

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Emerald Care Center Southwest LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>46653</p> <p>Based on record review and interview, the facility failed include and update a careplan for one (#27) of eight sampled residents whose careplans were reviewed.</p> <p>The administrator identified 64 residents resided in the facility.</p> <p>Findings:</p> <p>A facility Care Plan Process policy, dated 10/10/21, read in part, The plan of care must describe the services the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and mental, and social well-being .b. High-risk areas such as fall, skin/wounds, pain, safety (i.e., smoking, elopement), and weight loss must be care planned immediately upon identifying risk via evaluation.</p> <p>Resident #27 had diagnoses which included autism.</p> <p>On 12/11/24 at 10:30 a.m., the facility's smoking list was reviewed with the DON. Resident #27 was listed as a smoker.</p> <p>Resident #27's care plan was reviewed and smoking was not included in care plan.</p> <p>On 12/11/24 at 10:32 a.m., the DON reported Resident #27 smoking was not included in the care plan.</p> <p>On 12/11/24 at 10:49 a.m., Resident #27 reported they smoke three to five times a day.</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>46653</p> <p>Based on record review and interview, the facility failed to ensure a smoking assessment was completed for one (#27) of 19 residents sampled for smoking assessments.</p> <p>The DON identified 64 residents who resided in the facility.</p> <p>Findings:</p> <p>A facility's Resident Smoking Policy-Physical Environment policy, dated 01/2024, read in part, 7. Resident who smoke will be evaluated , using the Smoking/Nicotine Devices , to determine adaptive equipment and level of supervision required for smoking, or if residents is safe to smoke at all .15. Documentation to support decision making will be included in the resident's medical record, including but not limited to: b. Assessment of relevant functional and cognitive factors affecting the ability to smoke safely.</p> <p>Resident #27 had a diagnoses which included autism.</p> <p>On 12/11/24 at 10:30 a.m., the facility's smoking list was reviewed with the DON. Resident #27 was listed as a smoker.</p> <p>There was no smoking assessment located in Resident #27's electronic medical record.</p> <p>On 12/11/24 at 10:32 a.m., the DON reported Resident #27 had no smoking assessment.</p> <p>On 12/11/24 at 10:49 a.m., Resident #27 reported they smoked three to five times a day.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583</p> <p>Based on record review and interview, the facility failed to ensure:</p> <p>a. the correct inhaler medication was provided to a resident for one (#21) of one sampeld resident reviewed for medication administration;</p> <p>b. medications were administered according to physicians orders for two (#37 and #116); and</p> <p>c. a resident's chart was updated with a new antibiotic order to be continued after an ER visit for one (#116) of two sampled residents reviewed for UTI's.</p> <p>Findings:</p> <p>The administrator identified 64 residents resided in the facility.</p> <p>A Medication Administration and General Guidelines, policy, dated 2021, read in part, Medications are administered in accordance with written orders of the attending physician. The policy also read, Residents are identified before medication is administered. The policy also read, The resident's MAR is initialed by the person administering the medication. The policy also read, The physician must be notified when a dose of medication has not been given. The policy also read, Medications supplied for one resident are never administered to another resident.</p> <p>1. Resident #21 had diagnoses which included chronic obstructive pulmonary disease with acute exacerbation.</p> <p>On 12/11/24 at 11:21 a.m., LPN #2 was observed to take an inhaler to Resident #21 while they were in the therapy gym. They administered the inhaler. LPN #2 did not show the box to the surveyor prior to administering the inhaler.</p> <p>On 12/11/24 at 11:24 a.m., LPN was asked to see the box the inhaler came from. LPN #2 was observed to put the inhaler inside of a box and began to move boxes and look through the cart. LPN #2 was asked again to see the box the inhaler came from. LPN #2 then provided the box that read another residents name that was not Resident #21. The medication was Combivent 20/100 mcg/act.</p> <p>On 12/11/24 at 11:25 a.m., LPN #2 stated the inhaler was not Resident #21's. They stated the policy was to follow the five rights. LPN #2 stated they did not follow the policy.</p> <p>Upon review of Resident #21 orders there was no order for a Combivent inhaler found.