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	09/27/2024

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46703 On 09/26/24, an Immediate Jeopardy (IJ) situation was determined to exist due to the facility failing to assess, monitor, and intervene for a resident at risk for pressure ulcer. Resident #1 was admitted on [DATE]. The admission skin assessment documented no skin concerns to the coccyx area. Resident #1 was totally dependent on staff, placing them at increased risk of PU/PI development. The residents record documented a physician's order for weekly skin assessments. No concerns to the coccyx was documented in these assessments. On 09/19/24 the resident's family member noted a foul odor in the room. The resident's brief was removed revealing a wound over the coccyx measuring 11cm x 13cm. The necrotic bed measured 3.5cm x 5cm and 2cm at the deepest point. The physician was notified on 09/24/24 at which time the physician ordered calcium alginate and Medihoney to the wound bed daily. On 09/24/24 the resident was transferred to the hospital per family request. On 09/26/24 at 6:00 p.m., the OSDH was notified and verified the existence of the IJ situation. On 09/26/24 at 6:33 p.m., the administrator and DON were notified of the IJ situation. On 09/26/24 at 10:07 p.m., an acceptable plan of removal was provided. The plan of removal documented: At 7:29 p.m., the DON and ADON contacted all nurses via telephone to inform them of the IJ and told them the proper procedure for identifying, assessing, monitoring, and preventing skin breakdown. 1. The nurse identifies or gets report of a skin integrity concern will immediately assess the resident, report the findings to the Medical Director and the Director of Nursing. 2. Once orders are received from the physician, the nurse will immediately call the family or responsible party to inform them of the situation and if there is a new order/treatment. No treatments or medications are to be done without a physician's order. 3. The nurse will then implement a treatment order(s) on the residents' medical record (PCC) as directed. to include cleansing, dressings, interventions such as low air loss mattress if applicable, for the identified resident. The nurse will also document and describe the following: full assessment of pressure sore to include location, stage, length, width and depth, presence of exudates or necrotic tissue. (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
	375556	A. Building B. Wing	09/27/2024

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Any other interventions will be initiated per facility policy and resident need. 8:05 p.m. - DON and ADON initiated facility skin sweep 8:49 p.m. - all nurses were emailed the above information and protocol 9:20 p.m. - facility skin sweep complete. On 09/27/24 at 9:00 a.m., interviews were conducted with facility staff. Staff had knowledge of the plan or removal. After the facility conducted skin assessments on all residents, the DON stated no further skin issues were found. On 09/27/24 at 3:30 p.m., the administrator was informed the immediacy had been lifted. The IJ was lifted, effective 09/27/24 at 2:47 p.m., when all components of the plan of removal had been completed. The deficiency remained at a level of potential for more than minimal harm. Based on observation, record review and interview, the facility failed to assess, monitor, and intervene for a resident at risk for pressure ulcers. The DON identified two residents with pressure wounds. Findings: An undated document titled Pressure ulcers/Skin Breakdown - Clinical Protocol., read in part ., The nursing staff and attending physician will assess and document an individuals significant risk factors for developing pressure sores . Resident #1 was admitted to the facility on [DATE] with diagnoses which includes Parkinson's disease. A care plan, dated 08/26/24, documented to monitor for skin integrity issues during all activities of daily living . A nurse's note, dated 09/21/24, documented the wound measurements as 11cm x 13cm. The necrotic bed measured 3.5cm x 5cm and 2cm at the deepest point. A nurse's note, dated 09/24/24, documented the wound measurement as 10.1cm x 10cm x2cm with the necrotic area measuring 3.4cm x 6.0cm. On 09/26/24 at 4:14 p.m., the DON stated they received a call on 09/21/24 from LPN #1 regarding a wound on the coccyx area of Resident #1. They stated they thought the LPN had notified the physician, but they had not. The DON notified the physician on 09/24/24 and received orders to apply calcium alginate and Medihoney to the wound daily. The resident was transferred to the hospital per family request. On 09/27/24 at 12:38 p.m., LPN #1 stated a CNA notified them of the wound on 09/19/24. They thought they had notified the physician, but did not. They stated they did not notified the family.