STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375230	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Village Health Care Center	2154 South 85th East Avenue 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 34270 Based on record review and interview, the facility failed to ensure the dignity of a resident was maintained during and following perineal care for one (#1) of five sampled residents reviewed for abuse. A midnight census report, dated 07/01/24, documented 75 residents resided in the facility. Findings: A facility Resident Rights policy, dated 04/26/24, read in part, The Facility shall treat Residents with kindness, respect, and dignity and ensure Resident Rights are being followed. Resident #1 had diagnoses which included age related cognitive decline and dementia. On 07/02/24 at 2:03 p.m., CNA #1 stated on 06/27/24 on the evening shift they had provided perineal care to Resident #1. They stated they had attempted to clean Resident #1's vaginal area by picking off dry material with their hands instead of cleaning with wipes and cleanser. They stated the resident became upset, told CNA #1 to stop the care, and began crying. They stated they themselves became upset and assisted the resident put on their briefs then departed the room. They stated they did not otherwise assist the resident get clothed or close the door when they departed the room. They stated they did not inform the other staff on the unit of the resident's condition. On 07/02/24 at 2:30 p.m., CNA #2 stated that on 06/27/24, they had been relieved for break by CNA #2. They stated when they returned, they could not find CNA #2 on the unit. They stated CNA #3 was there. They stated CNA #2 was observed coming out of Resident #1's room. They stated when they checked the resident later, they had on a top and underwear. They stated the door had been open when they checked on the resident. On 07/02/24 at 3:03 p.m., CNA #3 stated that on the evening shift of 06/27/24 they observed CNA #1 come out of Resident #1's room. They stated after CNA #1 departed the checked on the resident and found them on the bed covered by a sheet and their clothes laying on the floor. They stated the door had been open when they checked on the resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375230	A. Building B. Wing	07/03/2024

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/03/24 at 12:10 p.m., the DON stated CNA #1 should have informed the other staff members of the Resident #1's condition before leaving so they could have assisted them. They stated CNA #1 should not have picked the resident perineal area instead of using a cleanser and wipe. They stated CNA #1 had not followed facility policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375230	A. Building B. Wing	07/03/2024

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34270 Based on record review and interview the facility failed to ensure a CNA provided perineal care in accordance with accepted standards of care for one (#1) of five sampled resident reviewed for abuse. A midnight census report, dated 07/01/24, documented 75 residents resided in the facility. Findings: A facility Incontinent Care policy, dated 07/21/22, read in part, Cleanse Perineal Area with a Perineal Cleanse. Females: Separate the labia, Cleanse one side and then the other, Cleanse center of the Labia wiping towards the Rectal Area. On 07/02/24 at 2:03 p.m., CNA #1 stated they had been asked by CNA #2 to watch the memory care unit while they took a break. CNA #1 stated while on the unit they made a visual inspection of the residents and found Resident #1 laying on their bed fully clothed. They stated they smelled something foul and asked the resident if they could remove their jeans. They stated they removed the resident's jeans and instructed the resident to remove their briefs and found that the resident was dry. They stated they did see vaginal discharge. They stated they asked the resident if they could clean their perineal area and the resident had said yes. They stated they noticed the discharge was dry, so they threw away the wipe they intended to use and instead began picking the dry material off the resident's vaginal area with their hands. They stated the resident reported they were uncomfortable, and they stopped. On 07/03/24 at 12:10 p.m., the DON stated CNA #1 should not have picked at the resident's vagina to clean the discharge and should have used a cleanser and wipes. They stated CNA #1's attempt at cleaning was substandard care and they required more training.