

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Claremore Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>42171</p> <p>Based on observation, record review, and interview, the facility failed to ensure the accuracy of an MDS assessment for one (#31) of five residents reviewed for MDS accuracy.</p> <p>The administrator reported the census was 80.</p> <p>Findings:</p> <p>Resident #31 had diagnoses including acute respiratory failure with hypoxia.</p> <p>A Medicare five-day assessment, dated 06/12/24, indicated the resident had required invasive mechanical ventilation while a resident at the facility.</p> <p>A review of Resident 31's orders did not document they had orders for a ventilator at the facility.</p> <p>On 06/27/24 at 2:19 pm, the DON stated they did not accept residents that required ventilators.</p> <p>On 06/27/24 at 2:30 pm, MDS coordinator #2 stated they had coded that Resident #31 required a ventilator because they required one before admission to the facility.</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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure the resident and the resident's representative were given a summary of the baseline care plan for one (#7) of two residents whose baseline care plans were reviewed.</p> <p>The administrator reported the census was 80.</p> <p>Findings:</p> <p>1. Resident #64 had diagnoses which included kidney failure and sleep apnea.</p> <p>On 06/25/24 at 9:23 a.m., Resident #7 stated they did not receive a summary of their baseline care plan.</p> <p>On 06/27/24 the Resident #7's clinical record was reviewed. There was no documentation of a baseline care plan.</p> <p>On 06/28/24 at 9:13 am MDS coordinator #1 stated that they did not give Resident #7 or their representative a copy of their baseline care plan because they were unaware that it was a requirement.</p> <p>On 06/28/24 at 12:41 pm, The DON stated that a summary of the baseline care plan should be given to all residents and their representatives.</p>

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<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>41809</p> <p>Based on record review and interview, the facility failed to ensure two (#58 and #7) of two residents/representatives reviewed for care plans, were involved in the care planning process.</p> <p>The administrator identified 80 residents who resided at the facility.</p> <p>Findings:</p> <p>1. Resident #58 admitted with diagnoses which included anxiety.</p> <p>On 06/25/24 at 8:32 a.m., Resident #58 stated they did not know when the care plan meetings were held.</p> <p>Review of progress notes revealed, no notes concerning care plan meetings.</p> <p>On 06/27/24 at 10:41 a.m., the MDS Coordinator stated they conducted the care plan meetings and invited the resident and resident representatives. They stated the invitations were not documented, however the representative for Resident #58 came. The MDS Coordinator stated they did not believe it was documented.</p> <p>On 06/27/24 at 10:59 a.m., the MDS Coordinator returned and stated they did not have anything the representative for Resident #58 had signed to indicate they had attended the care plan meeting.</p> <p>30267</p> <p>2. Resident #7 was admitted with diagnoses which included hypertension, depression, and over-active bladder.</p> <p>The care plan, last updated 06/21/24, did not document the resident/representative participated in the care plan process.</p> <p>On 06/25/24 at 09:23 a.m., Resident #7 stated they had not participated in a care plan meeting.</p> <p>On 06/27/24 the resident's clinical record was reviewed. There was no documentation the resident was notified of or participated in the care plan meeting.</p> <p>On 06/27/24 at 11:00 a.m., the MDS Coordinator stated when a resident's care plan was due, they informed the resident/representative of the meeting. They stated they did not document they informed the resident or their representative of the care plan meeting nor documented who participated in it.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>30267</p> <p>Based on observation, record review, and interview, the facility failed to provide showers for four (Resident #7, 21, 33, and Resident #37) of four sampled residents whose clinical records were reviewed for ADL care to dependent residents.</p> <p>The facility Administrator identified 80 residents.</p> <p>Findings:</p> <p>A facility policy, effective date 10/01/01, documented showering was important because it rid the body of surface dirt, eliminated body odors, stimulated circulation, and provided an opportunity to inspect the resident's skin for any abnormalities or breakdown.</p> <p>A quality improvement report, dated 04/01/24, documented the facility identified showers as a problem and suggested they dedicate one to two staff to provide showers.</p> <p>1. Resident #7 was admitted with diagnoses which included hypertension, depression, and over-active bladder.</p> <p>The care plan, revised 03/25/24, documented the resident required partial/moderate assistance with shower/bathing.</p> <p>The quarterly assessment, dated 06/07/24, documented the resident was mildly impaired in cognition and required partial/moderate assistance with shower/bathing.</p> <p>On 06/25/24 at 9:37 a.m., Resident #7 stated they did not received their showers as scheduled nor received showers when they requested. Resident #7 stated they bathed daily at home and would appreciate a shower daily or every other day. Resident #7 stated they would bathe themselves in the sink because they preferred to stay clean and did not care to be woke in the middle of the night or early morning to make up for a missed shower.