STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375556	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Manor Nursing Home	2416 West 51stsouth Tulsa, OK 74107

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 21731 Based on observation, record review, and interview, the facility failed to ensure privacy curtains were utilized during personal care for one (#1) of three sampled residents reviewed for privacy. The Administrator identified 67 residents lived in the facility. Findings: Resident #1 had diagnosis to include Parkinson's disease, and physical debility. An Activities of Daily Living care plan, dated 05/07/24, documented Resident #1 required assistance with ADLs, was incontinent of bladder, and staff were to assist with incontinent care and to change incontinent briefs. A Discharge Assessment, dated 06/01/24, documented Resident #1 required substantial to maximum assistance with toileting and personal hygiene, and was dependent for bathing, dressing the lower body and placement of footwear. A Daily Skilled Documentation assessment, dated 06/21/24 at 2:24 a.m., documented Resident #1 was alert and oriented to person and place, was incontinent of bladder and utilized briefs. The assessment documented Resident #1 required for staff to perform dressing, toileting, and hygiene. On 06/25/24 at 9:55 a.m., LPN #1 and CNA #1 entered Resident #1's room, closed the door, donned gloves, and initiated incontinent care. During the process, Resident #1 was exposed from the waist down, CNA #1, removed their gloves, and exited the room to obtain additional supplies needed. Resident #1 remained exposed and the privacy curtain was not pulled to ensure the resident was not exposed when CNA #1 exited the room. On 06/25/24 at 10:05 a.m., LPN #1 and CNA #1 were asked if there was a reason the privacy curtain was not in use. Both stated they did not need the privacy curtain due to the door being closed. The LPN and CNA were asked if Resident #1 had been exposed when CNA #1 exited the room to obtain additional supplies. LPN #1 stated, Yes.

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 21731 Based on record review and interview, the facility failed to ensure allegations of abuse were reported to all required state agencies within the required time for two, (#1, and #2) of three sampled residents reviewed for abuse allegations. The Administrator identified the facility census to be 67. Findings: An Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, revised April 2021, read in part, .All reports of resident abuse .are reported to local, state and federal agencies .must be reported immediately to the administrator and to other officials according to state law .'Immediately' is defined as . within two hours of an allegation involving abuse . 1. Resident #1 had diagnosis to include Parkinson's disease and physical debility. An Interim Payment Assessment, dated 06/03/24, documented Resident #1 had moderately impaired cognitive skills for daily decision making, and was dependent on staff for hygiene and toileting. An Initial Incident Report Form, dated 06/15/24, documented Resident #1 to have allegations of sexual abuse against CNA #2. A Notification of Nurse Aide/Nontechnical Service Worker Abuse, Neglect, Mistreatment or Misappropriation of Property form, dated 06/18/24, documented CNA #2 had allegations of abuse, and was suspended on 06/16/24. The investigative notes did not document CNA #2 had been reported prior to 06/18/24, three days after the allegation of abuse. 2. Resident #2 had diagnosis to include major depressive disorder, dysphagia, intellectual disability, and cognitive impairment. A Quarterly Assessment, dated 05/08/24, documented Resident #2 had unclear speech. A Combined Initial and Final incident report form, dated 06/02/24, documented the facility was notified on 06/13/24 at 3:00 p.m., of an allegation of possible exploitation of Resident #2 by CMA #1 and Laundry staff #1. The investigative notes, dated 06/13/24, documented on 06/12/24, during the afternoon hours, the administrator received a call from the sheriff's office regarding concerns of having video with FaceTime that included Resident #2, CMA #1, and Laundry Staff #1. The report documented CMA #1 and Laundry Staff #1 will be reported to the Nurse Aide/Nontechnical Worker registry. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Notification of Nurse Aide/Nontechnical Service Worker Abuse, Neglect, Mistreatment or Misappropriation of Property form, dated 06/14/24, documented CMA #1 was not suspended but was terminated on 06/12/24. A second form, dated 06/14/24, documented Laundry Staff #1 was suspended on 06/13/24. The Investigative notes did not document CMA #1 or Laundry Staff #1 had been reported from 06/12/24 until 06/14/24, two days after a call was received from the sheriff's office to report concerns of possible abuse, exploitation, or privacy. On 06/21/24 at 10:50 a.m., the Administrator and DON were asked what the facility abuse policy for the time frames to report an allegation of abuse has been reported and an investigation was initiated. The Administrator stated the facility reports all abuse to OSDH within 4 hours. They were shown the facility policy that documented reporting to all state agencies of an allegation of abuse within two hours. The Administrator stated, they did not realize the two hour limit was required.