STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375499	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care Center Claremore	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34270 Based on record review and interview, the facility failed to notify a resident's representative when a new antipsychotic medication had been ordered for one (#3) of five sampled residents reviewed for notifications of change. A resident listing report, dated 10/14/24, documented 109 residents resided at the facility. Findings: A facility policy titled Notification of Change Policy, dated 05/2017, read in part, It is the policy of this facility that changes is resident's condition or treatments are immediately shared with the resident and/or the resident's representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). Resident #3 had diagnoses which included delusional disorder. A physician's medication order, dated 01/11/24, documented Resident #3 was to be administered risperidone (antipsychotic medication) 0.5 mg tablet by mouth at bedtime for delusional disorder. The order was documented as discontinued on 06/13/24. A physician's medication order, dated 06/14/24, documented Resident #3 was to be administered risperidone 0.5 mg tablet by mouth at bedtime for delusional disorder. The order was documented as discontinued on 06/15/24. A physician's medication order, dated 06/14/24, documented Resident #3 was to be administered Nuplazid (antipsychotic medication) 34 mg tablets by mouth once daily for delusions and psychosis. A review of the progress notes for Resident #3 did not document the resident's representative had been notified of the medication changes. On 10/15/24 at 9:41 a.m. the ADON stated they did not find any documentation Resident #3's family had been notified of the change of antipsychotic medications. They stated their policy stated they should have been made aware.

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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(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. 34270 Based on record review and interview, the facility failed to conduct a thorough investigation into a missing container of narcotic pain medications. A resident listing report, dated 10/14/24, documented 109 residents resided at the facility. Findings: A facility policy titled Controlled Medication - Ordering and Receipt, dated 2001, documented medications were to be checked upon arrival to ensure all medications on the packing slip were received. A pharmacy manifest, dated 08/23/24, documented 168 tablets of Oxycodone/APAP (pain medication) 10-325 mg was delivered to the facility and represented a 28-day supply of the medication. The manifest was signed by facility nurse LPN #1. On 10/14/24 at 11:23 a.m., the ADON stated they had investigated 60 unaccounted for Oxycodone/APAP 10-325 mg tablets. They stated they had attempted to reorder the medication on 09/13/24 and were informed by the pharmacy that it was too soon to reorder. They stated that was when they realized there were missing pills. They stated they attempted to contact LPN #1 since that time, but they had not returned their calls or worked at the facility. They were asked to provide their documentation of the investigation they had conducted into the unaccounted medication. They stated they did not have documentation other than the incident report. They stated they had no documentation of interviews with any staff regarding the missing medication, the police officer declining to investigate the missing medication, or of the attempts to contact LPN #1. They stated they did not know what has happened to the missing pain medication. On 10/14/24 at 1:08 p.m., LPN #1 stated they worked at the facility only occasionally. They stated they were unaware of the missing medications. They stated no one from the facility had attempted to contact them regarding the missing medications. On 10/16/24 at 11:39 a.m., the ADON stated they had completed the investigation with the information they had to work with. They stated they never found out what had happened to the medications.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 34270 Based on record review and interview, the facility failed to assess and promptly treat a resident following an unobserved fall for one (#6) of two sampled residents reviewed for falls. A resident listing report, dated 10/14/24, documented 109 residents resided at the facility. Findings: Resident #6 had diagnoses which included hemiplegia and hemiparesis. A Falls Management policy and procedure, dated 04/2015, read in part, In the event a resident has fallen and/or is found on the ground, a complete head-to-toe assessment must be performed prior to moving the resident unless life-threatening safety concerns are present. Remain with the resident while calling for assistance, if at all possible. A progress note, dated 04/15/24 at 10:36 a.m., documented Resident #6 complained of pain in their right hip when they moved their right leg. The note documented the nurse observed the resident's right leg externally rotated and the resident was unable to straighten their leg. It further documented a nurse practitioner was in the building and ordered the resident to be sent to an emergency room . The note stated the resident and their family member were aware of the order to go to the emergency room . A hospital history and physical report, dated 04/15/24 at 4:20 p.m., documented Resident #6 reported they had fallen at the nursing facility and had decreased feeling in their lower right leg. A hospital consultation report, dated 04/15/24 at 5:37 p.m., documented an X-ray of Resident #6's pelvis found a fracture right hip fracture. An incident report, dated 04/22/24, documented a former administrator of the facility had substantiated a complaint lodged by family members of Resident #6 on 04/22/24. The former administrator's investigation documented on the report LPN #2 had stated they had conducted a head-to-toe assessment of the resident after a fall and found no issues and no report of pain. The document further stated the ADON and nurse practitioner assessed the resident the next day and found them to be in pain and their right leg was obviously externally rotated. The report documented LPN #2's employment was terminated. On 10/16/24 at 10:40 a.m., the ADON stated the resident had fallen the night of 10/14/24 and was not assessed adequately by LPN #2 which caused the resident to not receive treatment until the next day. They stated they stand by the statements documented on the incident report dated 04/22/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 12:45 p.m., the ADON presented documentation of the facility's actions to correct the deficiency they had identified regarding fall assessments and interventions. They included documentation nursing staff were in-serviced on the facility's fall protocols which included assessment and interventions post fall, monthly monitoring of falls by the ADON in April, May, and June of 2024, and QAPI meeting in May and June demonstrating the teams monitoring of the situation and a five percent decline in falls at the 06/14/24 meeting. Interviews with nursing staff during the survey confirmed the in-service had occurred and the content of the training.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34270 Based on record review and interview, the facility failed to prevent a medication administration record from erroneously recording a resident received a medication when the medication was not available for administration for one (#3) of six sampled residents reviewed for medication administration. A resident listing report, dated 10/14/24, documented 109 residents resided at the facility. Findings: A MAR, dated 06/01/24 through 06/30/24, documented Resident #3 had been administered Nuplazid (antipsychotic medication) 11 times between 06/14/24 and 06/30/24. A MAR, dated 07/01/24 through 07/31/24, documented Resident #3 had been administered Nuplazid five times between 07/01/24 and 07/26/24. On 10/15/24 at 9:30 a.m., CMA #1 stated they had reviewed the June and July MARs for Resident #3 and found they had documented they had administered Nuplazid to the resident on multiple dates. They stated those entries were in error as that medication had never arrived in the building because of an insurance issue. On 10/15/24 at 9:53 a.m., the ADON stated documents from their contracted pharmacy showed Resident #3's Nuplazid had never arrived at the facility and the documentation in the June and July 2024 MARs that indicated the medication was administered to the resident were errors.