STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375135	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care Center Southwest LLC	5600 South Walker Oklahoma City, OK 73109

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 48344 Based on record review and interview, the facility failed to ensure a resident's: a. emergency contact and physician were notified of a resident's refusal of urine specimen collection for urinalysis for 1 (#5); and b. physician was notified of a resident's low blood sugar as ordered for 1 (#5) of 3 sampled residents reviewed for care and treatment. The administrator identified 63 residents resided in the facility. Findings: A policy titled NOTIFICATION OF CHANGES POLICY, dated 01/2024, read in part, It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate. Resident #5 had diagnoses which included other symptoms and signs involving cognitive functions following cerebral infarction. A physician's order, dated 11/02/24, showed to notify provider if blood sugar less than 60 or greater than 250 two times a day for diabetes mellitus. Resident #5's admission resident assessment, dated 11/07/24, showed the resident had moderate cognitive impairment with a BIMS of 09. A physician's order, dated 11/22/24, showed left hip X-ray, pelvis X-ray, urinalysis, and oxycodone (narcotic medication) 15 mg every six hours. A nursing note, dated 11/22/24 at 5:53 p.m., read in part, UA with C&S one time only for lab for 1 day replied 'you get out of here' upon attempts to gather a sample. There was no documentation the physician and the resident's emergency contact were notified of the resident's refusal to obtain a urine specimen. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation the urinalysis was completed. A nursing note, dated 12/04/24 at 11:40 a.m., showed insulin was held for resident blood sugar of 57. There was no documentation the physician was notified of the resident's low blood sugar. On 04/07/25 at 11:00 a.m., Resident #5's emergency contact stated they were not aware the resident had an order for an urinalysis on 11/22/24. They stated they were not aware the resident refused to let staff obtain the urine specimen. On 04/07/25 at 1:01 p.m., LPN #3 stated if a resident's blood sugar was low, they would notify the physician for further instructions. They stated if the resident was alert, they would offer snacks and recheck the blood sugar. On 04/07/25 at 1:08 p.m., LPN #3 stated they could not find documentation the physician was notified of Resident #5's low blood sugar on 12/04/24 at 11:40 a.m. On 04/07/25 at 1:09 p.m., LPN #3 stated they were to notify the physician if a resident refused urine specimen collection for urinalysis. On 04/07/25 at 1:12 p.m., LPN #3 stated the physician was not notified of the resident's refusal to obtain a urine specimen on 11/22/24. On 04/07/25 at 1:13 p.m., LPN #3 stated Resident #5's emergency contact was not notified of the resident's refusal to obtain a urine specimen on 11/22/24. On 04/07/25 at 1:14 p.m., LPN #3 stated there was no documentation to show another attempt was made to obtain a urine specimen for the urinalysis. On 04/07/25 at 1:31 p.m., the DON stated the facility did not have a protocol for low blood sugars. The DON stated the nurse would follow whatever the physician wants them to do. They stated it was a nursing judgement call unless there was a physician's order. On 04/07/25 at 1:34 p.m., the DON stated Resident #5's order was to notify the physician if blood sugar was less than 60 or greater than 250. They stated it must have been a hospital order. On 04/07/25 at 1:37 p.m., the DON stated there was no documentation the physician was notified of Resident #5's low blood sugar on 12/04/24 at 11:40 a.m. On 04/07/25 at 1:39 p.m., the DON stated nurses were to educate the resident, notify the family, physician, and re-attempt if the provider ordered a re-attempt at obtaining the urine specimen for an urinalysis. On 04/07/25 at 1:40 p.m., the DON stated there was no documentation the physician and the emergency contact were notified of the resident's refusal to obtain a urine specimen.