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	11/27/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34270 Based on record review and interview, the facility failed to ensure residents were provided the right to refuse medication for two (#1 and #2) of three sampled residents reviewed for abuse. A daily census record, dated 11/15/24, documented 103 residents resided in the facility. Findings: The facility's Resident Rights policy, dated November 2017, read in part, The resident has the right to be informed of, participate in, his or her treatment, including .The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate and [sic] advance directive. 1. Resident #1 had diagnoses which included Alzheimer's disease. An Incident Report Form, dated 11/09/24, documented LPN #1 had allegedly forced Resident #1 to take medication against their will. An undated attachment to the incident report documented the facility staff had determined the incident had occurred and LPN #1's employment had been terminated. A printed copy of an email from visitor #1 to the facility ADON, dated 11/11/24, documented visitor #1 had observed LPN #1 forcibly medicate Resident #1 after they had verbally stated they did not want to take the mediation. They stated LPN #1 put the medication combined with pudding into the resident's mouth and when Resident #1 attempted to spit them out LPN #1 held a cup of water to the resident's mouth to which the resident pushed the water away. The email documents visitor #1 had told LPN #1 to allow the resident to drink the water on their own and the LPN put down the water and departed from the resident. On 11/27/24 at 8:45 a.m., visitor #1 stated on 11/09/24 they had observed LPN #1 force Resident #1 to take some unknown medications. They stated they observed Resident #1 verbally tell the LPN they did not want to take the medications. They stated LPN #1 mixed the medicine into pudding and forced the resident to take the mediations. They stated when the resident attempted to spit out the medicine LPN #1 held a cup of water to the resident's mouth even though they continued to object and say no. 2. Resident #2 had diagnoses which included vascular dementia. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A narcotic count sheet for lorazepam (antianxiety medication) 2 ml syringes for Resident #2, documented CMA #2 signed out one syringe of the medication on 11/08/24 at 6:00 p.m. An Incident Report Form incident date 11/09/24, documented LPN #1 had allegedly forced Resident #2 to take medication against their will. An undated attachment to the incident report documented the facility staff had determined the incident had occurred and LPN #1's employment had been terminated. A handwritten statement, dated 11/11/24, documented CMA #1 had witnessed LPN #1 forcibly administer Resident #2 the antianxiety medication lorazepam. The documented stated Resident #2 physically resisted taking the medication and LPN #1 held the resident's arms while they were given the medication. On 11/25/24 at 2:45 p.m., CMA #1 stated that on 11/08/24 after 5:00 p.m., they had been instructed by LPN #1 to bring Resident #2 some lorazepam to calm them down. CMA #1 stated when they attempted to administer the medication into their mouth Resident #2 put up their arms to resist taking the medication. CMA #1 then stated they observed LPN #1 hold the resident's arms and the CMA then administered the medication into the mouth of Resident #2. On 11/27/24 at 10:10 a.m., the ADON stated Resident #1 and Resident #2 had the right to refuse taking their medications and LPN #1 and CMA #1 had violated the residents' rights to refuse treatment.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 34270 Based on record review and interview, the facility failed to ensure a resident was not physically restrained for one (#2) of three sampled residents reviewed for abuse. A daily census record, dated 11/15/24, documented 103 residents resided in the facility. Findings: The facility's Abuse, Neglect, and Exploitation: policy, dated November 2017, read in part, The facility must ensure the resident is free of from physical or chemical restraints imposed for the purpose of discipline or convenience and that are not required to treat the resident's medical symptoms. Resident #2 Resident #2 had diagnoses which included vascular dementia. An Incident Report Form, dated 11/09/24, documented LPN #1 had allegedly forced Resident #2 to take medication against their will. An undated attachment to the incident report documented the facility staff had determined LPN #1 had physically restrained Resident #2's arms while attempting to administer medications to the resident. The document stated the facility staff determined the incident had occurred and LPN #1's employment had been terminated. On 11/25/24 at 2:45 p.m., CMA #1 stated that on 11/08/24 on the evening shift Resident #2 had repeatedly stood up from their wheelchair. They stated they would ask the resident to sit back down and they would, but would soon repeat the behavior. They stated Resident #2 then stood up and used the frame of the window of the nurses' station to walk to the nurses' station door. They stated at that point LPN #1 held the resident by their shoulders and moved them back into their wheelchair. They stated the LPN then pushed the wheelchair to a table in the common area and stood behind the chair so the resident could not stand. They stated the resident tried to push away from the table, but LPN #1 pushed them back. CMA #1 then stated LPN #1 held the resident's arms so they could not push away the medicine CMA #1 attempted to administer. On 11/27/24 at 10:10 a.m., the ADON stated LPN #1 had violated the rights of Resident #2 by using physical restraints to restrict their movements. They stated facility policy forbid such restraints and LPN #1 had been terminated.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. 34270 Based on record review and interview, the facility failed to ensure a chemical restraint was not used to keep a resident from repeatedly standing from their wheelchair for one (#2) of three sampled residents reviewed for abuse. A daily census record, dated 11/15/24, documented 103 residents resided in the facility. Findings: The facility's Abuse, Neglect, and Exploitation: policy, dated November 2017, read in part, The facility must ensure the resident is free of from physical or chemical restraints imposed for the purpose of discipline or convenience and that are not required to treat the resident's medical symptoms. 