</p> <p>On 06/27/24, a review of the clinical record documented Resident #7 received assistance with bathing on 06/02/24, 06/05/24, 06/12/24, 06/16/24, 06/19/24, and 06/26/24.</p> <p>On 06/27/24 at 1:10 p.m., CNA #2 stated the shower assignment list was usually 28 to 30 residents per day. The aide stated some residents require two or more person assistance for transfers and bathing and that required the aide to coordinate care with other staff for the additional help. The aide stated if they were unable to coordinate with staff for the additional help, the resident was left for the other shift to complete. The aide stated the residents requiring the additional help were often left for the other shift. The aide stated they left a list at the nurses station of all the residents who received a shower and the residents who did not receive a shower. The aide stated the following shift was to complete the remainder of the assigned showers.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/28/24 at 12:15 p.m., LPN #2 stated the shower aide would report to them when a resident refused their shower but had not reported to them that all assigned showers were not completed. The LPN stated all shower refusals were to be signed by the resident, the aide, and the nurse.</p> <p>On 06/28/24 at 1:15 p.m., the DON stated the facility employed one shower aide through the weekday and one shower aide on the weekends. The DON stated the shower aide may have 12 or more residents listed on the shower list for each weekday. The DON stated if the shower aide was unable to complete the assigned showers for the day, the other aides and shifts were expected to complete the assigned showers.</p> <p>2. Resident #21 had diagnoses which included chronic pain, Hodgkin's lymphoma, and sarcopenia.</p> <p>The care plan, dated 03/22/24, documented Resident #21 would like a shower once a week.</p> <p>The physician's order, dated 05/07/24, documented Resident #21 was admitted to hospice services.</p> <p>The care plan, dated 05/09/24, documented Resident #21 received bath/showers from hospice.</p> <p>On 06/25/24 at 12:33 p.m., Resident #21 was observed in bed. The resident's hair appeared uncombed and there was dirt and debris under the resident's finger nails. Resident #21 stated they had not received a shower in six weeks. Resident #21 stated they agreed to hospice services because they were promised if they did so, they would receive showers. Resident #21 stated they did not feel clean after they received a bed bath.</p> <p>On 06/28/24, the Resident #21's clinical record was reviewed, including the hospice records related to bathing. The hospice records documented Resident #21 received a bed bath on the following dates: 05/13/24, 05/15/24, 05/21/24, 05/23/24, 05/29/24, 06/17/24, and 06/24/24.</p> <p>On 06/28/24 at 1:15 p.m., the DON stated residents receiving hospice services were bathed by hospice staff. The DON stated a residents' bathing preference should be accommodated by hospice when clinically possible. The DON stated the facility was responsible for the coordination of care for all residents, including ensuring residents received their baths and their choice of bathing preference was respected.</p> <p>3. Resident #33 had diagnoses which included infection and inflammatory reaction due to indwelling urethral catheter and a stage three pressure ulcer.</p> <p>The quarterly assessment, dated 05/14/24, documented the Resident #33 was cognitively intact and was totally dependent on others for repositioning, transfers, and bathing.</p> <p>On 06/25/24 at 9:57 a.m., Resident #33 was observed in bed with their hair uncombed and gown stained with food. Resident #33 stated they had not received a shower in two weeks. Resident #33 stated when they were admitted, the facility had a shower bed but now they only have shower chairs. Resident #33 stated the shower chair was very uncomfortable and they did not feel they were clean when using the shower chair because they could not lean forward for their back to be washed and could not lift either hip up from the surface of the chair for the aide to wash their buttocks. Resident #33 also stated it was difficult for the aide to reach under the chair to wash the residents perineum.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/27/24 at 1:10 p.m., CNA #2 stated the shower assignment list was usually 28 to 30 residents per day. The aide stated Resident #33 required three staff members to assistance with their transfer to and from the shower chair. The CNA stated Resident #33 was in a lot of pain when up in the shower chair even when they padded the chair with multiple bath blankets. The aide stated they had not given the Resident #33 a shower in a few weeks. The aide stated they tried to start the bath schedule with those residents who they missed on their previously scheduled shower day to ensure the resident had at least one shower per week. The aide stated since the Resident #33 required the assistance of two other staff members, the resident was often left for the other shift to complete. The aide stated the residents requiring the additional help were often left for the other shift. The aide stated they left a list at the nurses station of all the residents who received a shower and the residents who did not receive a shower. The aide stated the following shift was to complete the remainder of the assigned showers.</p> <p>On 06/28/24 at 12:15 p.m., LPN #2 stated the shower aide would report to them when a resident refused their shower but had not reported to them that all assigned showers were not completed. The LPN stated all shower refusals were to be signed by the resident, the aide, and the nurse.