STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375375	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claremore Skilled Nursing and Therapy	920 East 16th Street Claremore, OK 74017

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse for 1 (#3) of 3 sampled residents reviewed for abuse. The administrator identifed 85 residents resided in the facility. Findings: A undated facility policy titled Resident Abuse, Neglect and Misappropriation of Property, read in part, The administrator and or facility designee will report all allegations to the QAPI committee. The QA committee will monitor for compliance.A member of the administrative staff will then conduct a thorough investigation of the incident/allegation to obtain information about the incident and complete ODH-283 [Oklahoma Department of Health]. An undated Transfer/Discharge Report documented the resident had diagnoses which included major depressive disorder, chronic pain, anxiety disorder, and persistent mood disorders. A discharge return anticipated assessment, dated 12/01/24, did not show a BIMS for the resident. The assessment showed the resident was independent for daily decision making. An OSDH incident report, dated 12/17/24, showed an allegation of abuse for Resident #3. The report showed an allegation that CNA #1 forcefully pushed the resident in their wheelchair away from the nurse station and hit the wall. The facility could not provide statements regarding the incident occurring 12/17/24 from the identified resident or the identified CNA. A quality assurance committee report, dated 12/31/24, did not show abuse was monitored for compliance. On 06/11/25 at 1:47 p.m., the administrator stated there were no documented resident or staff statements regarding the incident on 12/17/24. The administrator stated without statements they did not know if the incident was witnessed by other staff or residents or what time the incident occurred. On 06/11/25 at 2:45 p.m., the administrator stated they could not provide the documentation/investigation to show a thorough investigation was completed. The administrator reviewed the QAPI committee documentation and stated abuse had not been identified after the incident on 12/17/24.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interview, the facility failed to ensure bathing was provided for 2 (#2 and #4) of 4 sampled residents who were reviewed for activities of daily living. The administrator identified 85 residents resided at the facility. Findings: 1. A significant change assessment for Resident #2, dated 04/03/25, showed Resident #2 had a BIMS of 7, which indicated they were moderately impaired for daily decision making. The assessment showed Resident #2 was dependent for showers. Task flow sheets for showers in April, May, and June of 2025 showed Resident #2 was to receive showers twice a week. The flow sheet for April 2025 showed one shower was given on 04/15/25 out of nine opportunities for showers. The flow sheet for May 2025 showed four showers were given on 05/07/25, 05/23/25, 05/28/25, and 05/30/25 out of nine opportunities in the month for showers. The flow sheet for June showed no showers had been given as of 06/10/25. On 06/10/25 at 12:38 p.m., Resident #2 stated they had only get one shower a week. 2. A quarterly assessment, dated 05/13/25, showed Resident #4 had a BIMS score of 15 (which is indicative of intact cognition). The assessment showed Resident #2 was moderately dependent for showers. Task flow sheets for showers in April, May, and June of 2025 showed Resident #4 was to receive showers twice a week. The flow sheet for April 2025 showed four showers were given out of 9 opportunities. The flow sheet showed showers were given on 04/17/25, 04/19/25, 04/24/25, and 04/29/25. The flow sheet for May showed three showers were given out of nine opportunities. The flow sheet showed showers were given on 05/01/25, 05/03/25, and 05/17/25. The flow sheet for June showed one shower had been given on 06/05/25 as of 06/10/25. On 06/11/25 at 10:46 a.m., the regional nurse consultant stated the residents should get the opportunity for two showers a week. On 06/11/25 at 11:02 a.m., the administrator stated residents should get two showers a week.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. On 06/11/25, a past non-compliance situation was determined to exist related to the facility's failure to ensure staff provided supervision to prevent falls from lifts. A facility reported incident, dated 03/26/25, showed Resident #2 fell while being transferred by CNA #4 using a lift. 1. Immediate Action Taken: a. A quality assurance meeting was held to initiate a plan of action. b. all lifts and slings were inspected for wear and tear. 2. Systemic Changes Implemented: a. a schedule of inspection for slings and lifts to ensure all are in good working order. 3. Education and Training: a. All direct care staff were educated on safe use of lifts and slings. An initial incident report, dated 06/03/25, showed certain injuries for Resident #1 as a result of a sling failing during a transfer. 1. Immediate Action Taken: a. A quality assurance meeting was held to initiate a plan of action. b. Inspect all slings b. Discard all old slings and order new slings. 2. Systemic Changes Implemented: a. Method of laundering slings was changed to prevent excess wear by drying. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3. Education and Training: a. Direct care staff were educated on proper method of inspection for slings before use. Based on record review and interviews, the facility failed to ensure staff provided supervision to prevent falls from lifts which resulted in injury for 2 (#1 and #2) of 3 sampled residents who were reviewed for requiring transfers with lifts. The administrator reported 20 residents required the assistance of a lift. Findings: 1. An initial incident report, dated 03/26/25, documented in part .Witnessed fall by staff .Resident sent to ER for evaluation. BIMS of 12. CNA was suspended pending investigation .Upon investigation, it was determined that the sling detached from the lift during transfer. Resident was assessed by facility nurse and EMS called for transport to ER for assessment. ER X-rays showed rib fracture .All direct care staff inserviced on lift use and safety. Maintenance visually inspected all lifts and slings to ensure they were in good working order. Weekly documented checks will be conducted by maintenance to ensure lifts and slings are in working order. A progress note, dated 03/26/25 at 10:45 a.m., showed Res #2 had fallen to the ground while being assisted to a chair in a lift. A purple shower sling was noted hanging from the lift on 3 of the 4 hooks. A final incident report, dated 03/26/25, showed it was determined the sling detached from the lift during transfer and only one staff was operating the Hoyer lift and Resident #2 suffered a rib fracture as a result of the fall. A QAPI report, dated 03/26/25, showed a meeting was held and an action plan was developed. Inservice's were conducted for all direct care staff on safe transfers and the use of two staff when using all lift devices. The report showed compliance rounds to be initiated on 03/27/25. A significant change assessment, dated 04/03/25, showed Resident #2 had a BIMS of 7, which indicated severe cognitive impairment for decision making. The assessment showed the resident was dependent on staff for transfers and bathing. A care plan, dated 04/24/25, showed Resident #2 was dependent on a lift for transfers. On 06/10/25 at 12:38 p.m., Resident #2 stated the lift didn't get hooked properly. They reported there was only one person helping them transfer that day. 2. A significant change assessment, dated 03/24/25, showed Resident #1 had a BIMS of 3, which indicated severe cognitive impairment for decision making. The assessment showed Resident #1 required the use of a lift for transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An initial incident report, dated 06/03/25 showed certain injuries for Resident #1 as a result of a sling failing during a transfer. The report showed a fracture to the left arm and hip resulted from the fall. On 06/09/25 at 12:05 p.m., Resident #1 stated they were in the lift and the strap broke. Resident #1 stated they felt safe in the lift and they felt when the strap broke it was a freak accident. On 06/12/25, a review of documentation provided by the facility was conducted and included: 1. Quality assurance meeting held 06/04/25 2. Inservice's for staff conducted on 06/04/25 regarding the safe use and care of slings. 3. Documentation of new slings ordered on 06/04/25. 4. Weekly lift and sling checks. 5. Lift competency checks for CNA#3 and LPN #4 On 06/12/25, five direct care staff were interviewed regarding their prior education and current knowledge of proper and safe use of transfers and slings.