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	04/11/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42171 Based on observation and interview, the facility failed to ensure residents were treated with dignity for one (#44) of three residents sampled for dignity. The DON reported the census was 53. Findings: Resident #44 had diagnoses which included major depressive disorder and diabetes mellitus. A quarterly assessment, dated 03/29/24, documented the resident was cognitively impaired for daily decision making and was dependent on staff for assistance with eating. On 04/08/24 at 8:05 a.m., Resident #44 was seated in the dining room, they were observed to spill coffee on their shirt, pants, table, and breakfast plate. CNA #1 was in the dining room and went to Resident #44 and asked if they were okay, the resident responded that they were okay. On 04/08/24 at 8:33 a.m., Resident #44 was seated in the dining room, their shirt and pants were still wet, and the breakfast plate was still covered with coffee. Resident #44 stated that things like this happen all the time. Resident #44 also stated they would like clean clothes and they were still hungry. They stated they were unsure if the staff had ordered a new plate for them. On 04/08/24 at 8:41 a.m., staff provided the resident with cereal and milk. On 04/08/24 at 8:43 a.m., CNA #1 stated they checked on the resident to make sure they were okay and covered them up with some napkins so they could continue eating. CNA #1 stated they did not see the coffee on the plate, so they did not request a new plate for the resident. On 04/11/24 at 8:08 a.m., CNA #3 stated the resident should have been cleaned up immediately and another plate should have been offered. On 04/11/24 at 9:09 a.m., LPN #4 stated residents should be always treated with dignity and respect. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/11/24 at 11:58 a.m., the DON stated the resident should have been offered a change of clothes and a replacement tray.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 36191 Based on record review and interview, the facility failed to ensure an accurate code status was documented for one (#8) and residents were offered the choice to formulate an advanced directive for two (#22 and #24) of three sampled residents reviewed for advanced directives. The corporate administrator identified 53 residents who resided in the facility. Findings: An Advance Directive Policy and Procedure, revised 01/2024, read in part, .Upon admission, identify if the resident has an advanced directive and if not, determine if the resident wishes to formulate an advanced directive .Examples include a Living Will .DNR .Facility staff will provide the resident and/or the resident representative with written description of the facility's policies to implement an advance directive .All advanced directive document copies will be obtained and located in the resident chart . 1. Res #8 had diagnoses which included hemiplegia and hemiparesis following a cerebral infarction. A signed DNR form, dated 10/02/23, was located in the miscellaneous tab in the electronic record. The face sheet, and active physician orders in the electronic clinical record documented Resident #8 was a full code. On 04/09/24 at 10:29 a.m., LPN #2 stated Res #8's code status was documented on the TAR and the electronic face sheet. They stated Res #8 was a full code. On 04/09/24 at 10:33 a.m., the SSD stated Res #8 was a full code according to the electronic record. The SSD stated Res #8 also had a signed DNR dated 10/02/23 in the electronic record. On 04/09/24 at 10:51 a.m., the SSD was asked if they had any documentation Res #8 revoked the DNR. They stated no, they had the hospital discharge paperwork which documented Res #8 was a full code. On 04/09/24 at 12:09 p.m., the ADON stated they did not know if the staff called the physician to clarify Res #8's code status upon readmission from the hospital. The ADON stated they did not have any documentation Res #8 revoked the DNR. They stated if the Res #8 revoked the DNR it should be documented in their record. 2. Res #22 had diagnoses which included congestive heart failure, osteoarthritis, and non pressure chronic ulcer. The resident's clinical records did not document the resident and/or their representative was offered the choice to formulate an advanced directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/08/24 at 1:23 p.m., the SSD stated there was not an advanced directive or advanced directive acknowledgment in Res #22's clinical record. 42171 3. Res #24 had diagnoses which included spinal stenosis and scoliosis. A quarterly assessment, dated 02/26/24, documented the resident was cognitively intact, independent with toileting, and frequently in pain. A physician's order, dated 11/27/23, documented the resident was a full code. Review of the clinical record did not reveal the resident had been offered the option to formulate an advance directive. On 04/11/24 at 1:02 p.m., the SSD stated that they did not have documentation regarding formulating an advance directive for Resident #24.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36191 Based on record review and interview, the facility failed to ensure a missing laptop was replaced for one (#22) of one sampled resident who was reviewed for misappropriation of property. The corporate administrator identified 53 residents who resided in the facility. Findings: The facility's Abuse, Neglect and Exploitation policy, revised 01/2024, read in part, .Each resident has the right to be free from .misappropriation of resident property and exploitation . An assessment dated [DATE]. doucmented Res #22's cognition was intact. A document titled, Incident Report Form, dated 01/24/24, read in part, .Initial .Misappropriation of Resident Property .Resident reported to the morning aide, that [they] were missing [their] 13 inch mac book pro computer .administrator had resident contact [electronic store] where the resident did purchase online May 2023. [Electronic Store] did confirm price 1,463.89 and model number . A document titled, Incident Report Form, dated 01/29/24, read in part, .Final .Misappropriation of Resident Property .Administrator confirmed with the ADON and other staff that resident did own a 13 inch mac book pro computer .After doing staff interviews and investigation the facility could not locate the missing laptop [sic] and the facility is working on replacing residents laptop [sic] . On 04/08/24 at 11:15 a.m., Res #22 stated their laptop was stolen. Res #22 stated the former administrator had investigated the missing laptop and was supposed to see about replacing it. On 04/09/24 at 2:01 p.m., the corporate administrator stated they called corporate purchasing and there was not a record for replacement of the laptop. They stated they would not have expected it to take this long to replace the laptop. The corporate administrator was asked what the next step would be to replace the laptop. They stated they would discuss it with the finance department and purchasing to replace the laptop.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46582 Based on observation, record review, and interview, the facility failed to ensure comprehensive care plans were developed and/or implemented to address the residents' needs related to a urinary catheter for one (#49), pain for one (#24), and cardiovascular status for one (#22) of 24 residents whose care plans were reviewed. The corporate administrator identified 53 residents who resided in the facility. The ADON identified seven residents with a urinary catheter. Findings: A facility policy titled Pain Management, revised 01/24, read in part, .The facility must ensure that pain management is provided to residents who require services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences . 1. Res. #49 had diagnoses which included obstructive and reflux uropathy and benign prostatic hyperplasia without lower urinary tract symptoms. An admission assessment, dated 12/12/23, documented the resident was cognitively intact, dependent with toileting, and had a urinary catheter. A care plan, dated 12/12/23, documented the resident had an indwelling catheter related to BPH. The care plan documented to position the catheter bag and tubing below the level of the bladder. No additional interventions related to catheter maintenance and urinary tract infection prevention were documented. There was no physician order for a urinary catheter documented in the resident's medical record since 2/27/24. There was no documentation of catheter care or maintenance in the resident's medical record since 2/27/24. On 04/08/24 at 7:53 a.m., Res #49 was observed lying in bed. A urinary catheter bag with medium yellow urine was observed attached to the bed frame. Res #49 stated they had a urinary catheter for a long time since their stroke. They stated having spent time in the hospital a few weeks ago due to burning at the catheter entry site and a severe urinary tract infection. Res #49 stated the staff had performed catheter care intermittently during their stay in the facility. On 04/10/24 at 10:49 a.m., the ADON stated all residents with a urinary catheter should have a physician order for the catheter and orders in place for maintenance and infection prevention including catheter care every shift, catheter change every 30 days, and catheter flushes every shift for patency. The ADON stated these interventions should have been documented on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/10/24 at 10:41 a.m., LPN #1 stated catheter care is normally performed each shift. They stated having not realized Res #49 did not have a current physician order for the urinary catheter or catheter care in the medical record. They stated that they did not know if Res #49's catheter care had been performed routinely since his return from the hospital on 03/01/24. On 04/10/24 at 11:45 a.m., MDS coordinator #1 stated the maintenance of a urinary catheter should be documented on the care plan. They stated they assumed if the presence of a urinary catheter was documented on the care plan, then the nurses would complete all interventions related to catheter maintenance and infection prevention. MDS coordinator #1 stated they were not aware Res #49 had no current physician order for a urinary catheter. 