

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 05/17/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff provided dignity with dining for residents who required assistance with meals for two (morning and noon meal) of two meals observed for dining.</p> <p>The ADON identified 13 residents who were dependent on staff for eating.</p> <p>Findings:</p> <p>1. Resident #65 had diagnoses which included Alzheimer's disease.</p> <p>The quarterly assessment, dated 04/09/24, documented the resident was severely impaired in cognition for daily decision making and required supervision/touch assist of staff for eating.</p> <p>On 05/13/24 at 9:33 a.m., CNA #1 was observed to stand and assist Resident #65 with the morning meal.</p> <p>2. Resident #7 had diagnoses which included aphasia.</p> <p>The quarterly assessment, dated 03/13/24, documented the resident was severely impaired in cognition for daily decision making and was dependent on staff for eating.</p> <p>On 05/13/24 at 12:32 p.m., CNA #2 was observed to stand and assist Resident #7 with the noon meal.</p> <p>On 05/17/24 at 10:01 a.m., CNA #1 stated they had not sat to assist Resident #65 with their meal because there was not a chair available.</p> <p>On 05/17/24 at 1:48 p.m., the DON stated staff were to sit with the residents when they assisted them with meals to maintain their dignity. The DON stated staff were not supposed to stand while assisting residents with meals.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>35474</p> <p>46703</p> <p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were safe to self-administer medication for two (#22 and #31) of two sampled residents who were reviewed for self-administering medication.</p> <p>The administrator identified 114 residents resided in the facility.</p> <p>Findings:</p> <p>An undated policy titled Bedside Storage of Medications, read in part, .A written order for the bedside storage of medication is placed in the resident's medical record .Lockable drawers or cabinets are required .</p> <p>1. Resident #22 was admitted to the facility with diagnoses which included dementia.</p> <p>On 05/13/24 at 9:43 a.m., a bottle of medicated powder was observed on the resident's night stand. The label on the medicated powder documented to keep out of reach of children.</p> <p>On 05/13/24 at 11:00 a.m., the DON stated the medicated powder was to be secured and not kept at the resident's bedside for self-administration.</p> <p>On 05/17/24 at 2:49 p.m., LPN #1 stated the resident did not have an order for medicated powder and did not know where the powder came from. LPN #1 stated when they started their shift on Monday mornings they found medications at resident bedsides.</p> <p>2. Resident #31 was admitted to the facility with diagnoses which included COPD.</p> <p>On 05/13/24 at 11:02 a.m., a Ventolin (a bronchodilator) inhaler, a tube of Diclofenac (nonsteroidal anti-inflammatory drug) cream, an Incruse inhaler (a long-acting bronchodilator), Albuterol (a bronchodilator) ampules for a nebulizer, and Fluticasone (a steroid) drops were observed on the resident's night stand.</p> <p>On 05/16/24 at 11:10 a.m., LPN #1 stated an order from the physician was required to self-administer medication and keep medications at the bedside. LPN #1 reviewed the clinical record for Resident #31 and stated the resident did not have an order to self-administer medication.</p> <p>On 05/16/24 at 12:22 p.m., the DON stated an assessment and physician order was required for residents to self-administer medications. The DON reviewed the medical record for Resident #31 and stated there was no assessment or order for self-administering medication in the resident's record.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873</p> <p>Based on record review and interview, the facility failed to ensure an accurate code status was documented for one (#67) and residents were offered the choice to formulate an advanced directive for one (#96) of two sampled residents reviewed for advanced directives.</p> <p>The administrator reported 112 residents resided in the facility.</p> <p>Findings:</p> <p>A policy titled Advance Directive Policy and Procedure, dated [DATE], read in part It is the policy of the facility to establish, implement and maintain written policies and procedures for advance directive . The resident has the right and the facility will assist the resident to formulate an advance directive at their option . The facility will inform and provide resident with a written description of the facility's policy to implement advance directives .Resident has the right to accept, request, refuse and/or discontinue medical and surgical treatment and to participate in or refuse to participate in experimental research .Resident choices will be incorporated into treatment, care and services .Upon admission, identify if the resident has an advance directive and if not, determine if the resident wishes to formulate and advance directive .Facility staff will provide the resident and/or resident representative with written description of the facility's policies to implement an advance directive .All advance directive document copies will be obtained and located in the resident chart .Resident wishes will be communicated to the staff via the care plan and to the resident physician .Nurses and other care staff are educated to initiate CPR, as recommended by the American Heart Association unless: a valid Do Not Resuscitate order in in place .</p> <p>1. Resident #67 had diagnosis which included hypertension and depression.</p> <p>An Advance Directives form, dated [DATE], documented Resident #67 was a DNR code status.</p> <p>A quarterly assessment, dated [DATE], documented Resident #67's cognition was moderately impaired.</p> <p>A care plan, dated [DATE], documented no code status care area.</p> <p>A physician's order, date [DATE], documented code status was full code.