1. Resident #1 had diagnoses which included Alzheimer's disease. A narcotic count sheet for lorazepam (antianxiety medication) 2 ml syringes for Resident #2, documented CMA #2 signed out one syringe of the medication on 11/08/24 at 6:00 p.m. An Incident Report Form, dated 11/09/24, documented LPN #1 had allegedly forced Resident #2 to take medication against their will. An undated attachment to the incident report documented the facility staff had determined the incident had occurred and LPN #1's employment had been terminated. On 11/25/24 at 2:45 p.m., CMA #1 stated on 11/08/24 on the evening shift Resident #2 repeatedly stood from their wheelchair and had to be reminded to not walk, but sit back down in the wheelchair. They stated the resident would smile and sit back down, but later repeat the behavior. They stated the resident would always sit back down when asked. They stated at one point Resident #2 stood again, but that time used the window frame at the nurse's station to lean on and began walking toward the door of the nurse's station. They stated LPN #1 asked them if the resident had an order for lorazepam which they replied to LPN #1 they did. They stated LPN #1 told them to get the medication and they attempted to administer the medication, but the resident blocked the medication with their arms. They stated LPN #1 then held the resident's arms as they administered the medication. They stated when the resident tried to spit the medication out of their mouth LPN #1 held their hand over the mouth of the resident or one or two minutes. They stated LPN #1 then removed their hand and stated that was probably enough to calm the resident down. On 11/27/24 at 10:10 a.m., the ADON stated LPN #1 and CMA #1 had violated the rights of Resident #2 by using a chemical restraint to restrict their movements instead of less restrictive means. They stated facility policy forbid such restraints and LPN #1 had been terminated. They stated they were unaware CMA #1 had administered the medication and they had now been sent home pending an investigation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34270 Based on record review and interview, the facility failed to ensure an employee reported an allegation of abuse in the mandated time frame for one (#2) of three sampled residents reviewed for abuse. A daily census record, dated 11/15/24, documented 103 residents resided in the facility. Findings: The facility's Abuse, Neglect, and Exploitation: policy, dated November 2017, read in part, Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not late than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Resident #2 had diagnoses which included vascular dementia. An Incident Report Form, dated 11/09/24, documented when investigating another incident it was discovered the same alleged perpetrator, LPN #1, had been involved in an incident of forcing Resident #2 to take medications against their will. A handwritten statement, dated 11/11/24, documented CMA #1 had witnessed LPN #1 forcibly administer Resident #2 the antianxiety medication lorazepam on 11/08/24 sometime between 5:30 p.m. and 7:00 p.m. On 11/25/24 at 2:45 p.m., CMA #1 stated on 11/08/24 after 5:00 p.m., they had observed what they believed to have been abusive behavior from LPN #1 toward Resident #2. They stated they did not report the incident until 11/10/24 at 9:40 a.m. when they informed the ADON. On 11/27/24 at 10:10 a.m., the ADON stated CMA #1 had not followed the facility abuse policy by not reporting the allegation of abuse until more than 24 hours after they witnessed the incident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42171 Based on observation, record review and interview, the facility failed to ensure a comprehensive care plan was developed for one (#3) of three sampled residents reviewed for pressure ulcers. The administrator identied 103 residents resided in the facility. Findings: A facility policy titled Care Plan Process, revised 9/2019, read in part, The plan of care must describe the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and social well-being .Purpose .To ensure a care plan will be developed that is appropriate for each resident's needs and/or wishes based on assessment and reassessment. Resident #3 has diagnoses which included a pressure ulcer to the sacral region and hypertension. A physician order, dated 11/13/24, documented Resident #3 was to receive wound care to the coccyx/sacrum three times a week. A quarterly assessment, dated 11/20/24, documented Resident #3 had an unstageable pressure ulcer. On 11/26/24 at 11:15 a.m., a pressure ulcer was observed on Resident #3's sacrum. A review of Resident #3's care plan did not document interventions related to pressure ulcers. On 11/26/24 at 12:35 p.m., RN #1 stated pressure ulcers should be addressed on the care plan. On 11/26/24 at 12:40 p.m., LPN #2 stated interventions for pressure ulcers should be included on the care plan. On 11/26/24 at 12:45 pm, the ADON stated pressure ulcers should be care planned.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42171 Based on observation record review, and interview, the facility failed to ensure catheter bags were not on the floor for one (# 2) of four sampled residents reviewed for catheters. The roster matrix, date printed 11/15/24, documented nine residents in the facility had catheters. Findings: Resident #12 had diagnoses which included obstructive and reflux uropathy. A quarterly assessment, dated 09/09/24, documented Resident #12 had an indwelling urinary catheter. On 11/25/24 at 1:50 p.m., Resident #12 was observed seated in a recliner. Their catheter bag was observed on the floor next to the recliner. On 11/26/24 at 10:30 a.m., Resident #12 was observed seated in a recliner. Their catheter bag was observed on the floor next to the recliner. On 11/26/24 at 12:35 p.m., RN #1 stated catheter bags should not be on the ground. On 11/26/24 at 12:45 p.m., the ADON stated catheter bags should not be allowed to touch the floor.