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344 Based on record review and interview, the facility failed to ensure a urinalysis order was completed and an antibiotic was transcribed as ordered for 1 (#5) of 3 sampled residents reviewed for care and treatment. The administrator identified 63 residents resided in the facility. Findings: An undated facility policy titled Medication orders, read in part, Written transfer orders (sent with a resident by a hospital or other health care facility): Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician. A policy titled Laboratory Services and Reporting, dated 01/2024, read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law .The facility is responsible for the timeliness of the services. Resident #5 had diagnoses which included other symptoms and signs involving cognitive functions following cerebral infarction. Resident #5's admission resident assessment, dated 11/07/24, showed the resident had moderate cognitive impairment with a BIMS of 09. A physician's order, dated 11/22/24, showed left hip X-ray, pelvis X-ray, urinalysis, and oxycodone (a narcotic) 15 mg every six hours. A nursing note, dated 11/22/24 at 5:53 p.m., read in part, UA with C&S one time only for lab for 1 day replied 'you get out of here' upon attempts to gather a sample. There was no documentation the urinalysis was completed or other attempts were made to obtain a urine specimen. A nursing note, dated 11/30/24 at 10:02 a.m., read in part, Called EMSA [emergency medical services] after observing resident on the floor, prone position. They were yelling out and c/o [complained of] pain everywhere. They had two abrasions on their face, one on their left eyebrow, one on their forehead. A nursing note, dated 11/30/24 at 9:59 p.m., read in part, Patient returned from the ER today on antibiotics for UTI. A hospital AFTER VISIT SUMMARY, dated 11/30/24, showed Keflex (an antibiotic medication) 500 mg, take one capsule by mouth in the morning, at noon, in the evening, and at bedtime for seven days. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A physician's order, dated 12/01/24, showed Keflex oral capsule 500 mg, give 500 mg by mouth three times a day for UTI for seven days. A December 2024 medication administration record showed Resident #5 received Keflex 500 mg three times a day from 12/01/24 to 12/03/24. A nursing note, dated 12/04/24 at 11:40 a.m., showed insulin was held for resident blood sugar of 57. A nursing note, dated 12/04/24 at 1:41 p.m., showed the resident's blood sugar was 72. A nursing note, dated 12/04/24 at 2:32 p.m., read in part, Nurse was approached by CNA on duty who stated that resident was in room sitting in w/c [wheelchair] and nonresponsive. Upon entering room to assess resident, resident was sitting in w/c slumped over and drooling. Nurse sternal rubbed resident times 4 while calling out their name with no response or reaction. Nurse then contacted [name withheld] APRN [advanced practice registered nurse] and received an order to send resident to ER. Floor nurse on duty then came and checked patient FSBS which was 89 at that time. Resident VS [vital signs] were BP [blood pressure]- 138/79, P [pulse]-74, R [respiration]-12, O2 [oxygen]- 77% on RA [room air]. Nurse contacted EMS. Upon arrival of EMS resident FSBS was 77. Patient left the facility at 1430 [2:30 p.m.]. [Family member] was notified of the situation. A hospital Emergency Department record, dated 12/04/24, showed hypoglycemia and sepsis due to UTI with acute sepsis related organ dysfunction. On 04/07/25 at 9:54 a.m., the DON stated they could not locate lab results for the urinalysis ordered on 11/22/24. On 04/07/25 at 1:14 p.m., LPN #3 stated there was no documentation to show another attempt was made to obtain a urine specimen for the urinalysis. On 04/07/25 at 1:15 p.m., LPN #3 stated Resident #5 was sent to the ER for a fall on 11/30/24. On 04/07/25 at 1:17 p.m., LPN #3 stated the hospital diagnosis was UTI without hematuria. On 04/07/25 at 1:19 p.m., LPN #3 stated Keflex 500 mg one capsule by mouth in the morning, at noon, in the evening, and at bedtime for seven days was ordered. On 04/07/25 at 1:20 p.m., LPN #3 stated Resident #5 received Keflex 500 mg three times a day at the facility. On 04/07/25 at 1:40 p.m., the DON stated no other attempts were documented to obtain the urine specimen. On 04/07/25 at 1:48 p.m., the DON stated there was no documentation the facility provider changed the Keflex order upon returned. On 04/07/25 at 1:49 p.m., the DON stated the Keflex order was not transcribed accurately.