</p> <p>On [DATE] at 2:09 p.m., Resident #67's electronic medical record documented code status was full code.</p> <p>On [DATE] at 11:46 a.m., the DON reported Resident #67's code status was documented full code. The DON reported they were behind on updating residents' code status.</p> <p>On [DATE] at 3:00 p.m., the Administrator reported they would check on Resident #67's advance directive paperwork to clarify the code status. The Administrator reported no response to who followed up on the advance directives signed at admission.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:59 a.m., the electronic medical record documented Resident #67's code status was changed to DNR. The electronic medical record contained a signed DNR form, dated [DATE], uploaded on [DATE].</p> <p>2. Resident #96 had diagnoses which included fractures and hemiplegia.</p> <p>A physician's order, dated [DATE], documented Resident #96's code status was full code.</p> <p>An admission assessment, dated [DATE], documented Resident #96's cognition was severely impaired.</p> <p>On [DATE] at 12:17 p.m., admissions staff reported advance directives was not discussed with Resident #96 or the resident's representative.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was developed for three (#40, 55, and #64) of 22 sampled residents whose care plans were reviewed.</p> <p>The DON identified 114 residents who resided in the facility.</p> <p>Findings:</p> <p>1. Resident #40 had diagnoses which included dementia.</p> <p>The significant change assessment, dated 05/02/24, documented the resident was severely impaired in cognition for daily decision making and wandered one to three days during the look back period.</p> <p>On 05/13/24 at 10:04 a.m., Resident #40 was observed to wander, in their wheel chair, on the memory care unit. Resident #40 was observed to be redirected out of another resident's room by staff.</p> <p>2. Resident #55 had diagnoses which included dementia.</p> <p>The quarterly assessment, dated 04/29/24, documented the resident was severely impaired in cognition for daily decision making.</p> <p>On 05/13/24 at 10:17 a.m., Resident #40 was observed to wander, in their wheel chair, on the memory care unit.</p> <p>3. Resident #64 had diagnoses which included dementia.</p> <p>The admission assessment, dated 04/22/24, documented the resident was severely impaired in cognition for daily decision making.</p> <p>On 05/13/24 at 10:17 a.m., Resident #64 was observed to wander, in their wheel chair, on the memory care unit.</p> <p>On 05/14/24 at 1:46 p.m., Resident #64 was observed to be in another resident's bathroom.</p> <p>On 05/17/24 at 10:03 a.m., CNA #2 stated Resident #40, 55, and #64 frequently wandered.</p> <p>On 05/17/24 at 10:26 a.m., the MDS coordinator stated they did not know why, but they had not developed a care plan to address the wandering for Residents #40, 55, or #64.</p> <p>On 05/17/24 at 11:28 a.m., the ADON stated a care plan for wandering had not been developed for Resident #40, 55, or Resident #64 but should have been.</p> <p>41873</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>41809</p> <p>Based on observation, record review, and interview, the facility failed to ensure ADLs were provided according to the care plan for two (#73 and #93) of two sampled residents for ADLs.</p> <p>The ADON identified 22 residents who required assistance with bathing.</p> <p>Findings:</p> <p>1. Resident #73 had diagnoses which included diabetes type two and depression.</p> <p>An annual assessment, dated 09/24/23, documented Resident #73 required physical help of one person for bathing.</p> <p>A quarterly assessment, dated 03/12/24, documented Resident #73 bathing as not applicable, dressing required maximum assistance and for toileting Resident #73 was dependent for assistance.</p> <p>Review of the electronic clinical record and the shower sheets, dated 04/15/24 through 05/15/24, documented Resident #73 had received/four showers out of 13 opportunities.</p> <p>On 05/13/24 at 1:55 p.m., Resident #73 stated they only received one shower per week, but wanted more.</p> <p>On 05/16/24 at 3:21 p.m., CNA #4 stated showers were offered every other day, but did not know when the last shower was offered.</p> <p>On 05/16/24 at 3:26 p.m., LPN #4 stated the nurses tell the aides to complete the baths but they usually do not get completed and are left up to the next shift. They stated they monitor by rounding and observing the residents. LPN #4 stated when there is not enough staff to complete the bathing or the staff refuses they reported to the ADON and DON. They stated the heavy halls with multiple residents who require lifts need more than two CNAs.</p> <p>On 05/17/24 at 1:47 p.m., the DON stated they were aware showers were not completed three times a week. They stated they hired a shower aide over the last few weeks but they also had to work the floor. The DON stated the facility was trying to build up staff to include shower aides.</p> <p>41873</p> <p>2. Resident #93 had diagnoses which included hemiplegia and stroke.</p> <p>A care plan, dated 08/09/23, read in part, . Resident #93 has functional deficit with current ADLs related cardiovascular accident .Dependent on staff assist x 2 for bathing .</p> <p>A shower sheet, dated 04/01/24, documented I did not have time, I was the only aide for the reason resident #93's scheduled shower was not completed.</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 - Few</p>	<p>A quarterly assessment, dated 05/07/24, documented substantial/maximal assistance required for bathing. The assessment documented severely impaired cognition.</p> <p>A shower schedule, not dated, documented Resident #93 was scheduled for showers on Monday, Wednesday, and Friday.</p> <p>On 05/13/24 at 1:35 p.m., Resident #93 reported only getting 1 shower a week and prefers more often. The resident reported three showers a week were scheduled.