42171 2. Res #24 had diagnoses which included spinal stenosis and scoliosis. A quarterly assessment, dated 02/26/24, documented the resident was cognitively intact, independent with toileting and frequently in pain. A physician's order, dated 11/21/23, documented the resident was to be monitored for pain, all pain must be addressed, and that uncontrolled pain should be reported to the physician. A physician's order, dated 11/22/23, documented Res #24 was to be referred to a pain management physician. A care plan most recently revised on 01/11/24, documented no care plan for pain. On 04/04/23 at 1:00 p.m., Res #24 stated they have been taking medication for pain, but it is not really helping. They stated the facility does not do a good job addressing pain. On 04/10/24 at 11:51 a.m., MDS coordinator #1 stated that the care plan didn't address pain for Resident #24 because they sometimes complained of pain and then refused pain medications. On 04/11/24 at 9:09 a.m., LPN #4 stated that pain is what the resident says it is and they should treat that pain to the best of their ability. 46387 3. Res #22 had diagnoses which included diabetes mellitus, atrial fibrillation, atherosclerotic heart disease, hypertension, and heart failure. A physician order, dated 05/18/23, documented to administer insulin glargine subcutaneous injection 59 units twice daily for diabetes. A physician order, dated 05/26/23, documented to administer carvedilol 3.125 mg two times a day related to atherosclerotic heart disease and heart failure. The order documented to hold the medication for systolic blood pressure below 90 or heart rate below 55. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order, dated 09/16/23, documented to administer lisinopril 10 mg one time per day for hypertension. The order documented to hold the medication for systolic blood pressure below 90 or heart rate below 55. A care plan most recently revised on 03/26/24, documented no care plans for cardiovascular status or diabetes. On 04/11/24 at 9:10 a.m., MDS coordinator #1 stated they would not have thought to add the blood pressure medication or cardiovascular status to the care plan. On 04/11/24 at 9:14 a.m., MDS coordinator #1 stated there was no care plan for diabetes for the resident because they had initially not been informed to add diagnoses to the care plan. They stated they had not added Res #22's diagnoses yet.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46582 Based on record review and interview, the facility failed to update the care plan related to hospice services for one (#9) of two sampled resident reviewed for hospice services. The ADON identified five residents who received hospice services. Findings: A Hospice Services Facility Agreement policy, revised January 2024, read in parts, .The facility will under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Res #9 had diagnoses which included congestive heart failure, atrial fibrillation, and chronic kidney disease. A physician order, dated 09/18/23, documented hospice to evaluate and treat. A significant change assessment, dated 11/27/23, documented the resident was moderately cognitively impaired, dependent with most ADLs, and received hospice services. A care plan, revised 04/08/24, had no documentation of hospice services. On 04/10/24 at 9:30 a.m., hospice staff #1 stated the resident had received hospice services since 11/13/23. On 4/10/24 at 10:35 a.m., the ADON stated the resident received hospice services and should have had hospice services documented in the plan of care. On 04/10/24 at 11:35 a.m., MDS coordinator #1 stated the resident had received hospice services for a while and was not aware that this service was not documented in the plan of care. They stated all residents on hospice should have this service documented on their care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 36191 Based on observation, record review, and interview, the facility failed to ensure baths and incontinent care were provided as ordered for three (#8, 16 and #43) of three residents reviewed for assistance with ADL's. The ADON identified 36 residents who required assistance with incontinent care and 39 residents who required assistance with showers. Findings: The facility's Activities of Daily Living (ADL) policy, revised 01/2024, read in part, .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain .grooming .personal and oral hygiene . A Shower Schedule Process policy, undated, read in parts, .All showers are to be conducted per the paper shower schedule provided at the front desk in the shower binders .Every shower is to be documented on a shower sheet and turned in to the DON basket on DON door .All refused showers are to be documented on a shower sheet and signed by the resident .Inform your nurse of refusals to allow for education and documentation of refusal .All residents have a right to request a shower at any time on any shift. Please accommodate per preference . A document titled, Resident Council Meeting, dated 02/27/24, read in part, .Not receiving showers. Number of residents who share concern 8/10 [eight out of 10] . A document titled, Resident Council Department Response Form, dated 02/28/24, read in part, .Department response .Monitor alerts for no showers . 1. Res #8 had diagnoses which included hemiplegia and hemiparesis following a cerebral infarction. An assessment, dated 01/20/24, documented Res #8's cognition was moderately impaired, was dependent on staff assistance for toileting and transfers and was incontinent of bowel and bladder. An ADL care plan, revised 01/30/24, documented Res #8 had functional deficit with ADLs related to hemiplegia and hemiparesis following a cerebral infarction. The care plan documented Res #8's needs would be met and was dependent for toileting and transfers. On 04/09/24 at 12:37 p.m., LPN #1 and CNA #2 transferred Res #8 in bed. The back of Res #8's pants were observed to be wet. The staff did not check the resident for incontinence and did not change the resident. On 04/09/24 at 2:14 p.m., Res #8 was observed in bed wearing the same grey pants that were wet at 12:37 p.m. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/09/24 at 2:15 p.m., CNA #5 transferred Res #8 from the bed to the wheelchair. Res #8's pants were observed to be wet. The CNA did not check the resident for incontinence or change the resident. CNA #5 stated they were not working on that hall, they were just helping CNA #1. On 04/09/24 at 2:20 p.m., CNA #1 stated Res #8 was incontinent. CNA #1 was asked if there was a reason Res #8 was not checked for incontinence when the resident was assisted out of the bed. They stated no. On 04/09/24 from 2:20 p.m. through 2:46 p.m., Res #8 was observed in their wheelchair wearing the wet pants. On 04/09/24 at 2:49 p.m., CNA #2 and CNA #3 were observed to provide incontinent care to Res #8. Res #8's adult incontinent brief, pants, shirts, and bottom sheet were wet with urine. On 04/09/24 at 3:03 p.m., CNA #3 stated Res #8's incontinent brief, pants, sheet were wet. On 04/10/24 at 10:22 a.m., the DON was asked how often incontinent care was provided. They stated the standard was every two hours. The DON stated the staff should check residents who are incontinent to ensure they are not wet or soiled when they assisted them to bed and/or when they assisted the resident out of bed. The DON stated the staff had not provided timely incontinent care if the resident was assisted to bed wet and not checked. 46582 2. Res #16 had diagnoses which included end stage renal disease, ischemic heart disease, and type II diabetes mellitus. A quarterly assessment, dated 02/27/24, documented the resident was cognitively intact and dependent on staff for bathing and hygiene. A care plan, revised 03/21/24, documented the resident had functional deficits with ADLs and usually required the assistance of one staff member with bathing. The care plan documented the resident wished to complete bathing hygiene three times a week. A facility shower schedule documented Res #16 was to receive a bath/shower every Tuesday and Friday on the 3-11 shift. The March 2024 shower sheets documented Res #16 was bathed on one out of three opportunities from 03/20/24 through 03/31/24. There was no documented refusals during this time frame. The April 2024 shower sheets had no documentation Res #16 had received a bath from 04/01/24 through 04/11/24. There was no documented refusals during this time frame. On 04/08/24 at 7:38 a.m., Res #16 was observed lying shirtless in bed. A strong smell of body odor was observed. Res #16 stated they had not received a shower routinely. They stated having had one shower in the last two weeks. Res #16 stated they had requested a shower from the staff numerous times but the staff had ignored them. They stated they would prefer to have been bathed two to three times weekly but that had not happened. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/10/24 at 8:20 a.m., CNA #2 stated all baths are documented on the shower sheets and then provided to the nurse for review. They stated a resident's refusal of a bath must be documented on the sheet and the nurse should be notified of the refusal. On 04/10/24 at 12:07 p.m., the ADON stated all baths should be documented on the shower sheets and provided to the nurse for review. They stated they were aware of Res #16's body odor. The ADON stated Res #16 tended to refuse baths but the staff should have documented the refusals on the the shower sheets. They stated only one bath was documented for Res #16 from 03/26/24 until present. On 04/11/24 at 9:53 a.m., Res #16 was observed lying shirtless in bed. A strong smell of body odor was observed. The resident was wiping their chest with a damp washcloth. Res #16 stated they had taken it upon themselves to try and clean up. They stated they had not been bathed since the first interview on 04/08/24. Res #16 stated no staff had offered to assist them with bathing all week. 42171 3. Res #43 had diagnoses which included diabetes mellitus and arthritis. A quarterly assessment, dated 04/01/24, documented the resident was cognitively intact, dependent on staff for toileting and that bathing did not occur during the assessment period. On 04/08/24 at 10:28 a.m., Res #43 stated that they did not get many showers. The shower book documented Res #43 was to receive a shower on Tuesdays and Thursdays. Res #43's shower documentation was reviewed from 03/21/24 through 04/10/24. The resident was given a shower on 03/25/24 and refused a shower on 03/28/24. There was no documentation for the other four scheduled shower days. On 04/10/24 at 11:12 a.m., CNA #6 stated that the CNAs were responsible for giving showers on their assigned hall and that the facility did not have shower aides. On 04/10/24 at 1:48 p.m., LPN #3 stated CNAs give showers based on who has one scheduled for that day. They also stated the nurse on duty should ensure that showers are being given.

