker visited the facility on 10/31/23 and discussed the alleged incident with Employee #2. Resident #13's medical records and facility records were reviewed for documentation of an investigation regarding the Concern Form, dated 06/28/26. No investigative documentation regarding the alleged incident was found other than the Concern Form, dated 06/28/23 [misdated on the form as 06/28/26] and the APS investigation report, dated 10/31/23. On 02/06/24 at 8:44 a.m. the administrator stated the documentation of an investigation of sexual abuse for Resident #13 did not exist. They stated it was their expectation that allegations would be investigated promptly and reported to the required authorities in a timely manner as per facility policy.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34270 Based on record review and interview, the facility failed to conduct a thorough investigation of a report of alleged sexual abuse for one (#13) of three sampled residents reviewed for abuse. A facility census report, dated 01/31/24, documented 66 residents resided in the facility. Findings: Resident #13 had diagnoses which included chronic obstructive pulmonary disease and Parkinson's disease. A facility policy, titled Abuse, Neglect, and Exploitation, dated November 2017, documented suspected abuse would be investigated immediately and include interviews of residents, staff, and visitors that were in the area and document the entire investigation. A facility document, titled Concern Form, dated 06/28/26 [sic], documented Employee #1 had written that Resident #13's family member reported the resident had said a male aide had cupped their breast during a shower. It further documented Employee #1 was designated to act on the issue and was assigned to them on 06/28/23. It documented Employee #1 had met with the resident who stated they were not comfortable with a male aide providing showers. It further documented Employee #1 resolved the issue by changing the shower aide to a female. The resolution was dated 06/28/23. The form did not document any staff or resident interviews other than Resident #13. It did not identify a male aide accused of the alleged assault. Resident #13's medical records and facility records were reviewed for documentation of an investigation regarding the Concern Form, dated 06/28/26. No documentation was found. On 02/06/24 at 8:25 a.m., the administrator stated they had been unable to find any documentation of an investigation of sexual abuse for Resident #13. On 02/06/24, at 8:44 a.m. the administrator stated the documentation of an investigation of sexual abuse for Resident #13 did not exist. They stated it was their expectation that staff would report all allegations of abuse and the investigation would be completed in a timely manner. On 02/06/24, at 9:06 a.m., an APS worker stated they had discussed the allegations of sexual abuse with Employee #2 on 10/31/23. On 02/06/24, at 10:38 a.m., the MDS Coordinator stated they had not found any facility documentation of an investigation related to the accusation of sexual abuse regarding Resident #13.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to ensure a resident was not involuntarily discharged without notice and right to appeal and failed to document a discharge in a resident's medical record for one (#8) of three sampled resident reviewed for discharges. A facility Length of Stay By Discharge Reason Report, dated [DATE] through [DATE], documented 37 residents discharged from the facility during the specified period. Findings: Resident #8 had diagnoses which included fracture of the right tibia and schizoaffective disorder. A facility policy, titled Transfer and Discharge from the Facility Policy, dated [DATE], read in part, .The rights of residents who voluntarily or involuntarily are discharged from the facility will be upheld and that a resident will not be involuntarily discharged unless the circumstances meet specific criteria defined by regulations and laws. The facility will make every effort to provide care and services to the residents it serves .The objective of the transfer/discharge policy is to ensure that the resident is informed of an impending discharge and their right to appeal the discharge .the facility must ensure that the transfer or discharge is documented in the resident's medical record . A handwritten letter, dated [DATE], documented APRN #1's statement that Resident #8 had been refusing care for a wound as well as refusing hygiene care. The letter documented APRN #1 had informed the resident of the potential consequences of continued refusal of care which included infections, sepsis, and death. The letter documented what APRN #1 stated Resident #8 had replied to that information. The letter read in part, . [Resident #8] expressed that if [Resident #8] died , [Resident #8's] family would get money to [NAME] [Resident #8] from a court case . The letter further documented the resident understood the risks of declining care. APRN #1 then documented that in their opinion the resident was suicidal, and the resident required a psychiatric evaluation due to them being a danger to themselves. A progress note, dated [DATE] at 6:35 p.m., documented Resident #8 had been transferred to an acute care hospital on that date for a psychiatric evaluation. A meeting minutes, dated [DATE], documented a conference call had taken place on that date with Employee #1 [former DON at the facility], Employee #2 [former administrator at the