</p> <p>On 05/15/24, Resident #93's electronic medical record and shower sheets documented 5 showers were completed in the last 30 days out of 12 opportunities.</p> <p>On 05/17/24 at 1:47 p.m., the DON stated they were aware showers were not completed three times a week. They stated they hired a shower aide over the last few weeks but they also had to work the floor. The DON stated the facility was trying to build up staff to include shower aides.</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>41809</p> <p>Based on record review and interview, the facility failed to ensure appointments were scheduled for one (#73) of one resident sampled for vision appointments.</p> <p>The ADON identified 114 residents resided at the facility.</p> <p>Findings:</p> <p>Resident #73 had diagnoses which included diabetes type two, nicotine dependence, and hypertension.</p> <p>On 02/28/23 at 4:21 p.m., a social services note, documented Resident #73 had requested an eye and dental appointment through the [name removed] clinic. The note documented social services had provided the request to the receptionist to schedule the appointment and arrange transportation.</p> <p>On 05/13/24 at 1:54 p.m., Resident #73 stated they had not seen an eye doctor since admission.</p> <p>On 05/17/24 at 9:28 a.m., the social services director stated they were responsible for ensuring appointments were arranged.</p> <p>On 05/17/24 at 9:29 a.m., the DON stated the nurse on duty enters the order in the electronic record and provides the request to the receptionist to arrange the appointments. They stated it was ultimately their responsibility to see that it as followed through.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure chemicals/medications were secure on the memory care unit for four (#40, 55, 64, and #98) of four sampled residents who were reviewed for wandering and failed to implement fall interventions for one (#96) of four sampled residents who were reviewed for falls.</p> <p>The ADON identified nine residents who wandered on the memory care unit and 26 residents who experienced falls in the past 30 days.</p> <p>Findings:</p> <p>The MSDS for Lantiseptic (a skin barrier cream), read in part, .Irritating if placed in eyes or if ingested .</p> <p>The MSDS for peri wash, read in part, .Irritating if placed in eyes or if ingested .</p> <p>A Falls Management policy, revised 01/24, read in part, .A Risk Reduction, Falls and Injuries Program will be used to assess residents/patients to determine fall risk factors. The interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence .</p> <p>1. On 05/13/24 at 9:36 a.m., a bottle of purple nail polish remover with approximately 6 ounces of liquid in it, a container of vapor rub, a 7.5 ounce bottle of peri wash, and an unlabeled medication cup filled with a white cream was observed on the dresser in room [ROOM NUMBER] on the memory care unit. The label on the bottle of nail polish remover documented to keep out of reach of children.</p> <p>On 05/13/24 at 9:43 a.m., a bottle of medicated body powder was observed on a night stand in room [ROOM NUMBER] on the memory care unit. The label documented to keep out of reach of children.</p> <p>On 05/13/24 at 9:59 a.m., three bottles of shampoo/body wash and three tubes of Lantiseptic barrier cream were observed on top of the television cabinet in room [ROOM NUMBER] on the memory care unit.</p> <p>On 05/13/24 at 10:03 a.m., CNA #3 stated Resident #40 and Resident #64 utilized wheel chairs and wandered into other residents' rooms.</p> <p>On 05/13/24 at 10:04 a.m., Resident #40 was observed to wander into another resident's room, in their wheel chair, on the memory care unit.</p> <p>On 05/13/24 at 10:07 a.m., Resident #98 was observed to wander, in their wheel chair, down the hallway of the memory care unit. Resident #98 stated they were looking for their room.</p> <p>On 05/13/24 at 10:11 a.m., Resident #64 was observed in their wheel chair wandering up and down the hall of the memory care unit.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/13/24 at 10:15 a.m., Resident #64 was observed to wheel down the hall past room [ROOM NUMBER].</p> <p>On 05/13/24 at 10:17 a.m., Resident #55, 64, and Resident #98 were observed in the hall, by the door of room [ROOM NUMBER].</p> <p>On 05/13/24 at 10:23 a.m., a bottle of Hibiclens (an antiseptic skin cleanser) was observed on a nightstand in room [ROOM NUMBER]. The label documented for external use only.</p> <p>On 05/13/24 at 10:28 a.m., Resident #98 was observed to enter room [ROOM NUMBER].</p> <p>On 05/13/24 at 10:29 a.m., a staff member entered room [ROOM NUMBER] and assisted Resident #98 to the common area on the memory care unit.</p> <p>On 05/13/24 at 10:38 a.m., Resident #64 was observed to enter room [ROOM NUMBER]. The resident who resided in room [ROOM NUMBER] stood near the door to prevent Resident #64 from entering further, assisted in moving Resident #64 to the hallway, and closed their door.</p> <p>On 05/13/24 at 10:42 a.m., CNA #3 stated they kept cleaning supplies in a locked area and they kept the residents' personal items out of sight in drawers and cabinets in their rooms.</p> <p>On 05/13/24 at 10:51 a.m., LPN #3 stated they kept chemicals and other potentially hazardous items in a secured area due to residents who wandered. LPN #3 identified residents who wandered as Resident #64, 40, 55, and Resident #98. They stated they tried to hide personal care items that could be potentially harmful if ingested/misused in the residents' rooms.</p> <p>On 05/13/24 at 10:54 a.m., the DON stated all chemicals were to be secured on the memory care unit. They stated there was a designated place behind the locked nurses station for personal hygiene items. The DON stated the staff who worked on the memory care unit were to monitor to ensure chemicals/personal hygiene items were secured. The DON stated the staff assigned to the memory care unit had provided numerous items to them when they had found them to be unsecured in the past. The DON stated they were not sure how many residents wandered on the memory care unit.