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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. 36191 Based on observation, record review, and interview, the facility failed to ensure wound care was provided as ordered for one (#22) of one sampled resident who was observed for non pressure related wounds. The ADON identified five residents who had non pressure related wounds. Findings: Res #22 had diagnoses which included peripheral vascular disease, non pressure chronic ulcer of right foot, and diabetes. An assessment, dated 02/08/24, documented Res #22's cognition was intact, had no behaviors of rejection of care, was dependent on staff for dressing, personal hygiene, and transfers, had diabetic foot ulcers, and moisture associated skin damage. A physician's order, dated 04/03/24, documented to cleanse wound to right shin and knee with normal saline, pat dry, apply xeroform and cover with a bordered gauze dressing daily. A TAR, dated 04/01/24 through 04/09/24, documented the wound care had not been completed on 04/05/24, 04/06/24, and 04/09/24. On 04/08/24 at 9:47 a.m., Res #22 was asked about the dressing on their right shin dated 04/04/24. They stated they had diabetic sores. Res #22 stated they did not know how often the dressing was supposed to be changed, obviously it needed to be changed with the date of 04/04/24. Res #22 was observed to have two blisters on their right shin above the dressing. On 04/09/24 at 11:30 a.m., LPN #1 stated the wound care nurse usually completed the wound care. On 04/10/24 at 8:39 a.m., Res #22's dressing to right lower leg was dated 04/08/24. On 04/10/24 at 08:44 a.m., the DON stated the wound care for the right shin and knee was to be completed daily on the day shift. On 04/10/24 at 08:49 a.m., the DON observed the dressing on Res #22's right shin. The dressing was dated 04/08/24. On 04/10/24 at 8:50 a.m., the DON was made aware of the observation of dressing dated 04/04/24, when observed on 04/08/24. The DON stated the physician's orders for wound care were not being followed. The DON stated either the wound care nurse or the nurse who was assigned to care for the resident that day was responsible for completing the wound care. The DON stated the wound care orders should be documented on the TAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/10/24 at 10:15 a.m., the DON stated when the wound care was completed the nurse performing the wound care was supposed to initial the TAR. The DON stated the TAR was not initialed indicating the wound care had been completed on 04/05/24. They stated the TAR had a code of 9 which documented other/see nurses note for 04/06/24. The DON stated there was not a nurses note for not completing the wound care on 04/06/24. The DON stated RN #2 initialed the wound care had been completed on 04/07/24. On 04/10/24 at 3:40 p.m., RN #2 stated they had not completed Res #22's wound care for Res #22 over the past weekend 04/06/24 or 04/07/24. On 04/11/24 at 9:20 a.m., RN #1 stated they were scheduled to be in the facility to complete the wound care on Monday and Wednesdays. They stated the nurses were aware they needed to complete the wound care when they were not there. RN #1 stated they were aware the dressing had not been changed on 04/09/24 as ordered.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42171 Based on observation and interview, the facility failed to ensure oxygen cylinders were stored properly. The DON reported the census was 53. Findings: On 04/10/24 at 1:38 p.m., an unattended wheelchair was observed in the hallway, an oxygen cylinder was sitting upright in the seat of the wheelchair with the top leaned against the back of the wheelchair. On 04/10/24 at 1:41 p.m., an unknown staff member removed the cylinder from the wheelchair and placed the cylinder standing upright in the hallway. The staff member then took the wheelchair and walked off leaving the unsecured cylinder in the hallway unattended. On 04/10/24 at 1:43 p.m., the same unknown staff member returned with the wheelchair and placed the oxygen cylinder back in the seat of the wheelchair. On 04/10/24 at 1:48 p.m., LPN #3 stated that oxygen cylinders should be stored securely in a rack so they cannot be knocked over. On 04/10/24 at 1:54 p.m., the DON stated oxygen cylinders should be stored per manufacturers guidelines and they should not be left balanced in the seat of a wheelchair

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46582 Based on observation, record review, and interview, the facility failed to ensure physician orders for an indwelling urinary catheter and failed to ensure a resident with an indwelling urinary catheter received services to help prevent urinary tract infections for one (#49) of one resident reviewed for catheters. The ADON identified seven residents with an indwelling urinary catheter. Findings: Res #49 had diagnoses which included obstructive and reflux uropathy and benign prostatic hyperplasia without lower urinary tract symptoms. A physician order, dated 12/06/23, documented to perform catheter care and record output every shift. The order was discontinued on 02/27/24. A physician order, dated 12/10/23, documented to change the catheter anchor and bag weekly on Sunday. The order was discontinued on 02/27/24. An admission assessment, dated 12/12/23, documented the resident was cognitively intact, dependent with toileting, and had a urinary catheter. A care plan, dated 12/12/23, documented the resident had an indwelling catheter related to BPH. The care plan documented to position the catheter bag and tubing below the level of the bladder. No additional interventions related to catheter maintenance and urinary tract infection prevention were documented. A physician order, dated 01/01/24, documented to change the catheter every month and as needed for patency. The order was discontinued on 02/27/24. A nurse note, dated 02/23/24 at 1:12 a.m., documented the resident complained of burning in the penis and requested the catheter to be changed. The note documented the catheter was replaced and the resident was educated on the increased risk of infection with frequent catheter changes. A nurse note, dated 02/23/24 at 11:59 a.m., documented the nurse notified the physician of the resident's complaint of pain at the catheter entry site. The note documented green discharge was observed with possible UTI. The note documented the physician ordered a urinalysis and antibiotics. A nurse note, dated 02/24/24 at 7:41 a.m., documented the resident had screamed all night related to catheter burning pain and nausea/vomiting. The note documented the physician ordered the resident to be transferred to the hospital for possible UTI and sepsis. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Hospitalist History and Physical, dated 02/24/24, documented Res #49 had a urinary tract infection present on admission catheter associated and acute kidney injury. The assessment documented the catheter was reportedly changed the previous day at the nursing facility but had been improperly positioned likely in the prostrate. A nurse note, dated 03/01/24 at 3:22 P.M., documented the resident returned to the facility. There was no documentation of an order for an indwelling urinary catheter or catheter care/maintenance in the resident's medical record since 2/27/24. On 04/08/24 at 7:53 a.m., Res #49 was observed lying in bed. A urinary catheter bag with medium yellow urine was observed attached to the bed frame. Res #49 stated they had a urinary catheter for a long time since their stroke. They stated having spent time in the hospital a few weeks ago due to burning at the catheter entry site and a severe urinary tract infection. Res #49 stated the staff had performed catheter care intermittently during their stay in the facility. On 04/10/24 at 10:41 a.m., LPN #1 stated catheter care is normally performed each shift. They stated having not realized Res #49 did not have a current physician order for the urinary catheter or catheter care in the medical record. They stated that they did not know if Res #49's catheter care had been performed routinely since their return from the hospital on 03/01/24. On 04/10/24 at 10:49 a.m., the ADON stated all residents with a urinary catheter should have a physician order for the catheter and orders in place for care including catheter care every shift, catheter change every 30 days, and catheter flushes every shift for patency. The ADON stated they were unaware of the lack of an order for a catheter and catheter care for Res #49. They stated the orders were discontinued when the resident was admitted to the hospital and must not have been reinstated upon their return to the facility. The ADON stated they were unable to ensure the catheter had been changed or cared for since Res #49's return from the hospital due to the lack of documentation. The ADON stated the nurses probably had not completed catheter care since it was not listed on the TAR as a task to have been completed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 36191 Based on observation, record review, and interview, the facility failed to ensure a. the correct amount of water was administered via peg tube as ordered by the physician; b. the head of the bed was elevated during administration of water flushes and tube feeding through the peg tube; and c. a dietary recommendation was sent to the physician for one (#8) of one sampled resident who was administered nutrition through a peg tube. 1. Res #8 had diagnoses which included dysarthria (weakness in the muscles used for speech), hemiparesis and hemiplegia (Partial to complete paralysis on one side of the body) following a cerebral infarction. An assessment, dated 01/20/24, documented Res #8's cognition was moderately impaired, was dependent on staff assistance for eating and repositioning, had loss of liquids or solids from mouth when eating or drinking, coughed or choked during meals or when swallowed medications, had difficulty or pain with swallowing, and received nutrition through a peg tube. A physician's order, dated 02/29/24, documented to administer Isosource 1.5 250 ml bolus and flush with 185 ml of free water after bolus feeding five times a day. An Enteral Feeding care plan, dated 03/15/24, read in part, .The resident will be free of aspiration .The resident will maintain adequate nutritional and hydration status .The resident needs the HOB elevated 45 degrees during and thirty minutes after tube feed . A document titled, Dietitian's Recommendations for Primary Care Provider, dated 03/25/24, read in part, . Note: Current TF provides 1875 calories, 85 grams protein, and 950 ml free water. Current tube feeding meets nutritional needs and RDA requirements .RECOMMENDATION: 1) Continue with current TF, but change water flushes to 95 ml before and after each feeding. 2) Vitamin B 12 as methylocobalamin for better absorption, Statin and proton pump inhibitors decrease levels of Vitamin B 12 and CoQ10. 3) CoQ10 as Ubiquinol. It is a vitamin like substance that improves health condition in many ways as this is a very important antioxidant and has a crucial role in energy production within our cells . There was no documentation the dietary recommendation was provided to the physician. On 04/09/24 at 12:37 p.m., LPN #1 began to flush the peg tube with 30 ml of water with the HOB laying flat. LPN #1 was stopped and asked if the HOB should be elevated during administration of the water and tube feeding. LPN #1 elevated the HOB. LPN #1 was observed to administer 30 ml of water prior to the tube feeding and 30 ml after the tube feeding was administered. On 04/09/24 at 12:55 p.m., LPN #1 stated the physician's orders documented to administer 185 ml of water. The LPN stated they had not administered 185 ml as ordered. The LPN administered 60 ml of water 125 ml less than what was ordered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/09/24 at 1:10 p.m., LPN #1 stated the HOB needed to be raised 30 degrees while administering the tube feeding to prevent aspiration (When food or liquid enters the airway and eventually the lungs by accident.) LPN #1 stated they had forgotten to raise the HOB. On 04/11/24 at 8:51 a.m., the DON stated the dietitian had seen the resident on 03/25/24 and made dietary recommendations. The DON stated the recommendations had not been followed up by the physician. They stated the physician had ordered B-12 1000 mcg but they did not see any changes in the amount of flush or the recommendation for the CoQ10. The DON was made aware of the observation of the 60 ml amount of flush administered. The DON stated the LPN had not administered the correct amount of water.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36191 Based on record review and interview, the facility failed to provide sufficient staff to meet the needs of the residents for six (#7, 14, 16, 17, 27, and #43) of seven sampled residents who were reviewed for sufficient staffing. The corporate administrator identified 53 residents who resided in the facility. Findings: A document titled, Resident Council Minutes, dated 02/27/24, read in part, .Resident not getting medicine on time on weekends .Number of residents who share the concern 8 . The schedule for 03/31/24 was reviewed and compared with punch detail records. The schedule documented one CMA, one RN, and two LPNs were scheduled who had the qualifications to administer medications. 1. Res #7 had diagnoses which included constipation, essential hypertension, GERD, chronic rhinitis, history of venous thrombosis, and chronic pain. A MAR, dated 03/01/24 through 03/31/24 documented the following medications were not initialed as administered as ordered on 03/31/24: daily Vitamin, docusate sodium, Flomax, fluticasone propionate, lidocaine external gel, lisinopril, vitamin B-12, vitamin D3, Eliquis (blood thinner), tizanidine, diazepam, Metamucil, baclofen, and dantrolene. On 04/08/24 at 8:19 a.m., Res #7's family member stated at the end of March 2024 the residents on C hall did not get their medications. They stated there was only one CMA and the nurse was new and was not able to pass any of the medications on the C hall. Res #7's family member stated the residents are not getting their showers. 2. Res #14 had diagnoses which included diabetes and right below the knee amputation. The ADL care plan, dated 03/07/24, documented Res #14 had functional deficit with current ADLs and usually required assistance with bathing. On 04/11/24 at 7:54 a.m., Res #14 was observed sitting in their wheelchair in the hall. Res #14 reported to the MDS coordinator she wanted to take a shower. On 04/11/24 at 8:42 a.m., Res #14 stated they had not given them a shower. Res #14 stated the staff told them they had to wait until after lunch. Res #14 stated it had been nine days since they had their last shower. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/11/24 at 9:42 a.m., LPN #4 stated the CNA assigned to A and C hall went home sick and they were relying on the CNAs working on the other halls to help the residents. On 04/11/24 at 9:55 a.m., CMA #1 stated the CNAs were overwhelmed and rushed to get the work done. CMA #1 was asked why Res #14 was not able to take a shower that morning. They stated the CNA assigned to that hall had been sick and had to leave. 3. Res #16 had diagnoses which included end stage renal disease, ischemic heart disease, and type II diabetes mellitus. A quarterly assessment, dated 02/27/24, documented the resident was cognitively intact and dependent on staff for bathing and hygiene. A care plan, revised 03/21/24, documented the resident had functional deficits with ADLs and usually required the assistance of one staff member with bathing. The care plan documented the resident wished to complete bathing hygiene three times a week. A facility shower schedule documented Res #16 was to receive a bath/shower every Tuesday and Friday on the 3-11 shift. The April 2024 shower sheets had no documentation Res #16 had received a bath from 04/01/24 through 04/11/24. There was no documented refusals during this time frame. On 04/10/24 at 9:41 a.m., LPN #3 stated there had been times the residents had not received a shower on their shower days due to not having enough staff. On 04/10/24 at 12:07 p.m., the ADON stated only one bath was documented for Res #16 from 03/26/24 until present. On 04/11/24 at 9:53 a.m., Res #16 was observed lying shirtless in bed. A strong smell of body odor was observed. Res #16 stated they had not been bathed since the first interview on 04/08/24. Res #16 stated no staff had offered to assist them with bathing all week. 4. Res #17 had diagnoses which included depression, hypertension, and closed femur fracture. A MAR, dated 03/01/24 through 03/31/24 documented the following medications were not initialed as administered as ordered on 03/31/24: amlodipine, losartan potassium, multivitamin, polyethylene glycol, sertraline, spironolactone, and senna docusate. 5. Res #27 had diagnoses which included atherosclerotic heart disease, GERD, hypertension, depression, chronic kidney disease, end stage renal disease, and diabetes. A MAR, dated 03/01/24 through 03/31/24 documented the following medications were not initialed as administered on 03/31/24 as ordered: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	amlodipine, aspirin, Colace, escitalopram, fluconazole, fluticasone propionate, polyethylene glycol, lidocaine external patch, methocarbamol, pantoprazole, Ticagrelor, gabapentin, losartan potassium, and sevelamer. On 04/09/24 at 1:17 p.m., Res #27 stated they did not get their medication on 03/31/24. Res #27 stated the medication aide who works the weekends called in and the facility did not get a replacement for the medication aide. They stated the nurses were working as CNAs and they did not have anyone to administer their medications. On 04/10/24 at 3:13 p.m., the ADON stated on 03/31/24 one of the CMA's had called in and RN #2 had to administer the medications on hall A and hall C. The ADON was asked if they knew why the medications were not signed out for Res #17. They stated they did not know. The ADON was asked why Res #7 and #27 did not get their medications on 03/31/24 on the day shift. They stated they did not know. On 04/10/24 at 3:42 p.m., RN #2 stated the facility was short one CMA on 03/31/24. RN #2 stated they had administered medications on A hall. They stated they did not administer the medications to the residents on the C hall. On 04/11/24 at 9:42 a.m., LPN #4 stated they did not administer medications to the residents on 03/31/24. LPN #4 stated they did not pass medications because the facility had CMAs who passed the medications. 6. Res #43 had diagnoses which included diabetes mellitus and arthritis. A quarterly assessment, dated 04/01/24, documented the resident was cognitively intact, dependent on staff for toileting and that bathing did not occur during the assessment period. On 04/08/24 at 10:28 a.m., Res #43 stated that they did not get many showers. The shower book documented Res #43 was to receive a shower on Tuesdays and Thursdays. Res #43's shower documentation was reviewed from 03/21/24 through 04/10/24. The resident was given a shower on 03/25/24 and refused a shower on 03/28/24, there is no documentation for the other four scheduled shower days. On 04/10/24 at 11:12 a.m., CNA #6 stated that the CNAs were responsible for giving showers on their assigned hall and that the facility did not have shower aides. On 04/10/24 at 1:48 p.m., LPN #3 stated CNAs give showers based on who has one scheduled for that day. They also stated the nurse on duty should ensure that showers are being given. On 04/11/24 at 12:58 p.m., the ADON stated they had provided the book containing all of the shower sheets. No shower sheets were found for the evening shift for 04/09/24. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/11/24 at 1:07 p.m., the regional director of scheduling was asked about the CNA staffing for 04/09/24. They stated they had some employees call in on 04/09/24 on the evening shift. The regional director of scheduling stated the CMA and/or nurses would be responsible for giving showers if the CNAs was unable to give the showers. They stated they would offer the residents a shower the next day if they missed their shower day.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 36191 Based on record review and interview the facility failed to complete required nurse aide yearly performance reviews for one (CNA #1) of three direct care employee files reviewed. The corporate administrator identified 53 residents who resided in the facility. Findings: CNA #1's personnel file documented they had been hired on 05/07/22. There was no documentation a skills performance review had been completed. On 04/11/24 at 1:30 p.m., the HR director stated CNA #1's personnel file was missing. They stated they had a new administrator and DON at the time CNA #1 was rehired.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 36191 Based on observation, record review, and interview, the facility failed to post the required staffing information. The corporate administrator identified 53 residents who resided in the facility. Findings: Resident Council Meeting minutes, dated 02/27/24, documented the the staff were not introducing themselves to the residents and they did not know which staff members were working on their hall. The document titled, Resident Council Response form, dated 02/28/24, documented proposed action of a white board for daily nursing assignments. On 04/08/24 at 7:00 a.m., a working schedule with the staff assigned to each hall and shift was in a book at the nurse's station. The working schedule documented the census was 55. There was no white boards with staffing on the walls and the census was not correct. On 04/09/24 at 1:49 p.m., the dry erase board on hall B documented the nurse, CMA, and CNAs assigned to the hall. The board did not document the resident census. On 04/09/24 at 1:51 p.m., CNA #4 was asked about the dry erase board hanging on the wall on hall B. They stated the dry erase board had just been hung. On 04/11/24 at 8:08 a.m., a dry erase board was observed hanging on the wall on hall C. The board documented the nurse, CMA, and CNAs assigned to C hall. The resident census was not posted on the dry erase board. On 04/11/24 at 1:10 p.m., the regional director of scheduling stated the posted schedule should have the census dates and number of hours worked if it is up to date.

