STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375098	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care Center Midwest	2900 Parklawn Drive Midwest City, OK 73110

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 - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41872 Based on record review and interview, the facility failed to ensure staff notified the physician of a resident with an ongoing rash and no treatment prescribed for one (#6) of six residents reviewed for infection control. The Administrator identified 59 residents resided in the facility. Findings: A Notification of Changes Policy, dated 01/2024, read in part, .Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure the best outcomes of care for the resident . Resident #6 had diagnoses which included dementia, high blood pressure and dermatitis. A nurse progress note, dated 01/02/24 at 7:01 p.m., read in part .Resident noted to have rashes all over the body which were gotten worse with resident constantly scratching d/t itchiness. PCP was notified .new order for Clobetasol cream to be applied for 14 days twice a day . The January 2024 TAR documented Resident #6 was treated with the Clobetasol cream from 01/03/24 through 01/17/24. A skin/wound weekly observation note, dated 01/04/24 documented the resident had a rash. A nurse note, dated 01/05/24, documented the patient was seen by the wound doctor and to referred to dermatology. A physician progress note, dated 01/17/24, documented there were no new issues or concerns per patient or nursing. A skin/wound weekly observation note, dated 01/18/24, documented the resident had a rash. A skin/wound weekly observation note, dated 01/25/24, documented the resident had a rash. (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 - Some	Resident #6's February 2024 MAR and TAR did not document any treatment indicated for the resident's rash. A skin/wound weekly observation note, dated 02/01/24, documented the resident had a rash. A skin/wound weekly observation note, dated 02/08/24, documented the resident had a rash. A skin/wound weekly observation note, dated 02/15/2,4 documented the resident had a rash. A skin/wound weekly observation note, dated 02/29/24, documented the resident had a rash. A skin/wound weekly observation note, dated 03/07/24, documented the resident had a rash. A Derm Visit note, dated 03/07/24, read in part, .No significant rash, visible excoriations on chest, some on arms .Based on hx this is likely scabies .Treating with oral Ivermectin and topical permethrin . On 04/19/24 at 10:08 a.m., the IPC nurse was shown Resident #6' skin assessments from 01/25/24 through 02/29/24 and the February MAR and TAR and asked what had been implemented for treatment of the rash. They stated, they thought something was in place. On 04/19/24 at 10:24 a.m., the DON was shown Resident #6's skin assessments from 01/25/24 through 02/29/24 and the February MAR and TAR and asked why wasn't the resident treated or the doctor notified. They stated, they did not know why it wasn't done. They were asked if Resident #6 should have had some type of treatment for the ongoing rash for four weeks. They stated, yes.

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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	Provide and implement an infection prevention and control program. 41872 Based on record review and interview, the facility failed to implement their infection control policy for surveillance of scabies for four (#3, 4, 5 and #36) of six sampled residents reviewed for infection control. The Administrator identified 59 residents resided in the facility. Findings: An Infection Control-surveilance for infection policy, revised 01/2024, read in part .The Infectionist Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections .that have substantial impact on potential resident outcome and that may require transmission based precautions and other preventative interventions .Infections that include routine surveillance include those with .Pathogens associated with serious outbreaks .scabies . 1. Resident #3 had diagnoses which included congestive heart failure and sarcopenia. A Derm Visit note, dated 02/05/24, read in part .Rash located on [the residents] Upper body;scalp;neck for several months. Scabies vs atopic derm vs other .Rash: located on upper body;arms .Will treat as scabies . 2. Resident #4 had diagnoses which included, type two diabetes mellitus, and acute kidney failure. A Derm Visit note, dated 01/25/24, read in part .Scabies: located on upper body .will start on permethrin and tmc bid prn flares. Advised to treat the other members and to treat the bedding and clothes as well . 3. Resident #5 had diagnoses which included muscle weakness and palsy. A Derm Visit note, dated 03/07/24, read in part : .Rash: located on body .Patient lives in a facility, 3 others in facility near also have similar itching with rash .Patient treated for scabies six months ago .Likely scabies based on hx and presentation . 4. Resident #6 had diagnoses which included dementia, high blood pressure and dermatitis. A Derm Visit note, dated 03/07/24, read in part, .No significant rash, visible excoriations on chest, some on arms .Based on hx this is likely scabies .Treating with oral Ivermectin and topical permethrin . On 04/17/24 at 12:05 p.m., the DON was asked if there should be documentation the residents rooms had been cleaned. They stated the nurse should be documenting in the progress notes. The clinical health record did not contain documentation when resident rooms had been cleaned. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/18/24 at 12:57 p.m., housekeeper #1 was asked how they clean a room when the resident has scabies. They stated they had only worked there for two weeks and was waiting to be trained. On 04/18/24 at 1:12 the DON was asked to review the policy and procedure for surveillance and asked if they were aware of the policy. They stated, No. They were asked if they had been gathering surveillance data as part of the plan. They stated, No. The DON was asked if a resident with scabies should be monitored as part of the infection control plan. They stated, Yes, according to this plan. On 04/19/24 at 9:13 a.m., housekeeper #2 was asked how they clean the rooms when a resident has scabies. They stated, they had not cleaned the room when a resident had scabies the aides cleaned the rooms. They were unsure what was to be done. On 04/19/24 at 10:24 a.m., the IPC nurse was shown the infection surveillance plan and asked if they were aware of the policy. They stated, no. They stated another nurse was over infection control and thought they had been keeping a surveillance list but was unsure where it was. No documentation for a surveillance plan was provided.