</p> <p>On 05/13/24 at 10:57 a.m., room [ROOM NUMBER] was observed with the DON. The DON obtained the bottle of Hibiclens from the night stand and stated it should have been stored on the locked nurse's cart.</p> <p>On 05/13/24 at 10:58 a.m., room [ROOM NUMBER] was observed with the DON. The DON obtained three bottles of shampoo/body wash and three tubes of Lantiseptic barrier cream from the television cabinet. The DON stated, None of this should be here, apparently I need to make a sweep.</p> <p>On 05/13/24 at 11:00 a.m., room [ROOM NUMBER] was observed with the DON. The DON stated the resident's family brought items in but the staff should have secured them rather than leaving them in the room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/13/24 at 11:01 a.m., room [ROOM NUMBER] was observed with the DON. The DON obtained the nail polish remover, container of vapo rub, and the bottle of peri wash. The DON identified the white cream in the medication cup as Lantiseptic. The DON stated the items should have been secured and not left in room [ROOM NUMBER].</p> <p>On 05/13/24 at 11:02 a.m., the DON was asked how often they monitored to ensure chemicals/potentially hazardous items were not left unsecured on the memory care unit, which housed residents who wandered. The DON stated, Not often enough. That is too many rooms with things that shouldn't be there.</p> <p>On 05/13/24 at 11:07 a.m., the administrator stated staff were to keep chemicals/potentially hazardous items in the top of the residents' closets on the memory care unit. They stated potentially hazardous items should not be accessible to residents.</p> <p>On 05/13/24 at 11:31 a.m., the administrator stated they did not have a policy for the storage of chemicals. They stated they followed manufacturer's guidelines.</p> <p>41809</p> <p>2. Resident #96 had diagnoses which included hemiplegia and hemiparesis, history of stroke, and conversion disorder with seizure.</p> <p>A baseline care plan, dated 04/10/24, documented Resident #96 required assistance with ADLs. The baseline care plan did not specify the level of assistance required. The baseline care plan documented Resident #96 was at risk for falls and documented an intervention as: .staff will conduct routine visual rounding per routine care task to determine additional safety queing .</p> <p>A PT evaluation, dated 04/11/24, documented Resident #96 would safely perform functional transfers with supervision. The evaluation read in part, .Patient presents with decreased strength/coordination/proprioception [the body's ability to sense its movement, location and action] due to recent hosp [hospitalization] for subdural hematoma that is decreasing his indep[independence] with transfers and mobility altering his overall balance increasing his fall risk .</p> <p>The care plan, revised 04/26/24, documented a fall risk related to a right hip fracture on 04/15/24.</p> <p>On 05/14/24 at 9:54 a.m., Resident #96 was observed in a wheelchair next to their bed. The bed was made and the call light was on the bed next to the resident. Resident #96 stated they had been in the wheelchair since before breakfast. They stated they had fallen and broken their hip on 04/15/24 while alone in their room, trying to transfer themselves. Resident #96 stated they were supposed to wait for someone but it usually took a long time.</p> <p>On 05/17/24 at 11:27 a.m., the ADON stated they determined fall interventions after talking with the residents' family members. They stated they set the room up with a low bed and placed the call light in reach. The ADON stated the intervention of observation was not effective for Resident #96. The ADON did not provide an answer when asked how they monitored to ensure frequent observations were completed.</p> <p>41873</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #55 had diagnoses which included dementia and anxiety.</p> <p>A quarterly assessment, dated 04/29/24, documented severely impaired cognition and use of a manual wheelchair to ambulate with supervision.</p> <p>On 05/16/24 at 9:49 a.m., Resident #55 was observed in a manual wheelchair, self propelling up and down the hall ways of the locked unit, which they resided on.</p> <p>On 05/17/24 at 9:39 a.m., CNA #3 reported Resident #55 gets confused at times and tries to get into other residents beds.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>41809</p> <p>Based on record review and interview, the facility failed to ensure interventions were in place to prevent the unnecessary weight loss of three (#12, 21, #65) of four sampled residents reviewed for food/nutrition.</p> <p>The ADON identified three residents with significant weight loss.</p> <p>Findings:</p> <p>1. Resident #12 had diagnoses which included morbid obesity and malignant neoplasm of breast.</p> <p>A care plan, dated 04/03/24, documented Resident #12 had a risk for malnutrition and would maintain adequate nutritional and hydration status including stable weight, no signs or symptoms of malnutrition or dehydration through the review date. The care plan documented to develop an activity program that included exercise and mobility, and to offer activities of choice to help divert attention from food.</p> <p>On 01/13/24 at 8:27 p.m., a Nutrition/Dietary Note, read in part, Admission nutrition assessment completed. Diet is Regular with variable po intake that is fair overall. Stage 3 pressure ulcer to left heel and unstageable DTI [deep tissue injury] to right heel. Recommend Pro-Heal 30 mL [milliliters] BID [two times a day] and healthshake TID [three times a day] to assist with wound healing.