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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. 46387 Based on record review and interview, the facility failed to administer medications in accordance with physician orders for one (#22) of five sampled residents reviewed for unnecessary medications. The corporate administrator identified 53 residents resided in the facility with 17 residents receiving insulin. Findings: Res #22 had diagnoses which included diabetes mellitus, and anxiety. A physician order, dated 02/28/23, documented to administer Depakote tablet delayed release 125 m.g three times per day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. for anxiety. A physician order, dated 02/28/23, documented to administer Humalog subcutaneous injection according to sliding scale before meals and at bedtime at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m. A physician order, dated 05/18/23, documented to administer Insulin Glargine subcutaneous injection 59 units twice daily at 6:00 a.m. and 9:00 p.m. for diabetes mellitus. A MAR/TAR for February 2024 documented blanks in the insulin administration for the 6:00 a.m. dose of insulin glargine on 02/06/24, 02/07/24, 02/14/24, and 02/20/24. A MAR/TAR for February 2024 had a blank for Depakote oral tablet 2:00 p.m. administration on 02/23/24. A MAR/TAR for February 2024 had blanks for Humalog administration at 6:00 a.m. on 02/06/24, 02/07/24, 02/14/24, 02/20/24; the 11:00 a.m. administration was blank on 02/19/24; the 4:00 p.m. administration was blank on 02/02/24 and 02/12/24. On 04/09/24 at 12:35 p.m. LPN #2 stated the blanks on the MAR/TAR meant the medication or treatment was either not administered or not documented. They stated there was no way to verify the medication or treatment was completed if it was not documented in the computer. On 04/09/24 at 12:42 p.m., the DON stated they had never seen blanks on the MAR/TAR like those for Res #22 before. They stated they did not know what it meant when the administration was blank.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46387 Based on record review and interview, the facility failed to: a. develop and maintain policies and procedures for the monthly drug regimen review to include time frames for the different steps in the process, b. ensure a physician responded to a monthly medication review for one (#22) of five sampled residents reviewed for unnecessary medications, and c. ensure the facility followed up on requests made on the monthly medication review for one (#14) of five sampled residents reviewed for unnecessary medications. The corporate administrator identified 53 residents resided in the facility. Findings: A Drug Regiment Review policy, dated 2021, documented in part .The physician provides a written response of the report to the facility within one month after the report is sent .The facility maintains copies of signed reports on file for at least one year .Nursing personnel provide a written response to the review within two weeks after the report is received .The facility maintains copies of completed reports on file for at least one year . 1. Res #14 had diagnoses which included hypertension. A physician order, dated 06/05/23, documented to administer carvedilol 12.5 mg two times per day for heart. A physician order, dated 06/05/23, documented to administer losartan 100 mg one time per day for hypertension. A monthly drug regimen review, dated 07/04/23, documented a request to add hold parameters to the orders for carvedilol and losartan. A physician order, dated 09/11/23, documented to administer carvedilol 12.5 mg two times per day for heart. The order documented to hold the medication for systolic blood pressure below 95, diastolic blood pressure below 55, or heart rate below 55. A physician order, dated 09/11/23, documented to administer losartan 100 mg one time per day for hypertension. The order documented to hold the medication for systolic blood pressure below 95, diastolic blood pressure below 55, or heart rate below 55. A monthly drug regimen review, dated 09/15/23, documented a request to add hold parameters to the orders for carvedilol and losartan. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Res #22 had diagnoses which included depression and anxiety. A physician order, dated 02/28/23, documented to administer Depakote oral tablet 125 mg three times per day for anxiety. A physician order, dated 03/20/23, documented to administer olanzapine 5 mg, one tablet one time per day for anxiety. A physician order, dated 05/15/23, documented to administer pregabalin oral capsule 150 mg, give 150 mg by mouth three times a day for -. A physician order, dated 05/15/23, documented to administer senna-docusate sodium oral tablet 8.6-50 mg, give 2 tablets by mouth one time per day for -. A physician order, dated 05/15/23, documented to administer acarbose 25 mg tablet, give 25 mg by mouth with meals for -. A monthly drug regimen review, dated 06/02/23, documented a request to add a diagnosis for the senna, pregabalin, and acarbose orders. A monthly drug regimen review, dated 07/04/23, documented a request to reduce the olanzapine and/or Depakote. The medical record did not contain a documented response from the physician. A monthly drug regimen review, dated 12/01/23, documented Res #22's vitamin D level in November 2023 was 9.3 ng/ml. The review documented a request to add ergocalciferol 50,000 units weekly for eight weeks. The medical record did not contain a documented response from the physician. A monthly drug regimen review, dated 02/01/24, documented a request to reduce the olanzapine and/or Depakote. The medical record did not contain a documented response from the physician. On 04/09/24 at 12:26 p.m., the DON stated the ADON was responsible for the monthly drug regimen reviews. They stated the responses from the physician should be scanned into the chart. On 04/09/24 at 12:42 p.m., the DON stated they were unsure where the response would be if they were not scanned into the chart. On 04/09/24 at 2:06 p.m., the ADON was asked to provide the documentation of physician response to the monthly drug regimen reviews mentioned above. On 04/11/24 at 10:10 a.m., the ADON was asked again to provide the documentation of physician response to the monthly drug regimen reviews mentioned above. On 04/11/24 at 11:36 a.m., the ADON stated she was unsure what the facility's response time for monthly drug regimen reviews should be. They stated they had only been made responsible for them two weeks ago. They stated there was not a policy that dictated the turnaround time for monthly drug regimen reviews. They stated they were not provided policies nor had access to any policies regarding monthly drug regimen reviews. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/11/24 at 11:38 a.m., the ADON stated they were unable to locate documentation the physician responded to the GDR requests from 07/04/23 or 12/01/23.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46387 Based on record review and interview, the facility failed to ensure a resident did not receive unnecessary psychotropic medications for two (#17 and #22) of five sampled residents reviewed for unnecessary medications. The ADON identified eight residents received psychotropic medications. Findings: 1. Res #22 had diagnoses which included depression and anxiety. A physician order, dated 02/28/23, documented to administer Depakote oral tablet 125 mg three times per day for anxiety. A physician order, dated 03/20/23, documented to administer olanzapine 5 mg, one tablet one time per day for anxiety. A monthly drug regimen review, dated 07/04/23, documented a request to reduce the olanzapine and/or Depakote. The medical record did not contain a documented response from the physician. A MAR for July 2023 documented Res #22 received olanzapine 5 mg 27 out of 27 opportunities after the request to reduce was made. A MAR for July 2023 documented Res #22 received Depakote 125 mg 77 out of 81 opportunities after the request to reduce was made. A MAR for August 2023 documented Res #22 received olanzapine 5 mg 25 out of 31 opportunities after the request to reduce was made. A MAR for August 2023 documented Res #22 received Depakote 125 mg 70 out of 93 opportunities after the request to reduce was made. A MAR for September 2023 documented Res #22 received olanzapine 5 mg 29 out of 30 opportunities after the request to reduce was made. A MAR for September 2023 documented Res #22 received Depakote 125 mg 91 out of 93 opportunities after the request to reduce was made. A MAR for October 2023 documented Res #22 received olanzapine 5 mg 31 out of 31 opportunities after the request to reduce was made. A MAR for October 2023 documented Res #22 received Depakote 125 mg 92 out of 93 opportunities after the request to reduce was made. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A MAR for November 2023 documented Res #22 received olanzapine 5 mg 26 out of 30 opportunities after the request to reduce was made. A MAR for November 2023 documented Res #22 received Depakote 125 mg 82 out of 93 opportunities after the request to reduce was made. A MAR for December 2023 documented Res #22 received olanzapine 5 mg 26 out of 31 opportunities after the request to reduce was made. A MAR for December 2023 documented Res #22 received Depakote 125 mg 92 out of 93 opportunities after the request to reduce was made. A MAR for January 2024 documented Res #22 received olanzapine 5 mg 31 out of 31 opportunities after the request to reduce was made. A MAR for January 2024 documented Res #22 received Depakote 125 mg 92 out of 93 opportunities after the request to reduce was made. A monthly drug regimen review, dated 02/01/24, documented a request to reduce the olanzapine and/or Depakote. The medical record did not contain a documented response from the physician. A MAR for February 2024 documented Res #22 received olanzapine 5 mg 29 out of 29 opportunities after the request to reduce was made. A MAR for February 2024 documented Res #22 received Depakote 125 mg 86 out of 87 opportunities after the request to reduce was made. A MAR for March 2024 documented Res #22 received olanzapine 5 mg 30 out of 31 opportunities after the request to reduce was made. A MAR for March 2024 documented Res #22 received Depakote 125 mg 86 out of 93 opportunities after the request to reduce was made. A MAR for April 1-9 2024 documented Res #22 received olanzapine 5 mg eight out of eight opportunities after the request to reduce was made. A MAR for April 1-9 2024 documented Res #22 received Depakote 125 mg 24 out of 24 opportunities after the request to reduce was made. On 04/09/24 at 12:26 p.m., the DON stated the ADON was responsible for the monthly drug regimen reviews. They stated the responses from the physician should be scanned into the chart. On 04/09/24 at 12:42 p.m., the DON stated they were unsure where the response would be if they were not scanned into the chart. On 04/09/24 at 2:06 p.m., the ADON was asked to provide the documentation of physician response to the monthly drug regimen reviews mentioned above. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/11/24 at 10:10 a.m., the ADON was asked again to provide the documentation of physician response to the monthly drug regimen reviews mentioned above. On 04/11/24 at 11:36 a.m., the ADON stated she was unsure what the facility's response time for monthly drug regimen reviews should be. They stated they had only been made responsible for them two weeks ago. They stated there was not a policy that dictated the turnaround time for monthly drug regimen reviews. They stated they were not provided policies nor had access to any policies regarding monthly drug regimen reviews. On 04/11/24 at 11:38 a.m., the ADON stated they were unable to locate documentation the physician responded to the GDR requests from 07/04/23 or 12/01/23. 42171 2. Res #17 had diagnoses including depression and anxiety disorder. A physician's order, dated 03/20/24, documented the resident was to receive sertraline (an antidepressant) 100 mg by mouth every day. A care plan, revised on 03/28/24, documents that Res #17 receives an antidepressant and that they should be monitored for adverse reactions to antidepressant therapy. A review of Res #17's orders did not document a physician order for antidepressant side effect monitoring. A review of Res #17's TAR did not document the resident was being monitored for side effects of antidepressant therapy. On 04/11/24 at 9:09 a.m., LPN #4 stated there should be a physician's order for side effect monitoring and a place to document on the TAR. On 04/11/24 at 10:21 a.m., LPN #1 stated side effect monitoring for antidepressants should be documented on the TAR. On 04/11/24 at 11:36 a.m., the ADON stated they were told that side effect monitoring is now done by exception and should be charted in a nurse note.