</p> <p>On 06/28/24 at 1:15 p.m., the DON stated the facility employed one shower aide through the weekday and one shower aide on the weekends. The DON stated the shower aide may have 12 or more residents listed on the shower list for each weekday. The DON stated if the shower aide was unable to complete the assigned showers for the day, the other aides and shifts were expected to complete the assigned showers.</p> <p>4. Resident #37 had diagnoses which included impulse disorder.</p> <p>The quarterly assessment, dated 06/07/24, documented the resident was cognitively intact, exhibited no behaviors, and required partial/moderate assistance with bathing.</p> <p>The care plan, dated 06/19/24, documented the resident required partial/moderate assistance with bathing and to offer bathing at least twice a week.</p> <p>On 06/25/24 at 1:07 p.m., Resident #37 was in bed. The resident's hair appeared oily and their face unshaven. Resident #37 stated they did not receive their showers, even after asking for a shower. The care plan documented if the resident was to refuse, to try again later, document the refusal, and inform the nurse.</p> <p>On 06/26/24 at 9:00 a.m., the Resident #37's clinical record was reviewed. There was no documentation the resident received a bath in the last 30 days. There was no documentation the resident refused a bath in the last 30 days.</p> <p>On 06/27/24 at 1:10 p.m., CNA #2 stated Resident #37 required the assistance of a male staff member which was not always available.</p> <p>On 06/28/24 at 1:15 p.m., the DON stated the facility employed one shower aide through the weekday and one shower aide on the weekends. The DON stated male staff were assigned to provide the Resident #37 with a shower each week or document when the resident refused.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>42171</p> <p>Based on record review and interview, the facility failed to ensure appropriate communication between the facility and the dialysis provider for one (#16) of one resident reviewed for dialysis.</p> <p>The DON reported two residents received dialysis services.</p> <p>Findings:</p> <p>The Policy and Procedure Guidelines for Dialysis After Care policy, effective 07/11/12, read in part, . Schedule visits to dialysis center and coordinate care accordingly .</p> <p>A care plan intervention, revised on 05/15/24, documented to schedule dialysis every Monday, Wednesday, and Friday and to coordinate care with the dialysis center.</p> <p>A review of Resident #16's medical record did not document a Dialysis Communication Form had been completed for Resident #16 since 05/28/24.</p> <p>On 06/27/24 at 10:13 am, LPN #1 stated that until yesterday they were unaware that they were supposed to be filling out a Dialysis Communication Form and sending the form with the resident to the dialysis center. They also stated they had dropped the ball and from now on they would utilize the form.</p> <p>On 06/27/24 at 10:55 am, the DON stated the nurse on duty was responsible for sending the dialysis form with the resident and putting the information in the computer when the resident returned.</p> <p>On 06/28/24 at 8:33 am, LPN #2 stated that the communication form should be sent to dialysis with the resident and then entered into the computer upon the resident's return from dialysis. LPN #2 also stated the charge nurse was responsible for completing these tasks.</p> <p>On 06/28/24 at 10:40 am, LPN #3 stated nurse assigned to the dialysis residents hall was responsible for sending the dialysis for with the resident and ensuring it was entered into the computer.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>42171</p> <p>The facility failed to ensure lab work was completed as ordered for two (#39 and #33) of five residents reviewed for unnecessary medications.</p> <p>The administrator reported the census in the facility was 80.</p> <p>Findings:</p> <p>1. Resident #39 had diagnoses which included diabetes mellitus and hypertension.</p> <p>A physician's order, dated 02/16/24, documented to repeat a lipid level in 3 months, April 2024.</p> <p>A review of Resident #39 records did not document a lipid level had been collected in April of 2024.</p> <p>On 06/27/24 at 2:40 pm, The ADON stated that the lab had not been completed in April of 2024. They also stated the lab had been completed on 06/27/24 and the results had been addressed by the physician.</p> <p>On 06/28/24 at 12:41 pm, The DON stated the ADON was responsible for ensuring lab work was completed as ordered.</p> <p>30267</p> <p>2. Resident #33 had diagnoses which included atrial fibrillation and an unspecified coagulation defect.</p> <p>A laboratory report, dated 01.25.24, documented the resident had a critical low potassium level of 2.7 mEq/L (normal range 3.5-5.1 mEq/L).</p> <p>On the laboratory report was a hand written note, dated 01/26/24, which read to administer 40meq of potassium now, to start potassium 20meq daily, and to check the resident's potassium level by redrawing the lab on 01/29/24.</p> <p>There was no documented lab drawn on 01/29/24.</p> <p>A laboratory report, dated 01/30/24, documented the laboratory results of a complete blood count. The laboratory findings for a complete blood count does not measure the resident's potassium level.</p> <p>On 06/28/24 at 9:33 a.m., the resident's laboratory results were reviewed with the DON. The DON stated the redraw was not performed and a laboratory order for a complete blood count was ordered instead by mistake. The DON stated the facility did not have a system in place which would monitor laboratory orders for inaccuracies.</p>		