| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375094 | A. Building<br>B. Wing | 03/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Emerald Care Center Tulsa | 2425 South Memorial<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>45462<br><br>Based on interview and record review, the facility failed to facilitate the inclusion of residents' representative in their care plan conferences for two (#1 and #2) of three sampled residents whose care plan conferences were reviewed.<br><br>The Administrator identified 68 residents resided in the facility.<br><br>Findings:<br><br>A Care Plan Process policy, last revised 9/2019, read in parts, .every effort will be made to involve the resident and family or responsible party including private duty or nursing assistant, in the development, implementation, maintenance, and evaluation of the resident plan of care .families, or legal representatives will be notified of the care planning conference in writing at least seven (7) days prior to the conference . Participation in the resident care planning process will be documented by obtaining the signature of the resident, family, or legal representative .<br><br>1. Resident #2 had diagnoses that included type 2 diabetes and stage 4 pressure ulcer of sacral region.<br><br>On 03/14/24 at 1:50 p.m., during an interview with Resident #2's family member, they stated they had never been notified of a care plan meeting for Resident #2.<br><br>The Care Plan Conference form, dated 03/11/24, did not indicate Resident #2's family or responsible party had been invited nor attended their care plan meeting.<br><br>2. Resident #1 had diagnoses that included type 2 diabetes and end stage renal disease.<br><br>On 03/18/24 at 4:45 p.m., during an interview with Resident #1's family member, they stated they had never attended a care plan meeting and had not been notified of one.<br><br>The Care Plan Conference form, dated 01/26/24, did not indicate Resident #1's family or responsible party had been invited nor attended their care plan meeting.<br><br>(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 |
|---|---|---|

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/19/24 at 8:33 a.m., Social Services Dir. was asked the facility policy for including the residents' family or responsible party in the resident care plan conference. They stated the meetings are set up according to when the family can be there, or they can include them via phone. Social Services Dir. was asked if the families, or legal representatives of Resident #1 or Resident #2 were notified of the care planning conference in writing at least seven (7) days prior to the conference. They stated that was not done. Social Services Dir. was asked to review the documentation from the care plan conferences for Resident #1 and Resident #2. After reviewing the documents, they acknowledged facility policy had not been followed. |

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

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>45462<br><br>Based on observation, record review, and interview, the facility failed to accommodate a residents' need for adaptive equipment that would allow the highest possible level of physical functioning and well-being for one (#2) of one sampled resident reviewed for accommodation of needs.<br><br>The Administrator identified 68 residents resided in the facility.<br><br>Findings:<br><br>A Bed Rails policy, created 01/2024, read in parts, .The facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices .<br><br>A Facility Responsibilities policy, created 01/2024, read in parts, .5. Self-determination .i. The facility must consider the view of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility .<br><br>Resident #2 had diagnoses that included type 2 diabetes and stage 4 pressure ulcer of sacral region.<br><br>There was no physician's order on file for Resident #2 to have a trapeze placed on their bed.<br><br>On 03/14/24 at 1:50 p.m., during a phone interview with Resident #2's family member, they reported the facility had denied their request on admission for bed rails to be placed on the resident's bed to increase their ability to help with pulling up in bed. Family member stated they then requested a trapeze and was told an assessment would need to be done by physical therapy, but no one ever followed through.<br><br>On 03/14/24 at 2:15 p.m., observed bed in Resident #2's room. The bed was stripped of linen and there was no trapeze attached to the headboard. Maint. Supervisor was asked if they had been instructed to place a trapeze on the bed in Resident #2's room and stated no.