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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. 42171 Based on record review and interview, the facility failed to ensure labs were completed as ordered for one (#60) of five residents reviewed for unnecessary medications. The DON reported the census was 53. Findings: Res #60 had diagnoses which included diabetes mellitus and hypertension. A physician's order dated 12/28/23 documented that a CBC, CMP, B-12, TSH, A1C and a lipid panel were ordered for Res #60. The status of the order documented it had been completed. A review of Res #60's medical records did not document lab results from 12/28/23. On 04/10/24 at 11:57 a.m., MDS coordinator #1 stated the ordered labs had not been completed. On 04/11/24 at 9:09 a.m., LPN #4 stated she was unsure of the process for obtaining labs in the facility. On 04/11/24 at 10:20 a.m., LPN #1 stated the lab company would automatically draw any labs that had been put in their system, and that nursing staff was responsible for ensuring labs were completed as ordered. On 04/11/24 11:36 a.m., the ADON stated the nurse that takes the order for lab work should put it in the computer and the lab company will come to the facility and obtain the sample on the next scheduled lab day. They stated all nurses were responsible for monitoring to ensure labs were completed as ordered.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42171 Based on record review and interview, the facility failed to monitor food cooking and holding temperatures to ensure safe temperatures were maintained in the kitchen and on the steam table during meal service. The ADON reported 52 residents received services from the kitchen. Findings: A facility policy titled Food Safety Requirements, reviewed 01/24, read in part, .Factors implicated in foodborne illnesses .inadequate cooking and improper holding temperatures .foods require adequate cooking and proper holding temperatures to reduce the rapid and progressive growth of illness producing microorganisms . The facility food temperature log was reviewed from 03/29/24 through 04/08/24. For this review period, the facility failed to document the holding temperatures for 10 of 33 meals. On 04/10/24 at 9:53 a.m., the DM stated the cook on duty was responsible for logging the holding temperature of each meal in the food temperature log. They stated the DM was responsible for ensuring the cook logged the temperatures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42171 Based on observation, record review, and interview, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety. The ADON identified 52 residents who received meals from the kitchen. Findings: A facility policy titled Food Safety Requirements, reviewed 01/24, read in parts, .It is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all foods .The food service workers .are responsible to adhere to the food safety requirements .Document the temperature of external and internal refrigerator gauges .Refrigerators must be 41 degrees or less . On 04/08/24 at 7:24 a.m., a review of the temperature log sheets documented the temperature of the reach-in coolers and reach-in freezers had not been recorded since 04/05/24. On 04/08/24 at 7:28 a.m., a reach-in cooler was observed to contain packages of tortillas, tomatoes, carrots, cucumbers, shredded cheese, and ham with no dates. On 04/08/24 at 7:35 a.m., the dish machine log was observed on the wall near the dish machine. The log indicated the dish machine temperature and the concentration of sanitizer had not been recorded since 03/23/24. On 04/08/24 at 10:40 a.m., the DM was observed in the kitchen with no beard guard. The DM stated he should be wearing a beard guard, they also stated items in the reach-in cooler should be dated when they were received and temperatures of the freezers and coolers should be recorded twice a day. The DM further stated the cook on duty was responsible for ensuring the dish machine was at an appropriate temperature and chemical concentration. On 04/08/24 at 10:45 a.m., the inside of the ice machine was wiped with a paper towel, the towel came back with a black substance covering it. The DM stated that they thought an outside company came periodically and cleaned the ice machine, but they had never seen anyone cleaning it. They stated they had never cleaned the ice machine or instructed another employee to clean it. On 04/09/24 at 8:45 a.m., the maintenance supervisor stated the dietary department was responsible for cleaning the ice machine.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 42171 Based on observation and interview, the facility failed to ensure garbage was disposed of properly. The ADON reported 52 residents received services from the kitchen. Findings: On 04/09/24 at 11:30 a.m., the trash can near the handwashing sink was observed to have a box sitting on top of the lid, the box was full of garbage and garbage was falling onto the floor. On 04/10/24 at 9:53 a.m., the DM stated the trash should not be piled up on the trash can lid.

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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. 46582 Based on observation, record review, and interview, the facility failed to ensure: a. a surveillance system was in place to routinely identify infections and communicable diseases; b. a water management program to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems; c. linens and laundry were processed in accordance with accepted national standards to produce hygienically clean laundry and prevent the spread of infection to the extent possible; and d. soiled linen was handled in a manner to prevent cross contamination. The corporate administrator identified 53 residents who resided in the facility. Findings: A Infection Control - Surveillance for Infection policy, revised January 2024, read in parts, .The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent further infections .Analyze the data to identify trends .Compare the rates to previous months in the current year and to the same month in previous years, to identify seasonal trends .Consider how increases and decreases might relate to recent process changes, events, or activities in the facility .Surveillance date will be provided to the Infection Control Committee regularly . The Infection Control Committee will determine how important the surveillance data will be communicated to the physicians and other providers, the administrator, nursing units, and the local and state health departments . A Legionella Water Management policy, revised July 2017, read in parts, .As part of the infection control prevention and control program, our facility has a water management program, which is overseen by the water management team .The water management program includes the following elements: an interdisciplinary water management team, a detailed description and diagram of the water system in the facility, the identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, the identification of situations that could lead to Legionella growth, specific measures used to control the introduction and/or spread of Legionella, and documentation of the program . 1. On 04/10/24 at 9:00 a.m., the infection control surveillance program documentation for the last 12 months was requested. On 04/10/24 at 10:00 a.m., the DON provided infection control logs for the months of November 2023, December 2023, January 2024 and February 2024 and March 2024. There was no documentation a monthly analysis was completed on any of the documentation provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/10/24 at 10:10 a.m., the DON stated they were unable to locate any documentation for the months prior to November 2023. They stated they did not know who had completed the documentation or who the IP was during the missing months that had been requested. On 04/10/24 at 1:54 p.m., the DON was asked how the infection surveillance documentation provided had been analyzed and used to monitor for infection trends. The DON stated they could not answer because they had not been employed at the facility during this time. They stated there was no way to know if the data had been used for anything. The DON stated they did not know if the other months were completed because no documentation could be located. 2. On 04/10/24 at 3:00 p.m., the water management program to prevent the growth of Legionella documentation was requested. On 04/10/24 at 3:28 p.m., the maintenance supervisor stated they had never been informed of the requirement for the program. They stated the facility had not conducted any of the Legionella water management program measures documented in the policy in the last seven and a half months they had worked at the facility. 