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Form Approved OMB
No. 0938-0391

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	01/28/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41809 Based on record review and interview, the facility failed to ensure timely incontinent care was provided for one (#6) of three sampled residents reviewed for ADLs. The administrator identified 66 residents who resided at the facility. Findings: Resident #6 had diagnoses which included anxiety, depression and diabetes. Review of the resident council meeting minutes for December 2024 revealed four out of five residents reported a concern the night shift was not changing people at night. Review of the clinical record for Resident #6 revealed a general note, dated 01/26/25 at 9:49 p.m., the note read in part, This morning at [7:54 a.m.], I got a call from the Tulsa PD. Resident had called them and said that [they] had been wet all night. [They] told them that [They] been calling, but no one responded. Another call came in at [7:56 a.m.] from Pst [name withheld], who claimed to be the resident's pastor. [They] also noted that resident had called [them] for the same reason. I asked the oncoming aides to come in and clean her up. They changed [them] and helped [them] get into [their] wheelchair. On 01/27/25 at 12:36 p.m., Resident #6 was observed sitting up in their chair, eating lunch, with no odors present, and dressed. Resident #6 stated, I tell you what is not good, the late night care. They stated on Saturday morning (01/25/25) they were wet up to their waist and their sheets and gown were also. Resident #6 stated staff did not check and change them all night Friday night. They stated staff ignored them. Resident #6 stated they used their call light, but staff did not come. They stated they posted their concerns on social media and called their pastor and the police. Resident #6 stated the day shift had changed them when they came on shift. On 01/27/25 at 1:48 p.m., CNA #2 stated their day started with report, walking the hall, and check and change everyone before breakfast. They stated they completed rounds every two hours and documented when residents had been changed. CNA #2 stated if residents were soaked when they arrived they would change them and report it to the nurse. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/27/25 at 1:52 p.m., LPN #1 stated the CNAs did a check/change every two hours. They stated the nurse monitors by following up with the residents and reviewing their documentation at the end of their shift. LPN #1 stated verbal communication and paying attention to lights worked the best. They stated if a CNA had not done their duties it was documented and reported to the DON/ADON/administrator. On 01/27/25 at 1:56 p.m., the administrator stated the charge nurses monitored to ensure staff completed their rounds and checked/changed the residents by running a report from the electronic medical record. The administrator stated Resident #6 should not have had to call the police. They stated they had spoken to the CNA who worked the night shift on Saturday (01/25/25) and they had reported they had asked Resident #6 if they needed anything, were told no, and left after their shift. The administrator stated they do not think the CNA knew how long the light had been activated.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41809 Based on observation, record review, and interview, the facility failed to ensure infection control was maintained and enhanced barrier precautions were followed during pressure ulcer treatment for one (#5) of three sampled reviewed for wound care. The ADON identified 10 residents who had pressure ulcers. Findings: An MDRO PPE-Enhanced Barrier Precautions policy, revised January 2024, read in parts, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities .may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status .requires that staff participate in initial and on-going training on the facility's expectations about hand hygiene and gown and glove use, along with proof of competency regarding appropriate use and donning and doffing technique for PPE. Resident #5 had diagnoses which included type two diabetes and COPD. On 01/24/25 at 9:55 a.m., Resident #5 was observed to have a pillow in their wheelchair seat. On 01/27/25 at 10:10 a.m., RN #1 was observed to complete wound care for Resident #5 with the assistance of medical records CNA. RN #1 and medical records CNA were not observed to wear gowns. The wound dressing removed was dated 01/26/25. The wounds were observed to have white beds and were observed to be healing stage threes on the buttocks and left ischium. RN #1 was not observed to sanitize their hands between glove changes and did not change gloves consistently between dirty and clean. The medical records CNA was observed to wear gloves while holding Resident #5 on their right side during the dressing change. They were observed to hold the dressing in place with their dirty gloved hand while RN #1 secured the dressing with tape. On 01/27/25 at 10:50 a.m., RN #1 stated hands should be sanitized when entering and exiting a resident room and between glove changes. They stated they did not sanitize between glove changes. RN #1 stated EBP were not followed during the wound treatment.