<br><br>On 03/15/24 at 11:11 a.m., the Physical Therapist was asked how a resident's request for a trapeze would be handled. They stated the resident would be evaluated and, if cleared for safety, the Dir. of Rehab would address it in the Team meeting. Then nursing would obtain the order from the physician and have maintenance place the trapeze on the bed. The Physical Therapist reported Resident #2 had been assessed and the placement of a trapeze on the bed had been recommended and reported to nursing in a Team meeting after the decision was made.<br><br>A Physical Therapy- Therapy Progress Report, for period 02/21/24-03/06/24, documented Resident #2 required minimal assistance rolling bilaterally if provided upper extremity support and PT was continuing to request the facility supply the resident with an overhead frame.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/15/24 at 12:44 p.m., the DON was asked how physical therapy recommendations for adaptive equipment are handled. They stated all therapy recommendations are discussed in the Team meeting and then nursing obtains the orders from the physician as needed. The DON was asked if a recommendation was made by PT for Resident #2 to have a trapeze placed on their bed. They stated they were not aware it may have been before their employment here.<br><br>On 03/15/24 at 1:59 p.m., the Administrator was asked if they were aware of the recommendation from PT that a trapeze be placed on Resident #2's bed. They stated yes. The administrator was informed there was not a trapeze on Resident#2's bed and asked if the facility had provided the resident with the treatment and care that would allow the highest possible level of physical functioning and well-being. They stated they just found out today there was no trapeze on the bed. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>45462<br><br>Based on record review and interview, the facility failed to ensure resident representatives were notified of changes in condition for one (#1) of three sampled resident who were reviewed for notification of change.<br><br>The Administrator identified 68 residents resided in the facility.<br><br>Findings:<br><br>A Facility Responsibilities policy, created 01/2024, read in parts, .A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority the resident representative(s) when there is .An incident involving the resident .A significant change in the resident's physical, mental, or psychosocial status .A need to alter treatment .<br><br>Resident #1 had diagnoses which included type1 diabetes and end stage renal disease.<br><br>A facility incident report, dated 02/21/24 at 4:54 p.m., documented Resident #1 slipped out of their wheelchair trying to stand up. The incident report or nurse progress notes did not document the resident's POA had been notified.<br><br>A facility incident report, dated 02/22/24 at 1:29 p.m., documented Resident #1 was ambulating without an assistive device, lost their balance, and fell on their buttocks. The incident report or nurse progress notes did not document the resident's POA had been notified.<br><br>A facility incident report, dated 02/22/24 at 5:27 p.m., documented Resident #1 walked out of their room, became unsteady and fell on their buttocks on the floor. The incident report or nurse progress notes did not document the resident's POA had been notified.<br><br>A facility incident report, dated 02/22/24 at 9:20 p.m., documented Resident #1 was found in their room on the floor on their knees. The incident report or nurse progress notes did not document the resident's POA had been notified.<br><br>On 03/18/24 at 4:45 pm, the POA of Resident #1 reported resident had experienced unstable blood sugars and four falls in the last month and the facility had not notified them of any of the incidents. Family member stated they were informed by Resident #1.<br><br>On 03/19/24 at 8:09 a.m., the DON was asked the facility policy on notifying resident representatives when residents had a fall or a change in condition. They stated calls were placed to family members when residents had a change of condition or a fall and the incidents and notifications were documented in the residents' clinical record. The DON reviewed the incident reports referenced above and the nurse progress notes. They acknowledged there was no documentation the POA had been notified of the falls and that facility policy had not been followed. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>45462<br><br>Based on observations and interview, the facility failed to maintain a comfortable room temperature for three (#7, 8, and #9) of three sampled residents whose room temperatures were obtained.<br><br>The Administrator identified 68 residents resided in the facility.<br><br>Findings:<br><br>A Facility Responsibilities policy, created 01/2024, read in parts, .The facility must provide .Comfortable and safe temperature levels .maintain a temperature range of 71 to 81 degrees F .