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	11/25/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was provided with a written notice of transfer when transferred to a hospital for 1 (#5) 2 sampled residents reviewed for hospitalization.The DON identified 18 resident transfers in the past six months.Findings:A facility transfer and discharge policy, dated 05/2017, showed a resident was to be provided a written notice of transfer when practicable before transfer when a resident's urgent medical needs required immediate transfer.A quarterly MDS assessment for Res #5, dated 06/18/25, showed the resident had a brief interview for mental status score of 15 which indicated cognition was intact for decision making.A progress note for Res #5, dated 09/12/25 at 3:35 p.m., read in part, Resident sent to [hospital name withheld] for evaluation and treatment if indicated related to seizure like activity/High blood pressure and pulse. Resident's [family member] notified of transfer [family member name withheld].On 09/24/25 at 2:59 p.m., Res #5 stated they had been transferred to a hospital on [DATE].On 09/24/25 at 3:40 p.m., the DON was asked about the paperwork provided to residents when they were transferred to a hospital. Their recounting of the paperwork sent with residents did not include a written notice of transfer. They were asked if Res #5 had been provided with a written notice of transfer on 09/12/25 when they were transferred to an acute care hospital. They stated the staff had not given such notice to the resident on 09/12/25. The DON stated they were unaware of the requirement to provide a written notice of transfer.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure a comprehensive care plan was created for 1 (#56) of 16 sampled residents reviewed for care plans.The DON identified 58 residents resided in the facility required MDS assessments.Findings:A facility policy titled Care Plan Process, dated 09/2019, read in part, To ensure a care plan will be developed that is appropriate for each resident's needs and/or wishes based on the assessment and reassessment (Resident Assessment Instrument-RAI) process within the required timeframes.An MDS admission assessment for Res #56, dated 06/25/25, showed the resident had a facility entry date of 06/19/25. The assessment showed activities of daily living functioning, urinary incontinence, nutritional status, and pressure ulcers were selected to be care planned. The assessment showed MDS coordinator #1 had signed the assessment as completed on 06/25/25.Res #56's EMR was reviewed. The care plan section did not contain a comprehensive care plan. A baseline care plan, dated 06/20/25, was found in the EMR. On 09/24/25 at 11:15 a.m., the DON was asked to review Res #56's EMR for a comprehensive care plan. They stated they did not find a comprehensive care plan for Res #56. They were asked if there should be one for the resident. They stated the comprehensive care plan should have been created by that time. They stated it was their policy to complete the baseline care plans and comprehensive care plans in a timely manner.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to ensure a resident's dialysis catheter was assessed every shift for 1 (#35) of 2 sampled residents reviewed for dialysis care.The DON identified five residents in the facility received dialysis treatments.Findings:A facility policy titled Special Needs - Dialysis Transportation, dated 01/2024, read in part, Fistula/shunt site will be checked every shift for bruits, bleeding, increased pain, and signs of infection.A physician order for Res #35, dated 08/29/25, read in part, Right upper chest Perma Cath - Monitor catheter for bleeding and intact dressing every shift. Notify dialysis center of any concerns every shift. (Permacath is a type of catheter that is inserted into a person's body to provide access into their blood vessels).A September 2025 TAR for Res #35 showed the resident's right upper chest permacath was to be assessed for bleeding and an intact dressing once each shift. The TAR showed no documentation of the assessments having been completed on four of the 46 scheduled assessment dates on and between 09/01/25 and 09/23/25. The date and shifts of the missing assessment documentation were 09/02/25 1st and 2nd shifts, 09/17/25 1st shift, and 09/22/25 2nd shift. On 09/24/25 at 1:49 p.m., LPN #1 was asked to explain the assessment process for Res #35's dialysis treatments. During the explanation LPN #1 stated they assessed the resident's catheter that had been placed in their chest. They stated they checked the catheter every shift and before dialysis. They were asked how someone would know the checks of the catheter had been completed. LPN #1 stated the checks were documented in the resident's TAR. LPN #1 was asked to look at the resident's September 2025 TAR and explain what they observed. They stated four of the entries were not documented. They were asked if they worked any of those shifts. LPN #1 stated they did and they believed they did the checks, but may have pushed the wrong bottom on the computer. They stated they should have made sure the documentation was on the TAR.On 09/24/25 at 2:10 p.m., the DON was asked to look at the permacath assessment section on Res #35's September 2025 TAR. The DON stated when the assessments were completed the nurses put the information into the EMR's. They stated they were confident the assessments were done, but understood there was no documentation to prove it. They stated they believed the nurse made an error when they tried to put the information into the EMR. The DON stated they understood the assessments were important as was the documentation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure foods were labeled, dated, and stored correctly when opened or prepared for 1 of 2 observations in the kitchen.The DON identified 58 residents received nourishment from the kitchen.Findings: On 09/22/25 at 8:18 a.m., a tour of the kitchen was conducted. The following observations were made:a. two undated, unlabeled, plastic pitchers with lids of red juice, was stored on the prep table near the serving area,b. an undated, unlabeled, opened bottle of soy sauce was stored on the bottom shelf of the prep table, andc. an undated, unlabeled, unsealed, opened paper bag of grits was stored on the bottom shelf of the prep table. An undated policy titled Food Safety Requirements Policy, read in part, It is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all food .this includes the storage, preparations, distribution, and serving food in accordance with professional standards for food service safety. On 09/22/25 at 8:35 a.m., the food service director was shown the items that were not labeled or dated. The food service director stated, The items should be labeled and dated. The food service director stated the opened bag of grits should be in a sealable container of some type.