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48344 Based on observation, record review, and interview, the facility failed to provide care consistent with professional standards of practice and in accordance with physician orders for: a. a PICC line for 1 (#1) of 3 sampled residents reviewed for infection control; and b. the administration of IV fluids for 1 (#12) of 3 sampled residents reviewed for medications as ordered. The DON identified six residents with IV lines resided in the facility. Findings: 1. On 04/02/25 at 2:21 p.m., Resident #1's PICC line dressing was dated 03/20/25. A policy titled Special Needs, dated 01/2024, read in part, To address special needs, this facility will provide the necessary care and treatment, including medical and nursing care, consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This policy pertains to the following needs: parenteral fluids . PICC/IV. Resident #1 had diagnoses which included encounter for orthopedic aftercare following surgical amputation and atherosclerosis of native arteries of extremities with left leg gangrene. A physician's order, dated 03/20/25, showed to change right arm PICC line dressing weekly and PRN. Change needleless connectors with dressing change, one time a day every Thursday. Resident #1's admission resident assessment, dated 03/26/25, showed the resident had moderate cognitive impairment with a BIMS of 12. An IV therapy care plan, revised 03/26/25, showed the resident had a PICC line to their right arm. On 04/02/25 at 2:23 p.m., Resident #1 stated they were not sure about PICC line dressing change. On 04/02/25 at 2:43 p.m., LPN #2 stated they last cared for the resident on 03/28/25. On 04/02/25 at 2:47 p.m., LPN #2 stated PICC line dressing change was done every seven days. On 04/02/25 at 2:48 p.m., LPN #2 stated Resident #1's PICC line dressing change order was for every Thursday and as needed. On 04/02/25 at 2:50 p.m., LPN #2 stated the resident's PICC line dressing was dated 03/20/25. On 04/02/25 at 2:51 p.m., LPN #2 stated the PICC line dressing should have been changed on 03/27/25. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/02/25 at 3:40 p.m., the DON stated PICC line dressing change was every seven days or per physician's orders. On 04/02/25 at 3:40 p.m., the DON stated they expected nurses to follow the physician's orders. 2. On 04/03/25 at 3:49 p.m., Resident #12's IV infusion was observed to be infusing at a rate of about 90 ml/hr. The dial was between the 80 and 100 markings. The 1000 ml fluid bag showed normal saline 0.9 and to infuse at 75 ml/hr. Resident #12 had diagnoses which included unspecified severe protein-calorie malnutrition and metabolic encephalopathy. Resident #12's admission resident assessment, dated 03/07/25, showed the resident had moderate cognitive impairment with a BIMS of 09. A physician's order, dated 03/27/25, showed normal saline flush IV solution 0.9% sodium chloride flush, use 75 ml intravenously two times a day continuous. On 04/03/25 at 3:49 p.m., Resident #12 stated they did not know what rate the intravenous infusion was running. They stated they did not adjust the rate on the pump. On 04/03/25 at 4:45 p.m., LPN #2 stated the intravenous infusion was going at a rate of 85 ml/hr and they adjusted the infusion rate to 75 ml/hr to match the resident's infusion order.

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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. 