<br><br>On 03/14/24 at 11:12 a.m., Resident #7 was observed in bed wearing a sweatshirt and covered with two blankets. A heavy cold breeze was noted coming from their overhead vent. When asked about the temperature in their room they stated it was always very cold and they wished the air could be turned down.<br><br>On 03/14/24 at 11:36 a.m., Resident #9 was observed in bed with two blankets pulled up to her neck and a heavy cold breeze was noted coming from their overhead vent. Resident #57 was asked how they felt about the temperature in their room. They stated, It's way too cold. We've told them but they won't stop the air.<br><br>On 03/14/24 at 12:15 p.m., Maint. Supervisor was asked how often the temperatures were checked in the residents' rooms and stated they just generally checked the thermostats in the hallways. They were asked if residents were allowed to have the vents closed in their rooms and stated some of the vents can be closed but the rooms closer to the units will be colder.<br><br>On 03/14/24 at 12:23 p.m., Resident #8 stopped this surveyor in the hall and reported their room was very cold, especially at night. They stated, I keep asking and asking, but they don't fix it.<br><br>On 03/14/24 at 12:30 p.m., the Maint. Supervisor was asked to obtain temperatures in the rooms of Resident #7, 8, and #9. The readings were as follows:<br><br>Resident #7- air from the vent was 53.2 degrees F and the room temperature was 69.9 degrees F.<br><br>Resident #8- air from the vent was 53.7 degrees F and the room temperature was 68.0 degrees F.<br><br>Resident #9- air from the vent was 53.7 degrees F and the room temperature was 68.2 degrees F.<br><br>On 03/14/24 at 2:09 p.m., the Administrator was asked the appropriate temperature for resident rooms and how often they were checked. They stated room temperatures should be between 71-81 degrees F and random checks should be done weekly by the maintenance staff. The Administrator was informed of the above findings and acknowledged the temperatures in Resident #7, 8, and #9's rooms were not maintained at a comfortable level and according to facility policy. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>45462<br><br>Based on observation, record review, and interview, the facility failed to ensure wound assessments were completed for one (#6) of three sampled residents whose wound assessments were reviewed and failed to follow infection control practices during wound care for one (#5) of one sampled resident whose wound care was observed.<br><br>The administrator identified 68 residents resided in the facility.<br><br>Findings:<br><br>A Documentation Standards for Wound policy, last revised 01/2024, read in parts, .Resident with pressure ulcers receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection .it is important that documentation addresses .progress toward healing and identification of potential complications .description of dressings and treatments .<br><br>1. Resident #6 had diagnoses that included stage 2 pressure ulcers to left ischium, left hip, and right ischium.<br><br>A physicians' order, dated 03/08/24, documented treatment order to cleanse left ischium, left hip, and right ischium wounds with NS/dakins/wound cleanser, apply medihoney, cover with bordered 4x4 gauze and change daily and as needed if dressing is loose or soiled.<br><br>No wound assessments were documented for Resident #6 since 01/31/24.<br><br>2. Resident #5 had diagnoses that included peripheral venous insufficiency and non-pressure, chronic ulcers of left lower leg, foot, and heel.<br><br>A physicians' order, dated 03/08/24, documented the following treatment orders:<br><br>WOUND CARE- Left back of shin, left top of foot, left inner ankle- cleanse with NS/wound cleanser, apply calcium alginate with silver, cover with abd or gauze, wrap with rolled gauze, secure with tape. Change daily and prn soilage or loose dressing. one time a day.<br><br>WOUND CARE- Negative pressure wound therapy 125 mmHg Left heel and left medial foot wound. Cleanse wound with NS/wound cleanser/Vashe/Dakins, Apply skin prep peri wound,<br><br>frame wound with drape, apply SANTYL/collagenase to eschar, apply black foam, cover with drape and bridge wounds together. Patch holes/leaks with more drape prn. Change 3x/wk and prn for loose drsg.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/15/24 at 10:20 a.m, wound care by RN #1 was observed. RN #1 began by removing the old dressings from Resident #5's left lower leg and removing the wound vac from their left foot leaving all the wounds exposed and placing the resident's leg on a clean towel with the exposed left heel ulcer pressed against the footboard of their bed. When cleansing Resident #5's wounds, RN #1 took one 30ml syringe filled with NS and squirted a small amount of NS onto each of the resident's four wounds and patted them all dry with the same pad of two 4x4 gauze. Once done, RN #1 placed the resident's leg back on the towel with the wounds exposed and the heel wound pressed against the footboard of the bed and discarded the syringe and the used pad of two 4x4 gauze. While measuring the plastic film and sponge pieces for wound vac placement, RN #1 repeatedly placed the sponge and plastic film directly on Resident #5's exposed wounds after placing them on their bed sheets, towel, and covers. When changing the dressing on Resident #5's right lower leg RN#1 removed the old dressing and, without cleansing the wound, applied the new treatment and re-wrapped the wound.