

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Emerald Care Center Claremore		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 North Hickory 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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>45462</p> <p>Based on record review and interview, the facility failed to update the care plan with significant changes in condition for one (#2) of five sampled residents whose care plans were reviewed.</p> <p>The Administrator identified 106 residents resided in the facility.</p> <p>Findings:</p> <p>A 'Care Plan Process' policy, revised 09/2019, read in parts, .Responsibilities of the Interdisciplinary Team . complete a care plan review after each PPS Assessment for Managed Care residents to ensure the care plan is updated as the resident's status changes .</p> <p>Resident #2 had diagnoses that included senile degeneration of the brain and dementia.</p> <p>A physician's order, dated 11/06/23, documented Resident #2 was to receive a regular diet, pureed texture and thin consistency.</p> <p>A Significant Change MDS assessment, dated 11/19/23, documented Resident #2 required a mechanically altered diet and Hospice care.</p> <p>A physician's order, dated 12/12/23, documented Resident #2 was to be admitted to hospice as of 11/06/23 with diagnoses of senile degeneration.</p> <p>A review of Resident #2's care plan did not show it had been updated to include their re-admission to Hospice nor their change to a pureed diet.</p> <p>On 05/01/24 at 1:50 p.m., the MDS Coordinator #1 was asked the process for ensuring a resident's care plan was updated as their condition changed or if a significant change MDS was done. They stated when a significant change MDS is completed the changes are incorporated into the resident's care plan by the person completing the MDS or someone else on the IDT. MDS Coordinator was asked to review Resident #2's care plan for the changes listed above. After review, MDS Coordinator #1 acknowledged Resident #2's care plan had not been updated per facility policy.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>45462</p> <p>Based on observation and interview, the facility failed to follow infection control practices during wound care for four (#4, 6, 7, and #8) of five sampled residents whose wound care was observed.</p> <p>The administrator identified 106 residents resided in the facility. Twenty-three residents received wound treatments.</p> <p>Findings:</p> <p>1. Resident #8 had diagnoses that included MASD to sacrum.</p> <p>A physicians' order, dated 04/16/24, documented treatment order to cleanse with NS, pat dry, and apply clotrimazole cream then zinc and large foam dressing daily.</p> <p>On 04/29/24 at 4:12 p.m., RN #1 was observed during wound care for Resident #8. Resident #8's wound had no dressing on it when we arrived at their bedside. When cleaning the wound RN #1 wiped back and forth around the area of skin breakdown five times using the same gauze soaked in NS.</p> <p>2. Resident #4 had diagnoses that included stage 2 pressure ulcer to sacrum</p> <p>A physicians' order, dated 04/11/24, documented treatment order to cleanse with NS, pat dry, and apply calcium alginate and Medi honey with foam bandage daily.</p> <p>On 04/29/24 at 4:15 p.m., RN #1 was observed during wound care for Resident #4. Resident #4's wound had no dressing on it when we arrived at their bedside. When cleaning the wound RN #1 wiped in and around the wound nine times in up, down, and circular motions using the same gauze soaked in NS.</p> <p>3. Resident #7 had diagnoses that included s/p fracture of right femur and surgical wound to right hip.</p> <p>A physicians' order, dated 04/22/24, documented treatment order to cleanse incision to right hip with betadine and cover with dry dressing daily.</p> <p>On 04/29/24 at 4:20 p.m., RN #1 was observed during wound care for Resident #7. RN #1 donned gloves, removed the old dressing from their wound, and did not change gloves before treating the wound. When cleaning the wound RN #1 wiped up and down the length of the surgical site five times using the same betadine-soaked gauze.</p> <p>4. Resident #6 had diagnoses that included s/p fracture of right femur and surgical wound to right hip.</p> <p>A physicians' order, dated 04/22/24, documented treatment order to cleanse wound to right hip with betadine and cover with dry dressing daily.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/29/24 at 4:24 p.m., RN #1 was observed during wound care for Resident #6. RN #1 donned gloves, removed the old dressing from their wound, and did not change gloves before treating the wound. Resident #6 was noted to have two separate surgical wounds under the gauze covering once removed. RN #1 cleansed both wounds using the same betadine-soaked gauze and patted them both dry with the same dry gauze.</p> <p>On 04/29/24 at 4:45 p.m., RN #1 was asked the process for how wounds were to be cleaned. They stated you wipe-throw away, wipe-throw away. RN #1 was asked if separate wounds on the same resident should be cleaned with the same gauze. They stated I guess not. RN #1 was asked when your gloves should be changed during wound care. They stated after removing the old dressing and if they become soiled. RN #1 was informed of the observations made during dressing changes for Resident #4, 6, 7, and #8. They acknowledged they had not followed proper infection control measures to prevent infection or cross contamination.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45462</p> <p>Based on observation and interview, the facility failed to follow enhanced barrier precautions during wound care for two (#4 and #8) of five sampled residents whose wound care was observed.</p> <p>The administrator identified 106 residents resided in the facility. Twenty-three residents received wound treatments.</p> <p>Findings:</p> <p>1. Resident #8 had diagnoses that included MASD to sacrum.</p> <p>On 04/29/24 at 4:12 p.m., RN #1 was observed during wound care for Resident #8.</p> <p>2. Resident #4 had diagnoses that included stage 2 pressure ulcer to sacrum</p> <p>On 04/29/24 at 4:15 p.m., RN #1 was observed during wound care for Resident #4.</p> <p>RN #1 did not don a gown before providing wound care to Resident #4 nor Resident #8.</p> <p>On 04/29/24 at 4:45 p.m., RN #1 was asked when enhanced barrier precautions were used according to facility policy. They stated when providing direct care to residents with catheters, drains, PEG tubes, or IV's and when providing wound care. RN #1 was informed of the observations made during dressing changes for Resident #4 and #8. They acknowledged they had not followed facility policy for enhanced barrier precautions.</p>