facility], Director of Admissions, and the liaison participating in the call. It documented the subject of the conference call was to determine if Resident #8 would be allowed to return to the facility. It documented Employee #1 informed the group one of their physicians had reported they would not care for the resident if they returned. The document stated another physician was asked to take over the care, but it did not document the physician's reply. It documented the group that participated in the call decided the resident would not be allowed to return to the facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] Resident #8's medical record was reviewed for documentation regarding their transfer on [DATE] and the reason the resident did not return. No such documentation was found. On [DATE] at 3:07 p.m., DON stated there was no discharge summary for Resident #8 and they had been unable to locate any transfer or discharge notices for the transfer that occurred on [DATE] or the involuntary discharge that occurred on [DATE]. On [DATE] at 9:50 a.m., an anonymous hospital employee stated that on [DATE] Resident #8 had been evaluated for mental health issues and was cleared to return to the nursing home where they had resided. They stated the resident was scheduled to return to the facility on [DATE]. They stated FE #2 reported to the hospital on that date Resident #8 could not return to the facility but could go to a sister facility. They stated at 4:00 p.m., the director of admissions at the nursing home asked for a 72-hour hold and the resident could come after that time. They stated they agreed to that request. They stated on [DATE] the nursing home liaison arrived at the hospital and stated their physicians would not accept the resident back to the facility. On [DATE] at 10:20 a.m., the director of admissions for the nursing home company stated Resident #8 had been denied the ability to return to the facility because of behaviors. They stated Employee #1 and Employee #2 did not want the resident back in the facility. They stated they explained to Employee #1 and Employee #2 the legal aspects of that decision, but the two declined to allow the resident back. The director of admissions stated they were given the job of contacting the facility. They stated they tried to allow the resident back, but those in power would not allow them to return. They stated they were also informed by Employee #1 and Employee #2 that neither of the facility's physicians would care for the resident if they returned. On [DATE] at 10:34 a.m., the liaison stated they were given the job of informing the hospital that Resident #8 would not be allowed to return to facility. On [DATE] at 10:45 a.m., the administrator stated after searching Resident #8's medical records, no documentation of any type related to discharging the resident from the hospital on or after [DATE] was found.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 34270 Based on record review and interview, the facility failed to provide a notice of transfer and a notice of discharge for one (#8) of three sampled residents reviewed for discharges. A facility Length of Stay By Discharge Reason Report, dated 10/01/23 through 11/30/23, documented 37 residents discharged from the facility during the specified period. Findings: Resident #8 had diagnoses which included fracture of the right tibia and schizoaffective disorder. A facility policy titled Transfer and Discharge from the Facility Policy, dated May 2017, read in part, .Notice of transfer. Before a facility transfers or discharges a resident, the facility must - (i) Notify the resident and resident's representative(s) of the transfer or discharge and reasons for the move in writing . A progress note, dated 10/04/23, documented the resident had been transferred to an acute care hospital for psychiatric evaluation on the order of APRN #1. A meeting minutes, dated 10/10/23, documented a conference call was attended by Employee#1 [former facility DON], Employee #2 [former facility administrator], Director of Admissions, and Liaison #1. The minutes documented the conference call was about Resident #8 and their decision to no longer provide care to them. It documented it was decided the Director of Admissions and Liaison #1 would inform the hospital where the resident was sent that they would not accept the resident back to the facility. On 02/07/24 at 3:07 p.m., the DON stated there was no discharge summary for Resident #8 and they had been unable to locate any transfer or discharge notices for the time around 10/04/23. On 02/08/24 at 10:45 a.m., the Administrator stated they had been unable to find any documentation Resident #8 had been given a written notice regarding the transfer on 10/04/23 or the discharge that followed on 10/10/23.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 34270 Based on record review and interview the facility failed to provide a bed hold policy to a resident prior to transfer for one (#8) of three sampled residents reviewed for discharges. A facility Length of Stay By Discharge Reason Report, dated 10/01/23 through 11/30/23, documented 37 residents discharged from the facility during the specified period. Findings: Resident #8 had diagnoses which included fracture of the right tibia and schizoaffective disorder. A progress note, dated 10/04/23, documented the resident had been transferred to an acute care hospital for psychiatric evaluation. On 02/08/24 at 10:45 a.m., the Administrator stated that they had not found documentation that Resident #8 had received a bed hold policy, notice of transfer, notice of discharge, or a discharge summary prior to or after departing the facility on 10/04/23. At 1:52 p.m., the DON stated there was no documentation that Resident #8 had been given a copy of the bed hold policy. They stated they did not find a bed hold policy in the resident's medical records.