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	07/02/2026

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 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 3 (#3, #4 and #6) of 3 sampled residents reviewed for activities of daily living. The DON identified 106 residents resided in the facility.Findings: A care plan for Resident #3, dated 05/18/26, showed the resident had a functional deficit with current activities of daily living related to chronic obstructive pulmonary disease, diabetes mellitus, and congestive heart failure, and required assistance with personal hygiene. An undated Bath List showed Resident #3 was to receive baths weekly on Monday, Wednesday, and Friday. Shower Sheets for Resident #3 showed the resident received baths on the following dates:a. 06/03/26, andb. 06/17/26. 2. An undated Bath List showed Resident #4 was to receive baths weekly on Monday, Wednesday, and Friday. Shower Sheets for Resident #4 showed the resident received baths on the following dates:a. 06/01/26, b. 06/10/26, andc. 06/19/26. 3. A care plan for Resident #6, dated 06/16/26, showed the resident had a functional deficit with current activities of daily living related to osteoarthritis, and required partial assistance with bathing. An undated Bath List showed Resident #6 was to receive baths weekly on Monday, Wednesday, and Friday. Shower Sheets for Resident #6 showed the resident received baths on the following dates:a. 06/03/26, b. 06/10/26,c. 06/19/26,d. 06/22/26,e. 06/24/26, andf. 06/29/26.On 07/01/26 at 2:25 p.m. the DON stated residents should receive a shower three times weekly. The DON stated some residents were scheduled for showers two days weekly, but this had been care planned and scheduled. The DON stated the expectation was that the nurse offered a bed bath if the shower was refused and that there would be documentation of the refusal. On 07/01/26 at 3:10 p.m., CNA #1 stated they had attempted to provide showers when they were assigned, but there were times they were missed or the resident refused. CNA #1 stated they were supposed to notify the nurse on the hall, but they did not think that happened very often. They stated they usually just did not turn in a shower sheet.On 07/02/26 at 12:06 p.m., RN #3 stated residents generally had showers on the evening shift. RN #3 stated shower sheets were completed by CNAs and turned into the charge nurse on the hall to be reviewed. RN #3 stated if a resident refused their shower, the nurse would talk with them and follow up with family, if needed, to ensure they received the needed care. RN #3 stated they did not know why the shower sheets had not been completed for Resident #3, Resident #4, and Resident #6. They stated it appeared the showers had not been given.

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

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	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care Center Claremore	2800 North Hickory Street Claremore, OK 74017

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on record review and interview, the facility failed to ensure residents were free from significant medication errors for 1 (#1) of 5 sampled residents reviewed for medication administration. The DON stated 106 residents received medications from the facility.Findings: A policy titled Medication Administration and General Guidelines, dated 2021, read in part, medications are administered at the time they are prepared .observes the resident take the medications. A progress note for Resident #1, dated 06/26/26 at 6:40 p.m., showed the resident had drunk coffee with medications in it that belonged to another resident. A medication administration record for Resident #2, dated 06/26/26, showed Resident #1 received the following medications: Rexulti (a medication for agitation) half of a 4 mg tablet, buspirone HCl (a medication for anxiety) 10 mg, and alprazolam (a medication for anxiety) 0.5 mg.On 07/01/26 at 2:38 p.m., the DON stated medications should always be observed during medication administration to ensure the resident has taken all of their medication, as well as ensuring another resident did not take the medications.On 07/01/26 at 2:50 p.m., CMA #2 stated they did not watch Resident #2 take their medications on 06/26/26. CMA #2 stated they gave Resident #2 their medications in coffee and did not observe them drink the coffee with the medications in it.On 07/02/26 at 10:35 a.m., Physician #1 stated they were notified when Resident #1 had taken medications that belonged to Resident #2. Physician #1 stated they reviewed the medications that Resident #1 had taken, and provided orders to hold the evening medications, monitor vital signs, and perform assessments on Resident #1. Physician #1 stated they did not feel the medications Resident #1 received had an impact on the resident's condition.