</p> <p>On 02/07/24 at 12:54 p.m., a Nutrition/Dietary Note, read in part, Weight 187.3# [pounds] and stable. Diet is Regular with fair to good po intake overall. Resident accepts HS [hour of sleep] snack most evenings. Stage 3 pressure ulcer to left heel and stage 4 pressure ulcer to right heel. Nutrition interventions include healthshake TID with meals, Pro-Heal 30 mL BID, and MVI[multivitamin]. Recommend increase Pro-Heal to 60 mL BID.</p> <p>On 03/16/24 at 4:04 p.m., a Nutrition/Dietary Note, read in part, Resident with significant weight loss -5.9% x <30 days.</p> <p>Weight (lbs) [pounds]:</p> <p>184 (3/8/24)</p> <p>181 (3/5)</p> <p>192 (2/24)</p> <p>187 (2/2)</p> <p>186 (1/5) admission</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Diet is Regular with variable po intake that is fair overall. Resident does not usually accept HS snack. Stage 4 pressure ulcer right heel with improvement noted per wound doctor. Nutrition interventions include Pro-Heal 60 mL BID, healthshake with meals, and MVI. BMI [body mass index] 28.8 (overweight). Resident with weight increase in February; weight now appears to be stabilizing back to baseline. No nutrition changes needed at this time.</p> <p>On 04/06/24 at 5:17 p.m., a Nutrition/Dietary Note Dietitian, read in part, Quarterly nutrition assessment completed. Resident with significant weight loss over 30 days. PO [by mouth] intake recently declined and she requires more assistance with eating as well. Stage 4 pressure ulcer to right heel. Nutrition interventions include healthshake with meals and Pro-Heal liquid protein 60 mL BID. Meds include Bumex [a loop diuretic] which may impact fluid/weight changes. Noted renal labs correlation with hypovolemia [a condition in which the liquid portion of the blood (plasma) is too low] and order for NS [normal saline] IVF[intravenous fluids] for replacement. Resident with recent jaw pain with left parotid [a salivary gland, located in front of and below the ears] gland swelling. Diet downgraded to mechanical soft on 4/4/24 per SLP [speech language pathologist]. Expect soft diet texture to aid in mastication [chewing] and overall intake. No additional nutrition recommendations at this time. RD [registered dietician] to continue to follow.</p> <p>On 05/14/24 at 11:04 a.m., the representative for Resident #12 stated the facility was supposed to do a test for chewing and swallowing a couple of weeks ago and the representative had not heard back. The representative stated Resident #12 had lost weight and the facility had not informed them of how much weight was lost.</p> <p>On 05/17/24 at 10:35 a.m., LPN #1 stated the nurses enter the weights in the electronic medical record, if a gain they call the doctor, if a loss they tell the ADON so they can email the dietician. LPN #1 stated they had learned today Resident #12 had not been eating.</p> <p>On 05/17/24 at 10:40 a.m., the ADON stated the DON and the dietician monitored the weights. They stated after the weights were entered into the electronic medical record the DON printed a weight report.</p> <p>On 05/17/24 at 10:44 a.m., the DON stated they monitored the weights monthly for weight loss and gain. They stated they discussed the weights with the dietician and entered in nutritional recommendations. The DON stated the physician was notified of all weight loss, but it was not documented because they had not documented.</p> <p>On 05/17/24 at 11:14 a.m., the DON stated they tried to work the dietician's recommendations within five days. They stated weight meetings had not been taking place, but weights were discussed in the morning clinical meeting. The DON stated they identified significant weight loss when they printed out the weight report. The DON stated no recommendation was made in April even though weight loss was continued because the dietician did not give a recommendation.</p> <p>41873</p> <p>2. Resident #21 had diagnoses which included hypertension, edema, and coronary artery disease.</p> <p>A physician's visit note, dated 04/25/24, documented an order for a healthshake three times a day.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An admission assessment, dated 04/27/24, documented Resident #21's cognition was severely impaired.</p> <p>A nutrition/dietary note, dated 4/29/24, read in part, .Admission nutrition assessment completed .Diet is regular with fair by mouth intake .Weight 138.6 pounds with a BMI 19.9, consistent with low BMI in elderly . Recommend healthshake daily.</p> <p>On 05/17/24 at 9:02 a.m., Resident #21 was observed eating scrambled eggs, a cinnamon roll, and oatmeal. The resident ate 76% -100% of the meal and had no difficulty feeding self.</p> <p>On 05/17/24 at 11:14 a.m., the DON stated they monitored resident weights once a month. The DON stated they follow up with the registered dietitian when a resident identified with a significant weight loss.</p> <p>On 05/17/24 at 2:32 p.m., RN reported weight loss or weight gain for five pounds or more should be reported to the physician. The RN reported Resident #21's documented weight on 05/12/24 of 127.4 pounds and 05/05/24 of 134.6 pounds was a seven pound weight loss and should have been reported to the resident's physician. The RN reported they had failed to report the weight loss.</p> <p>3. Resident #65 had diagnoses which included Alzheimer's disease, bipolar, and major depressive disorder.</p> <p>The electronic clinical record documented Resident #65 weighed 109.8 pounds on 01/05/24.</p> <p>A nutrition dietary note, dated 05/01/24, read in part, .resident with significant weight loss over 90 days and also significant weight loss over the last week .resident meets criteria for severe protein calorie malnutrition . significant weight loss >7.5 % x 3 months .recommend increase health shake to TID with meals .recommend start med pass 2.0 - 120 mL BID .recommend appetite stimulant .</p> <p>The electronic clinical record documented a weight of 98.6 pounds on 05/03/24 for Resident #65.