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to allow a resident's return to the facility after being transferred to a local hospital for a mental health evaluation for one (#8) of three sampled residents reviewed for discharges. A facility Length of Stay By Discharge Reason Report, dated 10/01/23 through 11/30/23, documented 37 residents discharged from the facility during the specified period. Findings: Resident #8 had diagnoses which included fracture of the right tibia and schizoaffective disorder. A facility policy, titled Transfer and Discharge from the Facility Policy, dated May 2017, read in part, .The rights of residents who voluntarily or involuntarily are discharged from the facility will be upheld and that a resident will not be involuntarily discharged unless the circumstances meet specific criteria defined by regulations and laws. The facility will make every effort to provide care and services to the residents it serves .The objective of the transfer/discharge policy is to ensure that the resident is informed of an impending discharge and their right to appeal the discharge . A progress note, dated 10/04/23 at 6:35 p.m., documented Resident #8 had been transferred to an acute care hospital on that date for a psychiatric evaluation. A meeting minutes, dated 10/10/23, documented a conference call had taken place on that date with Employee #1 [former DON at the facility], Employee #2 [former administrator at the facility], Director of Admissions, and the liaison on the call. It documented the subject of the conference call was to determine if Resident #8 would be allowed to return to the facility. It documented Employee #1 informed the group one of the physicians had informed Employee #1 that Resident #8 required Ltach [long term acute care hospital] level of care and was inappropriate for skilled nursing level of care. The document stated another physician was asked to take over the care, but it did not document the physician's reply. It documented the participants of the conference call decided Resident #8 would not be accepted back to the facility. On 02/02/24 Resident #8's medical record was reviewed for documentation regarding their transfer on 10/04/23 and the reason the resident did not return. No such documentation was found. On 02/07/24 at 3:07 p.m., DON stated there was no discharge summary for Resident #8 and they had been unable to locate any transfer or discharge notices for the time around 10/04/23. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/08/24 at 9:50 a.m., an anonymous hospital employee stated that on 10/05/23 Resident #8 had been evaluated for mental health issues and was cleared to return to the nursing home where they had resided. They stated the resident was scheduled to return to the facility on [DATE]. They stated Employee #2 reported to the hospital on that date Resident #8 could not return to the facility but could go to a sister facility. They stated at 4:00 p.m., the director of admissions at the nursing home asked for a 72-hour hold and the resident could come after that time. They stated they agreed to that request. They stated on 10/09/23 the nursing home liaison arrived at the hospital and stated their physicians would not accept the resident back to the facility. On 02/08/24 at 10:20 a.m., the director of admissions for the nursing home company stated Resident #8 had been denied the ability to return to the facility because of behaviors. They stated Employee #1 and Employee #2 did not want the resident back in the facility. They stated they were also informed by Employee #1 and Employee #2 that neither of the facility's physicians would care for the resident if they returned. They stated they explained to Employee #1 and Employee #2 the legal aspects of that decision but the two declined to allow the resident back. The director of admissions stated they were given the job of contacting the facility. On 02/08/24 at 10:34 a.m., the liaison stated they went to the hospital and informed the staff that Resident #8 would not be allowed to return to the facility. On 02/07/24 at 3:07 p.m., DON stated there was no discharge summary for Resident #8 and they had not located any transfer or discharge notices for the time around 10/04/23. At 10:45 a.m., the administrator stated after searching Resident #8's medical records, no documentation of any type related to discharging the resident from the hospital on or after 10/04/23 was found.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34270 Based on observation, record review, and interview, the facility failed to ensure: a. residents received baths as requested and according to schedule for two (#9 and #14) of three sampled residents reviewed for baths; b. medications were administered as ordered by a physician for two (#15 and #17) of three sampled resident reviewed for following physician orders; and c. blood sugars levels were obtained as ordered by a physician for two (#15 and #17) of three sampled residents reviewed for following physician orders. A facility census report, dated 01/31/24, documented 66 residents resided in the facility. Findings: A Medication Administration and General Guidelines policy, dated 2021, documented medications were to be administered as prescribed and the resident's medication administration record was to be initialed by the person who administered the medication. A Resident Rights policy, dated November 2017, documented residents had the right to receive services to meet their needs and preferences. 