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 21731 Based on observation, record review, and interview, the facility failed to implement a pressure ulcer policy to fully assess and monitor a new pressure wound for one (#1) of three sampled residents reviewed for pressure ulcers. The Wound Care Physician identified the facility had 3 wounds in the facility. Findings: The facility Pressure Ulcer/Skin Breakdown -- Clinical Protocol policy, revised on April 2018, read in parts, . Assessment and Recognition .nurse shall describe and document/report the following .full assessment . including location, stage, length, width, and depth, presence of exudates or necrotic tissue . Resident #1 had diagnosis to include Parkinson's Disease, falls with fractures, and physical debility. A Daily Skilled Documentation assessment, dated 06/02/24 at 6:16 a.m., documented Resident #1's skin color was normal. The assessment did not identify concerns with skin issues. An Interim Payment Assessment, dated 06/03/24, documented resident #1 had moderate cognitive impairment, and no skin issues. A Daily Skilled Documentation assessment, dated 06/03/24 at 11:16 p.m., documented Resident #1 had bruises, skin tear/laceration and an unstageable ulcer. The assessment did not document a location or description of an unstageable ulcer. The TAR, dated June 2024, documented on 06/04/24, documented Resident #1 was to be provided treatment to a blister until resolved. The order was discontinued on 06/11/24. The clinical record did not contain documentation Resident #1 had a blister, the location or a description of the blister. Daily Skilled Documentation assessments documented on 06/05/24 at 1:32 a.m., 06/06/24 at 2:24 a.m., and 06/06/24 at 9:18 a.m., Resident #1 had bruises. The assessments did not address the skin tear/laceration or the unstageable ulcer identified on 06/03/24. Daily Skilled Documentation assessments documented on 06/07/24 at 12:46 p.m., and on 06/08/24 at 12:42 p.m., Resident #1 had bruises and redness to the sacrum. The assessments did not document a full skin assessment to include measurements or additional description. Daily Skilled Documentation assessments documented on 06/09/24 at 5:24 a.m., 06/10/24 at 5:38 a.m., and 06/11/24 at 2:47 a.m., documented Resident #1 had bruises. A Daily Skilled Documentation assessment, dated 06/11/24 at 1:39 p.m., documented Resident #1 had bruises, a skin tear/laceration and a deep tissue injury. The assessment did not identify where the skin tear/laceration or the deep tissue injury were located or a description of the areas. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record did not identify if the unstageable ulcer were the same as identified on 06/03/24 at 11:16 p. m. A Daily Skilled Documentation assessment, dated 06/12/24 at 2:55 a.m., documented Resident #1 had bruises. The assessment did not identify a skin tear/laceration or an unstageable ulcer. A Daily Skilled Documentation assessment, dated 06/12/24 at 10:25 a.m., documented Resident #1 had bruises, skin tear/laceration, and a deep tissue injury. A Physician Order, dated 06/12/24, documented Resident #1 was to receive wound care to include, cleanse the wound on the right buttock with normal saline, pat dry, apply MediHoney, apply dressing one a day and as needed. Daily Skilled Documentation assessments, dated 06/13/24 at 3:16 a.m., and on 06/14/24 at 4:20 a.m., documented Resident #1 had pressure ulcers. The assessments did not identify the location or a description of the wound. Daily Skilled Documentation assessment, dated 06/15/24 at 3:46 p.m., and 06/17/24 at 2:50 a.m., documented Resident #1 had a skin tear/laceration. The assessments did not address a pressure ulcer. A Daily Skilled Documentation assessment, dated 06/17/24 at 12:30 p.m., documented Resident #1 had a pressure ulcer. The assessment did not identify the location or a description of the pressure ulcer. A Daily Skilled Documentation assessment, dated 06/17/24 at 8:45 p.m., documented Resident #1's skin was pallor. The assessment did not identify a pressure ulcer. Daily Skilled Documentation assessments, dated 06/18/24 at 2:49 a.m., and 06/18/24 at 9:35 a.m., documented Resident #1 had pressure ulcers. The assessments did not contain a location or description of the pressure ulcers. A Daily Skilled Documentation assessment, dated 06/18/24 at 9:25 p.m., documented Resident #1's skin was pallor. The assessment did not identify other skin issues or a pressure ulcer. Daily Skilled Documentation assessments, dated 06/19/24 at 3:52 a.m., 06/19/24 at 9:18 a.m., and 06/20/24 at 3:10 a.m., documented Resident #1 had pressure ulcers. The assessments did not include the location or a description of the pressure ulcer. A Daily Skilled Documentation assessment, dated 06/20/24 at 10:01 a.m., documented Resident #1 had bruises. The assessment did not identify pressure ulcers or other wounds. Daily Skilled Documentation assessments, dated 06/21/24 at 2:24 a.m., 06/21/24 at 11:35 a.m., 06/22/24 at 3:23 a.m., 06/23/24 at 5:39 a.m., and 06/24/24 at 6:22 a.m., documented Resident #1 had a pressure ulcer. The assessments did not identify a location or a description of the pressure ulcer. The TAR, dated June 2024, documented Resident #1 had received wound treatment of MediHoney to the right buttock from 06/12/24 thru 06/21/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Daily Skilled Documentation assessment, dated 06/24/24 at 10:35 a.m., documented Resident #1's skin color was pallor and bruises were present. The assessment did not address pressure ulcers. The clinical record did not contain a full assessment of a blister or a pressure wound to include the location or description of the blister or pressure wound that were identified in the daily skilled documentation notes. On 06/25/24 at 10:25 a.m., the DON was asked what should be documented in the skin or wound assessments. They stated what the wound looks like, the size and measurements of the wound, and what treatment is in place. The DON was asked how often the information was to be documented. They stated with every wound treatment. The DON was asked where was the blister located as documented in Resident #1's medical record. They stated, they did not know there was a blister and did not see documentation in the record. The DON was asked where the pressure wound was located on Resident #1. They stated the order documented the right buttock. The DON was asked how was the pressure wound monitored if the daily skilled documentation notes had discrepancies and there were no measurements or description of the pressure wound in the medical record. They stated the wound should have been measured, and the facility needed to work on documentation.