</p> <p>2. Resident #37 had diagnoses which included UTI, congenital occlusion of ureteopelvic junction, hydronephrosis, obstructive and reflux uropathy, crossing vessel, and stricture of ureter.</p> <p>A physician's order, dated 05/30/24, documented to give Macrobid (antibiotic medication)100 mg two times a day for UTI for five days. Completed on 06/04/24.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A physician's order, dated 07/24/24, documented to give Keflex (antibiotic medication) 500 mg three times a day for UTI for 10 days. Completed on 08/03/24.</p> <p>A physician's order, dated 11/17/24, documented to give amoxicillin-pot clavulanate (antibiotic medication) 875-125 mg two times a day for UTI for three days. Completed on 11/20/24.</p> <p>Review of the July and August 2024 electronic medication administration record documented the resident received the first dose of Keflex 500 mg on 07/25/24 at 8:00 a.m. and the last dose documented was on 08/02/24 at 8:00 p.m. There was OF documented for the doses on 08/03/24 at 8:00 a.m. and 2:00 p.m.</p> <p>Review of Resident #37 progress notes documented the resident went to the ER for an elevated lab on 08/03/24 at 1:27 a.m. and returned to the facility on [DATE] at 1:30 p.m. The resident did not receive the last two doses of the antibiotic.</p> <p>On 12/12/24 at 11:57 a.m. the ADON stated Resident #37 received the Keflex up until they were sent out on 08/03/24. They stated Resident #37 returned on 08/04/24. The ADON stated the antibiotic was not continued through completion as they did not see an order to restart and did not see another order for the missed doses to be given. The ADON stated the charge nurse should have been notified so they would get an order to either continue or discontinue. They stated with the resident's kidney issues and recurrent UTI the medication should have been completed.</p> <p>3. Resident #116 had diagnoses which included UTI, obstructive and reflux uropathy, hydronephrosis with renal and ureteral calculous obstruction, and unspecified hydronephrosis.</p> <p>A physician's order, dated 12/04/24, documented to give Macrobid 100 mg two times a day for UTI for seven days.</p> <p>Review of the December 2024 EMAR documented 9 on 12/05/24 for 7:00 a.m. - 11:00 a.m. The first dose was documented on 12/06/24 at 7:00 a.m. - 11:00 a.m. The last documented dose was on 12/11/24 at 7:00 a.m. - 11:00 a.m. The resident received five and a half days of medication when they were ordered to receive seven.</p> <p>On 12/11/24 at 1:46 p.m., CMA #1 stated blanks on the EMAR meant they did not get it. They stated 9 meant to see other/nurse notes. CMA #1 stated they put in their own note and told the nurses to put a note in. They stated the initials for 12/05/24 at 7:00 a.m. -11:00 a.m. were theirs and they recalled they let the nurse know the medication was not there.</p> <p>On 12/11/24 at 1:48 p.m.,CMA #1 stated Resident #116 was still receiving the medication and provided Resident #116's narcotic record. The record documented the amount of medication ordered was 14 and the amount received was 14. The first dose was signed out on 12/06/24 at 8:00 a.m. and it documented there were three pills remaining.</p> <p>On 12/11/24 at 2:12 p.m., the DON stated the process for new orders was the order would be given from the physician, entered into the electronic medical record or the appropriate system, and track for infection control. The DON stated they did not know why the resident did not receive the antibiotic when it arrived. The DON stated they did not know what happened and they extended the days by three days and had not figured out where the breakdown was.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/11/24 at 2:29 p.m., the DON stated the order was written at 5:45 p.m. on 12/04/24. They stated Resident #116 went to the emergency roignom on [DATE] so no dose should have been given. They stated the medication came in on 12/05/24. The DON stated the resident returned back to the facility before midnight on 12/04/24. They stated the UA results were on 12/05/24 and the antibiotic came in on 12/05/24. They stated they did not understand the second dose not being given.</p> <p>On 12/11/24 at 2:30 p.m., the DON stated the documentation was not an accurate reflection of the resident's medication and was not administered per physician order.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46653</p> <p>Based on observation and interview, the facility failed to ensure a medication cart was securely locked and attended to according to facility policy and procedure.</p> <p>The administrator identified 64 residents resided in the facility.</p> <p>Findings:</p> <p>An undated facility Medication Storage in the Facility policy, read in part, Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p> <p>On 12/10/24 at 11:43 a.m., the medication cart on the North end of the main lobby was found unlocked and unattended.