48344 Based on record review and interview, the facility failed to ensure a urinalysis order was completed in a timely manner for 1 (#7) of 3 sampled residents reviewed for care and treatment. The administrator identified 63 residents resided in the facility. Findings: A policy titled Laboratory Services and Reporting, dated 01/2024, read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law .The facility is responsible for the timeliness of the services. Resident #7 had diagnosis which included neuromuscular dysfunction of bladder. A physician's order, dated 02/18/25, showed urinalysis with culture and sensitivity one time only for lab for one day. A nursing note, dated 02/21/25, read in part, Resident's representative [name withheld] called and stated that resident is being very hateful and accusing everyone of stealing their belongings, [name withheld] informed this nurse that when [Resident #7] does this, it is usually because they has a UTI. This nurse notified the NP [nurse practitioner] of representative's concerns and residents' behaviors, new orders given for UA with C&S. [Name withheld] is aware of order for UA. [Lab company name withheld] notified. A Laboratory Report, dated 02/21/25, showed a urine specimen was collected on 02/21/25. There was no documentation a urine specimen was collected prior to 02/21/25. A Provider's Progress Note, dated 02/24/25, read in part, patient seen today for lab results returned. Urinalysis with culture returned with MRSA [Methicillin-resistant Staphylococcus aureus] in the urine. On 04/04/25 at 12:09 p.m., LPN #1 stated nurses were responsible for collecting urine specimens and notifying lab for pick up. On 04/04/25 at 12:10 p.m., LPN #1 stated the expectation was to obtain the ordered urine specimen immediately. On 04/04/25 at 12:21 p.m., the ADON stated the urinalysis ordered on 02/18/25 was put in their lab system on 02/18/25 and was collected on 02/21/25. On 04/04/25 at 12:24 p.m., the ADON stated there was no documentation to support why the urinalysis was not completed prior to 02/21/25. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/04/25 at 12:28 p.m., the DON stated they do not have specific time frames when an ordered urinalysis was to be completed. They stated the expectation was if the urinalysis was ordered today, then it should be completed today. The DON stated if nurses were unable to collect the urine specimen, they should document the reason in the residents' notes. On 04/04/25 at 12:30 p.m., the DON stated the urinalysis order was not completed in a timely manner.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 48344 Based on observation, record review, and interview, the facility failed to follow the menu for one of one meal service observed. The DON identified 63 residents who received their meals from the kitchen. Findings: On 04/03/25 at 12:39 p.m., cook #1 was observed to plate four regular plates with each containing three chicken tenders, one scoop of coleslaw, one scoop of mashed potatoes, and one scoop of gravy. On 04/03/25 at 12:44 p.m., cook #1 was observed to plate a mechanical soft diet plate with one scoop grounded chicken tenders, one scoop of mashed potatoes, one scoop of gravy, and one scoop of cooked cabbage. On 04/03/25 at 1:06 p.m., cook #1 was observed to plate a pureed diet plate with one scoop pureed chicken tenders, one scoop mashed potatoes, and two scoops gravy. No pureed vegetables were served on the puree plate. A policy titled Menus and Adequate Nutrition dated 01/2024, read in part, The purpose of this policy is to assure menus are developed and prepared, based on reasonable efforts to meet resident choices and reflect the resident's nutritional, religious, cultural, and ethnic needs .Be followed. A week one extended menu Diet Spreadsheet, dated 2025, showed the following serving sizes: a. coleslaw 4 ounces, b. ground chicken tenders #8 scoop (equivalent to 4 ounces), c. pureed chicken tenders #6 scoop (equivalent to 5 ounces), and d. soft, cooked vegetables #16 scoop for pureed residents (equivalent to 2 ounces). On 04/03/25 at 12:36 p.m., cook #1 stated the ground chicken tenders should be served with 3 ounce spoon, pureed chicken tenders with 4 ounce spoon, and the coleslaw with 3 ounces scoop. On 04/03/25 at 1:09 p.m., cook #1 stated they did not puree any vegetables. They stated it was their fault. On 04/03/25 at 2:44 p.m., cook #1 stated the extended menu serving size for coleslaw was 4 ounces. They stated they served 3 ounces. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/25 at 2:45 p.m., cook #1 stated the extended menu serving size for ground chicken tenders was #8. They stated they served 3 ounces. On 04/03/25 at 2:46 p.m., cook #1 stated the extended menu serving size for pureed chicken tenders was #6 scoop. They stated they served 4 ounces. On 04/03/25 at 2:48 p.m., cook #1 stated they did not follow the menu.