</p> <p>On 05/17/24 at 11:14 a.m., the DON stated they monitored resident weights once a month. The DON stated they follow up with the registered dietitian when a resident identified with a significant weight loss. The DON stated it was their responsibility to follow up on recommendations made by the registered dietitian within five days.</p> <p>On 05/17/24 at 11:35 a.m., the DON stated the recommendation for an appetite stimulant for Resident #65 had not been addressed.</p> <p>46703</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of weight loss for two (#12 and #21) of four sampled residents who were reviewed for weight loss.</p> <p>The ADON identified three residents who had significant weight loss.</p> <p>Findings:</p> <p>Resident #12 had diagnoses which included morbid obesity and malignant neoplasm of breast.</p> <p>A care plan, revised 04/03/24, documented Resident #12 had a risk for malnutrition and would maintain adequate nutritional and hydration status including stable weight, no signs or symptoms of malnutrition or dehydration through the review date. The care plan documented to develop an activity program that included exercise and mobility, and to offer activities of choice to help divert attention from food.</p> <p>On 01/13/24 at 8:27 p.m., a Nutrition/Dietary Note, read in part, Admission nutrition assessment completed. Diet is Regular with variable po intake that is fair overall. Stage 3 pressure ulcer to left heel and unstageable DTI [deep tissue injury] to right heel. Recommend Pro-Heal 30 mL [milliliters] BID [two times a day] and healthshake TID [three times a day] to assist with wound healing.</p> <p>On 02/07/24 at 12:54 p.m., a Nutrition/Dietary Note, read in part, Weight 187.3# [pounds] and stable. Diet is Regular with fair to good po intake overall. Resident accepts HS [hour of sleep] snack most evenings. Stage 3 pressure ulcer to left heel and stage 4 pressure ulcer to right heel. Nutrition interventions include healthshake TID with meals, Pro-Heal 30 mL BID, and MVI[multivitamin]. Recommend increase Pro-Heal to 60 mL BID.</p> <p>On 03/16/24 at 4:04 p.m., a Nutrition/Dietary Note, read in part, Resident with significant weight loss -5.9% x <30 days.</p> <p>Weight (lbs)[pounds]:</p> <p>184 (3/8/24)</p> <p>181 (3/5)</p> <p>192 (2/24)</p> <p>187 (2/2)</p> <p>186 (1/5) admission</p> <p>(continued on next page)</p>

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Diet is Regular with variable po intake that is fair overall. Resident does not usually accept HS snack. Stage 4 pressure ulcer right heel with improvement noted per wound doctor. Nutrition interventions include Pro-Heal 60 mL BID, healthshake with meals, and MVI. BMI [body mass index] 28.8 (overweight). Resident with weight increase in February; weight now appears to be stabilizing back to baseline. No nutrition changes needed at this time.</p> <p>On 04/06/24 at 5:17 p.m., a Nutrition/Dietary Note Dietitian, read in part, Quarterly nutrition assessment completed. Resident with significant weight loss over 30 days. PO [by mouth] intake recently declined and she requires more assistance with eating as well. Stage 4 pressure ulcer to right heel. Nutrition interventions include healthshake with meals and Pro-Heal liquid protein 60 mL BID. Meds include Bumex [a loop diuretic] which may impact fluid/weight changes. Noted renal labs correlation with hypovolemia[a condition in which the liquid portion of the blood (plasma) is too low] and order for NS [normal saline] IVF [intravenous fluids] for replacement. Resident with recent jaw pain with left parotid[a salivary gland, located in front of and below the ears] gland swelling. Diet downgraded to mechanical soft on 4/4/24 per SLP[speech language pathologist]. Expect soft diet texture to aid in mastication [chewing] and overall intake. No additional nutrition recommendations at this time. RD [registered dietitian] to continue to follow.</p> <p>On 05/14/24 at 11:04 a.m., the representative for Resident #12 stated the facility was supposed to do a test for chewing and swallowing a couple of weeks ago and the representative had not heard back. The representative stated Resident #12 had lost weight and the facility had not informed them of how much weight was lost.</p> <p>On 05/17/24 at 10:35 a.m., [NAME], LPN #1 stated the nurses enter the weights in the electronic medical record, if a gain they call the doctor, if a loss they tell the ADON so they can email the dietician. LPN #1 stated they had learned today Resident #12 had not been eating.</p> <p>On 05/17/24 at 10:40 a.m., the ADON stated the DON and the dietician monitored the weights. They stated after the weights were entered into the electronic medical record the DON printed a weight report.</p> <p>On 05/17/24 at 10:44 a.m., the DON stated they monitored the weights monthly for weight loss and gain. They stated they discussed the weights with the dietician and entered in nutritional recommendations. The DON stated the physician was notified of all weight loss, but it was not documented because they had not documented.</p> <p>41873</p> <p>2. Resident #21 had diagnoses which included hypertension, edema, and coronary artery disease.</p> <p>A physician's visit note, dated 04/25/24, documented an order for a healthshake three times a day.</p> <p>An admission assessment, dated 04/27/24, documented Resident #21's cognition was severely impaired.</p> <p>A nutrition/dietary note, dated 4/29/24, read in part, .Admission nutrition assessment completed .Diet is regular with fair by mouth intake .Weight 138.6 pounds with a BMI 19.9, consistent with low BMI in elderly . Recommend healthshake daily.</p> <p>(continued on next page)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/17/24 at 9:02 a.m., Resident #21 was observed eating scrambled eggs, a cinnamon roll, and oatmeal. The resident ate 76% -100% of the meal and had no difficulty feeding self.