1. Resident #9 had diagnoses which included a fracture of the right tibia and end stage renal disease. A facility bathing record, dated October 2023, documented Resident #9 had received three baths between 10/01/23 and 10/25/23. The record documented the resident refused baths twice on the same day, 10/23/23. A progress note, dated 10/25/23 at 4:15 p.m., documented the resident discharged from the facility. 2. Resident #14 had diagnoses which included chronic obstructive pulmonary disease and chronic diastolic congestive heart failure. A facility bathing record, dated January 2024, documented Resident #14 had received seven baths between 01/01/24 and 01/31/24. The record documented the resident refused a bath on 01/20/24. 3. Resident #15 had diagnoses which included end stage renal disease and type 2 diabetes mellitus. Resident #15's medication administration record for February 2024 was reviewed. There was no documentation to indicate if the resident received evening doses of three ordered medications on 02/05/24 and 02/06/24. The medications missing documentation were for the following; a. Carvedilol Oral Tablet 6.25mg five 1 tab by mouth twice daily for hypertension; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Calcium Acetate Oral Capsule 667 mg give two capsules by mouth for end stage renal disease; and c. Nephrocaps Capsules 1 mg give one by mouth three times daily with meals for a supplement. A medication order, dated 03/09/23, documented the resident was to be administered Levemir Flex Touch Solution Pen-injector 100 units per milliliter, 10 units at bedtime. A Blood Sugar record, dated 01/01/24 through 01/31/24, had no blood glucose level documented for 01/16/24. It also did not document if the resident was administered their prescribed insulin at bedtime on that date. 4. Resident #17 had diagnoses which included heart failure and type 2 diabetes mellitus. Resident #17's medication administration record for January 2024 was reviewed. There was no documentation to indicate if the resident received multiple doses of 10 prescribed medications. The medications and dates of undocumented doses were the following; a. Atorvastatin Calcium Oral Tablet 20 mg give one tablet by mouth once daily. Missing doses on 01/11/24, 01/12/24, 01/24/24, and 01/25/24; b. Donepezil HCL Tablet 10 mg give one tablet by mouth at bedtime. Missing doses on 01/11/24, 01/12/24, 01/24/24, and 01/25/24; c. Levothyroxine Sodium Oral Tablet 50 mcg give one tablet by mouth in the morning. Missed doses on 01/09/24, 01/11/24, 01/12/24, 01/17/24, and 01/29/24; d. Melatonin Oral Tablet 3mg give one tablet by mouth at bedtime. Missing doses on 01/11/24, 01/12/24, 01/24/24, and 01/25/24; e. Metoprolol Tartrate Oral Tablet 50 mg give one tablet by mouth at bedtime. Missing doses on 01/11/24, 01/12/24, 01/24/24, and 01/25/24; f. Trazadone HCL Oral Tablet 50 mg give one tablet by mouth at bedtime. Missing doses on 01/11/24, 01/12/24, 01/24/24, and 01/25/24; g. Glipizide Oral Tablet 5 mg give one tablet twice daily. Missing evening doses on 01/11/24, 01/12/24, 01/24/24, and 01/25/24; h. Hydroxyzine HCL Oral Tablet 10 mg give one tablet by mouth twice daily. Missing evening doses on 01/11/24, 01/12/24, 01/24/24, and 01/25/24; i. Percocet Oral Tablet 5-235 mg give one tablet twice daily. Missing evening doses on 01/11/24, 01/12/24, 01/24/24, and 01/25/24; and j. Ticagrelor Oral Tablet 90 mg give one tablet by mouth twice daily. Missing evening doses on 01/11/24, 01/12/24, 01/24/24, and 01/25/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Blood Sugar record, dated 01/01/24 through 01/31/24, had no blood glucose level documented for the morning of 01/09/24, 01/11/24, and 01/17/24. An afternoon level on 01/15/24, and a bedtime level on 01/16/24. It also did not document if the resident was administered their prescribed insulin Lispro-aabc subcutaneous Solution 100 units per milliliter, administered per sliding scale. On 02/06/24 at 11:00 a.m., Resident #14 was observed in their room. They stated they do not get all the baths they want. They stated they can clean themselves except for their back side. They stated the staff often says they cannot give bed baths when requested. On 02/06/24 at 11:24 a.m., Resident #17 stated they were satisfied with the care they received and did not believe they had missed any medications. On 02/06/24 at 12:30 p.m., the DON stated the residents were given two to three baths per week and more if requested. They stated if a resident requested a bed bath, they could have one. On 02/06/24 at 1:00 p.m., Resident #15 was observed in bed in their assigned room. They stated they believed they had received all their medications. On 02/08/24 at 1:06 p.m., the DON stated there never should be blank spaces in the medication administration records, blood sugar records, or bath records unless it was not scheduled. They stated it could not be determined if the baths and medications were provided as ordered. They stated they expected medical records to be filled out as required by policy.