3. On 04/11/24 at 10:03 a.m., a tour of the laundry room was conducted. The following observations were made: a. no paper towels were available beside the sink in the dirty linen sorting area to dry hands after handwashing; b. an accumulation of plastic bags, disposable gloves, dryer sheet boxes, plastic hoses, and other debris and dust on the top to the washing machine; c. an accumulation of dust, plastic spoons, condiment packages, disposable mask remnants, and an open spilled bottle of powder detergent behind the washer in the recessed drainage area; d. multiple cardboard boxes labeled paper towels and toilet paper stacked directly adjacent to the washing machine preventing access to the eye wash station; e. no safety eyewear available for use; f. an accumulation of dust and debris covering the front doors of the two washing machines; and g. the ceiling directly in front of the washing machines underneath a fluorescent light fixture had an approximately 12-inch in diameter hole. The area was black and brown in color with sheet rock flaking off. The clear plastic light cover was dark brown in appearance with water stains. On 04/11/24 at 10:12 a.m., the housekeeping supervisor stated they were new to the position and were still learning all the processes. They stated they had not been able to deep clean the laundry area yet. The housekeeping director stated the ceiling had leaked when it rained the day before. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/11/24 at 10:15 a.m., the housekeeping supervisor #2 stated they were from another facility and had come to assist the new housekeeping staff to learn their duties. They stated the laundry room is unkempt and in need of deep cleansing and organization. Housekeeping supervisor #2 stated paper towels, eyewear, and access to the eyewash station should have been available to ensure proper infection control measures. On 04/11/24 at 10:25 a.m., the maintenance supervisor was made aware of the observations. They stated having not been made aware of the leaking ceiling until now. 36191 4. On 04/08/24 at 12:25 p.m., the soiled laundry barrel was observed in D hall without a lid. There was a container of disinfectant wipes and incontinent breifs on top of the soiled trash barrel. On 04/08/24 at 12:28 p.m., CNA #1 was asked if they normally stored clean supplies on top of dirty trash barrel. They stated no, they had been cleaning the beds. On 04/08/24 at 12:29 p.m., the dirty linen barrel remained uncovered in hall D. On 04/08/24 at 12:32 p.m., CNA #1 put a bag in the soiled trash barrel. They left the clean incontinent. briefs on top of trash barrel and left the soiled laundry barrel open On 04/08/24 at 12:37 p.m., CNA #1 stated they took the lid off of the soiled linen barrel and placed it on the soiled trash barrel because the trash barrel did not have a lid and it smelled bad. On 04/09/24 at 2:49 p.m., CNA #2 and CNA #3 were observed to provide incontinent care to Res #8. Res #8's adult incontinent brief, pants, shirts, and bottom sheet were wet with urine. CNA #2 placed the soiled linen and clothes on the floor. On 04/09/24 at 3:03 p.m., CNA #2 stated they had placed the soiled linen and clothes on the floor because they did not have a bag to transport the soiled laundry.

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	04/11/2024

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

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 46387 Based on record review and interview, the facility failed to maintain an antibiotic stewardship program for one (#4) of one sampled residents reviewed for antibiotic use. The ADON identified three residents were receiving antibiotics. Findings: An infection control policy, revised January 2024, documented in part .Facility nursing staff will initiate the appropriate clinical data review by completing the specific FORMS evaluations .that will be implemented once an antibiotic is ordered to determine if the utilization of the antibiotic is justified and meets criteria. The IP nurse will review the completion of the individuals triggered FORM to ensure complete and accurate data collection .The IDT will review new antibiotic orders in the clinical morning meeting, identified issue will be acted upon immediately by the IP nurse . Res #4 had diagnoses which included COPD and chronic respiratory failure. A physician order, dated 04/05/24, documented to administer amoxicillin-potassium clavulanate tablet 875-125 mg one tablet two times daily for infection/rep for ten days. Progress notes and assessments were reviewed. There was no documentation to support why the antibiotic was ordered. There was no assessment completed to meet antibiotic stewardship requirements documented. On 04/11/24 at 12:21 p.m., the DON was asked for documentation to show antibiotic stewardship was completed for Res #4. On 04/11/24 at 12:37 p.m., the DON stated there was not an assessment for Res #4 prior to initiating antibiotics. They stated if the assessment was not there then policy was not followed.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 46387 Based on record review and interview, the facility failed to designate an individual as the infection preventionist. The corporate administrator identified 53 residents resided in the facility. Findings: On 04/08/24 at 8:15 a.m., the DON was asked to identify their infection preventionist. They stated they believed it was RN #1. On 04/11/24 at 9:20 a.m., RN #1 was contacted via phone. They were asked if they were the IP for the facility. They stated they had the required certification but had not been asked to perform the duties of the IP for the facility. They stated they were unsure who the IP was. On 04/11/24 at 11:23 a.m., the corporate administrator stated RN #1 had the IP credentials. They stated the DON also had the credentials. When asked who was designated and acting as the IP the corporate admin was unable to state an employee.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 46387 Based on record review and interview, the facility failed to offer influenza vaccinations for four (#17, 22, 27, and #43) of five and pneumococcal vaccinations for five (#8, 17, 22, 27, and #43) of five sampled residents reviewed for vaccinations. The corporate administrator identified 53 residents resided in the facility. Findings: A facility influenza immunization policy, revised 01/2024, documented in part .Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees .Prior to the vaccination, the resident .will be provided information and education regarding the benefits and potential side effects of the influenza vaccine .Provision of such education shall be documented in the .medical record .For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the .medical record .A resident's refusal of the vaccine shall be documented . A facility pneumococcal immunization policy, revised 01/2024, documented in part .prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated .If refused, appropriate entries will be documented in each resident's medical record .For residents who receive the vaccines, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record . 1. Res #8's medical record did not document pneumococcal vaccine was offered or refused. 2. Res #17's medical record did not document influenza or pneumococcal vaccines were offered or refused. 3. Res #22's medical record did not document influenza or pneumococcal vaccines were offered or refused. 4. Res #27's medical record did not document influenza or pneumococcal vaccines were offered or refused. 5. Res #43's medical record did not document influenza or pneumococcal vaccines were offered or refused. On 04/11/24 at 10:42 a.m., documentation regarding influenza and pneumococcal vaccinations were requested from the DON. On 04/11/24 at 11:31 a.m., the DON stated they were unable to locate documentation the above residents were offered, received, or declined vaccinations for influenza and/or pneumococcal.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 42171 Based on observation and interview, the facility failed to ensure a kitchen reach-in refrigerator was in good repair. The ADON reported 52 resident received services from the kitchen. Findings: A facility policy titled Food Safety Requirements, reviewed 01/24, read in parts, .It is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all foods .The food service workers .are responsible to adhere to the food safety requirements .Document the temperature of external and internal refrigerator gauges. Refrigerators must be 41 degrees or less .If temperatures are out of range, notify maintenance and follow facility policy for food disposal . On 04/08/24 at 7:24 a.m., the temperature of a reach-in cooler was observed to be 73 degrees Fahrenheit. The daily temperature monitoring log that was hanging on the door did not document the temperature of the refrigerator had been recorded since 04/05/24. The refrigerator was observed to contain cartons of milk, lettuce, and tomatoes. The items in the refrigerator did not feel cold. On 04/08/24 at 10:40 a.m., the DM stated that the refrigerator was working properly yesterday because they had gotten a bottle of water out of it, and it felt cold. The DM stated the cook on duty was responsible for logging the temperature of the refrigerators and freezers twice a day, and they were responsible for ensuring the temperature was logged. The DM reported the refrigerator had been repaired recently and they would contact a repairman and dispose of the contents of the refrigerator.