</p> <p>On 05/17/24 at 11:14 a.m., the DON stated they monitored resident weights once a month. The DON stated they follow up with the registered dietitian when a resident identified with a significant weight loss.</p> <p>On 05/17/24 at 2:32 p.m., RN reported weight loss or weight gain for five pounds or more should be reported to the physician. The RN reported Resident #21's documented weight on 05/12/24 of 127.4 pounds and 05/05/24 of 134.6 pounds was a seven pound weight loss and should have been reported to the resident's physician. The RN reported they had failed to report the weight loss.</p> <p>46703</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>41809</p> <p>Based on record review and interview, the facility failed to ensure adequate staffing to ensure bathing was completed according to resident preferences for two (#73 and #93) of five sampled residents who were reviewed for ADL care.</p> <p>The ADON identified 22 residents who required assistance with bathing.</p> <p>Findings:</p> <p>1. Resident #73 had diagnoses which included diabetes type two and depression.</p> <p>A quarterly assessment, dated 03/12/24, documented Resident #73 required substantial/maximal assistance of staff for most ADLs and bathing was documented as not applicable.</p> <p>Review of the electronic clinical record and the shower sheets, dated 04/15/24 through 05/15/24, documented Resident #73 had received/was offered four showers out of 13 opportunities.</p> <p>On 05/13/24 at 1:55 p.m., Resident #73 stated they only received one shower per week but wanted more.</p> <p>2. Resident #93 had diagnoses which included hemiplegia and stroke.</p> <p>A shower sheet, dated 04/01/24, documented I did not have time, I was the only aide for the reason Resident #93's scheduled shower was not completed.</p> <p>A quarterly assessment, dated 05/07/24, documented substantial/maximal assistance was required for bathing.</p> <p>On 05/13/24 at 1:35 p.m., Resident #93 reported only getting one shower a week but preferred more.</p> <p>On 05/15/24, Resident #93's electronic medical record and shower sheets documented 5 showers were completed in the last 30 days out of 12 opportunities.</p> <p>On 05/16/24 at 3:26 p.m., LPN #4 stated the nurses tell the aides to complete the baths but they usually did not get completed and were left for the next shift. LPN #4 stated when there was not enough staff to complete the bathing or the staff refused they reported to the ADON and DON. They stated the heavy halls with multiple residents who required lifts needed more than two CNAs.</p> <p>On 05/17/24 at 12:34 p.m., the administrator stated they and the ADON were responsible for staffing.</p> <p>On 05/17/24 at 1:47 p.m., the DON stated they were aware showers were not completed three times a week. They stated they hired a shower aide over the last few weeks but they also had to work the floor. The DON stated the facility was trying to build up staff to include shower aides.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/17/24 at 2:20 p.m., the ADON stated they determined the staffing levels needed by utilizing the state minimum requirements. They stated they also staffed according to acuity and adjustments were made everyday depending on the needs of each hall. The ADON stated they utilized the PRN (as needed) pool for unanticipated staffing shortages. They stated they had not had any concerns for staffing brought to their attention.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>35474</p> <p>Based on record review and interview, the facility failed to ensure adequate monitoring of side effects for residents who received antipsychotic medications for two (#4 and #64) of five sampled residents who were reviewed for unnecessary medications.</p> <p>The ADON identified 20 residents who received an antipsychotic medication.</p> <p>Findings:</p> <p>1. Resident #64 had diagnoses which included dementia.</p> <p>A physician's order, dated 04/15/24, documented Resident #64 was ordered Olanzapine (an antipsychotic medication) 2.5 mg twice daily.</p> <p>Review of the electronic clinical record not reveal monitoring for side effects related to the use of antipsychotic medication.</p> <p>On 05/17/24 at 11:09 a.m., the DON stated they previously documented side effect monitoring on the MAR/TAR but they removed it because it was the standard of practice to monitor for side effects of medications. They stated they documented in the progress notes if a resident experienced any side effect from any medication. The DON stated they assessed for tardive dyskinesia by conducting an AIMS assessment every 90 days. They stated the charge nurses were responsible to complete the AIMS assessments. AIMS assessments for Resident #64 was requested from the DON.</p> <p>On 05/17/24 at 1:50 p.m., the DON stated the AIMS assessments had not been scheduled or completed for Resident #64. They stated they were supposed to follow regulatory guidelines for monitoring side effects of psychotropic medications but had failed to do so.</p> <p>41809</p> <p>41873</p> <p>2. Resident #4 had diagnoses which included major depressive disorder, delusional disorder, and anxiety disorder.</p> <p>Resident #4's current physician orders documented hydroxyzine 10 mg give 1 tablet by mouth three times a day related to anxiety disorder, start date 02/05/24.</p> <p>A monthly medication review, dated 03/13/24, documented pharmacist recommendation for a gradual dose reduction attempt for hydroxyzine 10 mg three times a day for anxiety. The monthly medication review documented resident #4's physician agreed on 03/28/24 to decrease hydroxyzine to twice a day.</p> <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A quarterly assessment, dated 05/08/24, documented cognition was intact and routine use of antipsychotic meds.</p> <p>On 05/17/24 at 12:17 p.m., the DON reported being responsible following up on medication changes approved by the physician on medication regimen review. The DON reported this gradual dose reduction approved by the physician for resident #4 had been missed and the order was not changed.