</p> <p>On 12/10/24 at 11:44 a.m., LPN #2 reported the medication cart should have been locked.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <ul style="list-style-type: none"> a. hair nets were worn appropriately; b. the kitchen was kept clean and maintained in good repair; c. food items were labeled, dated, and stored according to facility policy; and d. hand washing and glove usage were appropriate. <p>The DON identified 60 residents ate from the kitchen.</p> <p>Findings:</p> <p>A Preventing Foodborne Illness-Employee Hygiene and Sanitary policy, dated [DATE], documented food and nutrition service employees would follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. It documented employees were to wash their hands after handling soiled equipment or utensils, during food preparation, and as often as necessary to prevent cross contamination when changing tasks. It documented hair nets or caps and/or beard restraints were to be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens.</p> <p>A Food Receiving and Storage policy, revised [DATE], documented all foods were to be covered, labeled, and dated.</p> <p>On [DATE] at 8:40 a.m., dietary aide #1 and #2 were observed with their hair nets only covering the top area of their hair. Dietary aide #1 had the ends of their braids below the hair net and dietary aide #2 had hair outside of the hairnet all the way around their head.</p> <p>On [DATE] at 8:44 a.m., mouse droppings were observed across the tops of four baking soda boxes, a corn starch box was open and undated, and the Worcestershire sauce was found to be expired in the dry storage area. The floor of the kitchen had particles of dirt and debris all over. There were two plastic containers that had miscellaneous dishes. The containers had dirt and debris inside with the miscellaneous dishes. A cup of water with a straw was observed on the dish rack with the large pots and pans.</p> <p>On [DATE] at 8:54 a.m., the dietary manager stated they were unsure what the mouse droppings were, but stated it was not something that needed to be there. They stated they did not know why the corn starch box was open or undated. They stated the Worcestershire sauce had an expiration date of [DATE]. The dietary manager stated, I'm not going to act like I know how long it lasts.</p> <p>On [DATE] at 8:56 a.m., the dietary manager stated the two plastic containers on the bottom rack that had miscellaneous dishes looked like items they did not need. They stated if they were not using the items they needed to get rid of them.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 8:58 a.m., the dietary manager stated they had daily and weekly deep cleaning schedules. They stated, There should have been daily sweeping, but I have been on vacation.</p> <p>On [DATE] at 9:00 a.m., the freezer was observed to have no thermometer. the dietary manager stated that someone had broken the freezer thermometer, but they had new ones. When asked about the observed food with no label or date in the refrigerator, they stated I know these pineapples were from last Friday. I'm not going to make up no lies and waste your time.</p> <p>On [DATE] at 9:12 a.m., the dietary manager stated that hair nets were worn to keep hair from dropping in food.</p> <p>On [DATE] at 11:18 a.m., dietary aide #1 was observed touching the inside of the puree machine and replacing the blade with their bare hands.</p> <p>On [DATE] at 11:19 a.m., dietary aide #1 stated they were supposed to wear gloves all the time or when handling food. They stated they did not wear gloves when they touched the inside of the puree machine.</p> <p>On [DATE] at 12:03 p.m., the dietary manager was observed touching the serving cart with their gloved hands and then went directly back to making plates and touching the bread. They did not wash their hands or change gloves.</p> <p>On [DATE] at 12:26 p.m., the dietary manager was observed opening a new package of bread and then continuing to touch the bread without changing gloves or washing their hands.</p> <p>On [DATE] at 12:55 p.m., the dietary manager stated they were supposed to wash their hands and change gloves if they touched anything besides what was needed to serve the food.</p> <p>On [DATE] at 3:06 p.m., the administrator stated the kitchen was supposed to be cleaned daily, staff were to wear hair nets correctly, and food should be sealed, labeled, and dated.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>45583</p> <p>Based on record review and interview, the facility failed to follow the antibiotic stewardship policy by ensuring a standardized tool for initiation of antibiotics was completed for the treatment of UTI's for one (#37) of three sampled residents reviewed for UTI's.