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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. 48344 Based on observation, record review, and interview, the facility failed to ensure infection control was maintained during the provision of incontinent care and PICC line dressing change for 2 (#1 and #9) of 3 sampled residents reviewed for infection control. The administrator identified 63 residents resided in the facility. Findings: 1. On 04/02/25 at 3:02 p.m., LPN #2 donned a gown, gloves, a mask, and entered Resident #1's room with a PICC line dressing change kit. They instructed Resident #1 to wear a mask. LPN #2 informed the resident they would be changing their PICC line dressing. A staff passing by the resident's room closed the door for privacy. The resident was sitting in their wheelchair. On 04/02/25 at 3:04 p.m., LPN #2 opened the PICC line dressing kit and placed it on the resident's bed. They removed their gloves and donned the sterile gloves from the kit. LPN #2 removed the resident's old PICC line dressing and the PICC line stabilization device. LPN #2 discarded their gloves and donned new gloves they retrieved from their pocket. They cleaned the PICC site with items from the kit. On 04/02/25 at 3:11 p.m., LPN #2 attached a new PICC line stabilization device, but could not apply the new dressing. They took off their gown, gloves, mask, and went out to get a new PICC line dressing kit. On 04/02/25 at 3:14 p.m., LPN #2 returned with a new PICC line dressing kit. They donned a gown, gloves, a mask, and provided privacy. They opened the new dressing kit on the resident's bed. They donned regular gloves and applied the new PICC line dressing. LPN #2 dated and initialed the new dressing. On 04/02/25 at 3:27 p.m., LPN #2 attached an alcohol cap to the PICC line. A policy titled Infection Prevention and Control, revised 01/2024, read in part, It is the policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Resident #1 had diagnoses which included encounter for orthopedic aftercare following surgical amputation and atherosclerosis of native arteries of extremities with left leg gangrene. A physician's order, dated 03/20/25, showed to change right arm PICC line dressing weekly and PRN. Change needleless connectors with dressing change, one time a day every Thursday. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1's admission resident assessment, dated 03/26/25, showed the resident had moderate cognitive impairment with a BIMS of 12. On 04/02/25 at 3:29 p.m., LPN #2 stated PICC line dressing change should be a sterile procedure. They stated they should have used the regular gloves to remove the old dressing and used the sterile gloves for the rest of the procedure. On 04/02/25 at 3:34 p.m., LPN #2 stated they did not perform a sterile dressing change and should have put the dressing kit on a clean working table. On 04/02/25 at 3:41 p.m., the DON stated if the PICC line dressing change was supposed to be sterile, then the nurse should have used sterile technique. They stated they were to follow standard regulation of practice. 2. On 04/03/25 at 11:03 a.m., CNA #1 entered Resident #9's room. They stated they would be performing incontinent care. The Resident's representative was at the bedside and the resident was lying in bed. CNA #1 had on gloves and they provided privacy. On 04/03/25 at 11:04 a.m., CNA #1 cleaned Resident #9's peri area. The Resident's peri area had redness. On 04/03/25 at 11:07 a.m., CNA #1 rolled Resident #9 to their right side and cleaned their buttocks. They applied cream to the resident's buttocks and coccyx area. CNA #1 turned the resident back and applied cream to the redness on the resident's peri area. CNA #1 discarded the wet brief in the trash. On 04/03/25 at 11:09 a.m., CNA #1 put a clean brief on the resident and clean clothing. CNA #1 did not change their gloves prior to putting cream on the resident. They did not change their gloves prior to putting clean clothing on the resident. On 04/03/25 at 11:09 a.m., CNA #1 with the same gloves, picked up the bed remote and adjusted Resident #9 in bed. On 04/03/25 at 11:15 a.m., CNA #1 with the same gloves, retrieved a brush and brushed Resident #9's hair. They put the resident's hair in a ponytail. On 04/03/25 at 11:19 a.m., CNA #1 took the trash and the resident's dirty clothes to the soiled utility room. Resident #9's clothes were not in a bag. CNA #1 discard their gloves. Resident #9 had diagnoses which included acquired absence of right leg below knee. Resident #9's Medicare 5 day resident assessment, dated 03/20/25, showed the resident had moderate cognitive impairment with a BIMS of 12. The assessment showed the resident was dependent on staff assistance for toileting and dressing. A self-care performance care plan, dated 04/03/25, showed the resident required one person substantial assist with toilet use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375135	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care Center Southwest LLC	5600 South Walker Oklahoma City, OK 73109

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/25 at 11:22 a.m., CNA #1 stated they should change their gloves once or twice during incontinent care. On 04/03/25 at 11:23 a.m., CNA #1 stated they did not change their gloves during the provision of incontinent care for Resident #9. They stated changing gloves would prevent cross contamination. On 04/03/25 at 11:25 a.m., CNA #1 stated dirty linens should be bagged during transportation. They stated they did not put the resident's dirty clothes in a bag during transportation. On 04/03/25 at 11:35 a.m., the DON stated staff should change their gloves when working from dirty to clean. On 04/03/25 at 11:36 a.m., the DON stated dirty linens should be put in a bag during transportation.