<br><br>On 03/15/24 at 11:07 a.m., RN #1 was informed of observations made during wound care for Resident #5. They acknowledged the observations and stated they saw no problem with using the same gauze to pat each wound dry, but having the resident's open heel wound pressed against the footboard may be a problem.<br><br>On 03/15/24 at 12:44 p.m., the DON was informed of the observations made during Resident #5's dressing change by RN #1. They acknowledged RN #1 had not followed proper infection control measures to prevent infection. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>45462<br><br>Based on record review and interview, the facility failed to ensure there was ongoing communication with the dialysis center for one (#1) and ongoing assessments of residents before and after dialysis treatments for three (#1, 3, and #4) of four sampled residents reviewed for dialysis care.<br><br>The Administrator identified 68 residents resided in the facility. The were six residents receiving dialysis treatments.<br><br>Findings:<br><br>A Special Needs policy, created 01/2024, read in part, .This policy pertains to the following needs . and dialysis .The facility will communicate relevant information with outside providers to ensure safe continuous care of the resident .<br><br>A Dialysis Care policy, revised 09/01/21, read in part, .All residents receiving dialysis will be assessed before and after dialysis treatment .<br><br>1. Resident #1 had diagnoses that included type 1 diabetes and end stage renal disease.<br><br>Resident # 1 had physicians' orders, dated 02/21/24, to receive dialysis treatments 3 times a week on Monday, Wednesday, and Friday; and to obtain and chart pre- and post-dialysis assessments with vital signs.<br><br>There were no pre- or post-dialysis assessments documented in Resident #1's clinical record for February nor March 2024.<br><br>A progress note for Resident #1, dated 02/29/24 04:40, documented resident had been transferred to the hospital from dialysis on the previous day without facility notification. It also documented facility was not aware of Resident #1's whereabouts and initiated calls to local hospitals, jails, resident's family, and the local police department. The documentation stated Resident #1 was located at the hospital ER by the police.<br><br>2. Resident #3 had diagnoses that included type 2 diabetes and end stage renal dialysis.<br><br>Resident #3 had physicians' orders, dated 08/08/2023, to receive dialysis treatments 3 times a week on Monday, Wednesday, and Friday; and to obtain and chart pre- and post-dialysis assessments with vital signs.<br><br>No pre-dialysis assessments were documented for 13 of 16 opportunities between 02/01/24 and 03/15/24.<br><br>No post-dialysis assessments were documented for Resident #3 for 13 of 16 opportunities between 02/01/24 and 03/15/24.<br><br>3. Resident #4 had diagnoses that included type 2 diabetes and end stage renal disease.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #4 had physicians' orders, dated 08/27/2023, to receive dialysis treatments 3 times a week on Tuesday, Thursday, and Saturday; and to obtain and chart post dialysis vitals and weight upon return from dialysis.<br><br>No post-dialysis assessments were documented for Resident #4 for 15 of 16 opportunities between 02/01/24 and 03/15/24.<br><br>On 03/15/24 at 12:44 p.m., the DON was asked the policy for monitoring residents receiving dialysis treatments. They stated dialysis residents should have orders for assessment before and after dialysis treatments. These are done by the nurse and documented in PCC. The DON was informed of the above observations and acknowledged facility policy had not been followed.<br><br>On 03/19/24 at 12:12 p.m., LPN #2 was asked to describe the system for monitoring when residents return from dialysis treatment. They stated we usually see them arrive with the transport people. LPN #2 was asked how information was communicated between the dialysis center and the facility. They stated the dialysis would normally call the facility if there problems were encountered during the treatment. LPN #2 reported no one from dialysis had called to report Resident #4 had been transferred to the hospital from dialysis on 02/28/24 and stated a better system of communicating between the dialysis center and the facility needs to be set up. |