</p> <p>The administrator identified 64 residents resided in the facility.</p> <p>Findings:</p> <p>A Antibiotic Stewardship Policy, dated 01/2024, read in part, The facility will track antibiotic use once ordered. The policy also read, The facility will utilize McGeer and or LOEB Criteria, a practical guide to use in nursing homes.</p> <p>Resident #37 had diagnoses which included congenital occlusion of uretoperelvic junction, hydronephrosis, obstructive and reflux uropathy, crossing vessel, and stricture of ureter.</p> <p>Resident #37's care plan, updated 04/06/24, documented the resident had a nephrostomy tube. The focus documented the resident would have no signs or symptoms of a urinary infection.</p> <p>A physician's order, dated 05/30/24, documented to give Macrobid (antibiotic medication) 100 mg two times a day for UTI for five days. Completed on 06/04/24.</p> <p>A physician's order, dated 07/24/24, documented to give Keflex (antibiotic medication) 500 mg three times a day for UTI for 10 days. Completed on 08/03/24.</p> <p>A physician's order, dated 11/17/24, documented to give amoxicillin-pot clavulanate (antibiotic medication) 875-125 mg two times a day for UTI for three days. Completed on 11/20/24.</p> <p>Review of the infection control book and Res #37's electronic medical record did not reveal a McGeer form was completed for the use of antibiotics in May 2024, July 2024, or November 2024.</p> <p>On 12/12/24 at 11:57 a.m., the ADON stated they were not able to locate the McGeer form for the use of the antibiotics in May, July, and November. They stated they should have been completed.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>49701</p> <p>Based on record review and interview, the facility failed to provide documentation pneumococcal vaccines were offered and/or administered for two (#37 and #216) of five sampled residents reviewed for immunizations.</p> <p>The administrator identified 64 residents resided in the facility.</p> <p>Findings:</p> <p>An Infection Control Immunizations policy, dated 3/20/24, read in part, all residents will be offered pneumococcal vaccines. Assessments of pneumococcal vaccination status will be conducted within five working days of the resident's admission.</p> <p>A review of Resident #37's immunization record did not document the resident had received or been offered a pneumococcal vaccination.</p> <p>A review of Resident #216's immunization record did not document the resident had received or been offered a pneumococcal vaccination.</p> <p>On 12/12/24 at 10:57 a.m., LPN #1 stated they did not know how the vaccines got ordered, but if an order pops up we did it. They stated they did not skip the vaccinations if they were ordered to be done on their shift.</p> <p>On 12/12/24 at 11:01 a.m., the DON stated on admission, they were to document if the resident had the vaccines or not, and if not, then they were to get consent and provide the vaccination if the resident wanted it.</p> <p>On 12/12/24 at 11:43 a.m., the ADON/Infection Preventionist stated they were unable to locate the pneumococcal vaccination documentation for Res #37 or Res #216.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>49701</p> <p>Based on observation, record review, and interview, the facility failed to maintain effective pest control.</p> <p>The administrator identified 64 residents resided in the facility.</p> <p>Findings:</p> <p>A Pest Control Program policy, dated 11/17/24, read in part, Facility will maintain an effective pest control program that eradicates and contains common household pests.</p> <p>On 12/09/24 at 8:44 a.m., upon initial tour of the kitchen multiple mouse droppings were observed across the tops of four boxes of baking soda in the dry storage area.</p> <p>On 12/09/24 at 8:49 a.m., the dietary manager denied knowing what the mouse droppings were, but stated it was not something that needed to be there. They then threw four boxes of baking soda away.</p> <p>On 12/09/24 at 11:04 a.m., a cockroach was observed crawling on Resident #216's hand and prosthetic leg while sitting in the dining room.</p> <p>On 12/10/24 at 2:01 p.m., housekeeper/CNA #1 stated every once in a while, you see a roach. I know they have someone out for that pretty frequently.</p> <p>On 12/10/24 at 2:03 p.m., CNA #1 stated they had seen roaches and bedbugs. They spray and they go away, but they come back.</p> <p>On 12/10/24 at 3:06 p.m., the administrator stated pest control was just there last week. They denied seeing pests and stated it could take from 24-48 hours for the treatments to take effect. They stated, The residents come in with them, all you can do is keep calling pest control to come out.</p>