</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>46703</p> <p>Based on record review and interview, the facility failed to ensure dental needs were provided for two (#6 and #73) of two sampled residents who were reviewed for dental needs.</p> <p>The administrator identified 114 residents resided in the facility.</p> <p>Findings:</p> <p>1. Resident #66 had diagnoses which included hemiplegia, seizures, and anxiety.</p> <p>A progress note from the dentist, dated 03/07/23, documented the resident should be seen by an oral surgeon to extract a cracked tooth.</p> <p>On 05/14/24 at 10:56 a.m., Resident #66 stated they had a cracked tooth on their right lower jaw which caused pain while eating.</p> <p>On 05/17/24 at 9:28 a.m., the social services director stated they had not seen a dental referral for Resident #66 to see an oral surgeon. They stated they did not know if the appointment had been made since they were recently employed by the facility.</p> <p>On 05/17/24 at 9:30 a.m., the DON stated the charge nurse should give the information for a referral to the receptionist, who would then make the appointment and transportation arrangements. The DON stated ultimately it was their responsibility to ensure appointments were made.</p> <p>On 05/17/24 at 10:40 a.m., the administrator stated they had hired a new receptionist and gave the nurses an in-service regarding giving all referrals to the receptionist. The administrator stated Resident #66 was missed.</p> <p>2. Resident #73 had diagnoses which included depression.</p> <p>A note by social services, dated 02/28/23, documented the resident requested an appointment with the dental clinic.</p> <p>On 05/16/24 at 3:01 p.m., Resident #73 stated they needed to see a dentist because they had their natural lower teeth but no top teeth, which caused difficulty when eating.</p> <p>On 05/16/24 at 3:24 p.m., LPN #2 reviewed the medical record for Resident #73 and stated the request for a dental appointment had not been addressed.</p> <p>On 05/16/24 at 3:35 p.m., the receptionist stated they make the appointments and transportation arrangements for the residents. After reviewing the appointment and transportation records, they stated there was no documentation Resident #73 had a dental appointment scheduled.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>41809</p> <p>Based on observation, record review, and interview, the facility failed to ensure food was provided in a palatable and attractive manner.</p> <p>The ADON identified 112 residents who ate food from the kitchen.</p> <p>Findings:</p> <p>On 05/13/24 at 1:42 p.m., Resident #73 stated the food was cold.</p> <p>On 05/14/24 at 2:00 p.m., Resident #96 stated the food was delivered cold to their room.</p> <p>On 05/17/24 at 8:31 a.m., CNA #5 delivered styrofoam drinks to burgandy hall, uncovered, and placed on drink cart. The drinks were milk.</p> <p>On 05/17/24 at 9:09 a.m., a meal cart arrived on burgandy hall.</p> <p>On 05/17/24 at 9:10 a.m., staff began to pass meal trays on burgandy hall.</p> <p>On 05/17/24 at 9:11 a.m., meals were observed to be served on styrofoam plates with plastic covers and no heated bottoms. The milk on drink cart was observed to be uncovered and not on ice. Staff delivered the milk with the food to residents.</p> <p>On 05/17/24 at 9:14 a.m., the meal cart was observed to be left open during meal pass. The staff were not observed to sanitize hands between passing trays.</p> <p>On 05/17/24 at 9:17 a.m., a cleaning cart was observed to pass by the uncovered drinks on the drink cart.</p> <p>On 05/17/24 at 9:30 a.m., a surveyor received the last hall tray on burgandy hall. Breakfast was served on a styrofoam plate with no heated bottom. The milk was out for 1 hour uncovered, temperature was 51.2 degrees Fahrenheit. The scrambled eggs were scorched and cold. The oatmeal was room temperature. The cinnamon roll was room temperature.</p> <p>On 05/17/24 at 9:46 a.m., CNA #6 stated they typically do not receive the milk until they received the meal cart. They stated the drinks were received uncovered and they did not know where the lids were kept.</p> <p>41873</p> <p>On 05/13/24 at 11:17 a.m., resident #34 reported the food is cold. The resident reported the food is horrible, the scrambled eggs are full of water, and there is no sugar for the tea right now.</p> <p>On 05/13/24 at 2:08 p.m., resident #67 reported food is not good. The resident pointed at her plate and reported I did not eat much of my food because it was not good.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure pureed food was prepared to meet the needs of the resident for one (the noon meal) of one meal observed during meal preparation.</p> <p>The ADON identified five residents who received a puree diet.</p> <p>Findings:</p> <p>The Therapeutic Diet Orders policy, dated January 2024, read in part, .To assure that residents receive and consume foods in the appropriate form .</p> <p>On 05/14/24 at 11:52 a.m., dietary aide #3 was observed to puree the noon meal. The taco meat was observed to be grainy and have pieces of meat which remained after it was pureed. The flour tortillas were observed to be lumpy and have chewable pieces of tortilla which remained after it was pureed. The pureed taco meat and the pureed tortillas were not a smooth consistency and were placed on the steam table for serving.</p> <p>On 05/14/24 at 12:19 p.m., dietary aide #1 plated a pureed diet for Resident #22 and placed it on the hall cart.</p> <p>On 05/14/24 at 12:23 p.m., dietary aide #5 began wheeling the meal cart out of the kitchen for service. Dietary aide #1 and the dietary manager stated the pureed meal was ready to be served to the resident. The dietary manager was informed of the observation of the taco meat and the flour tortillas not being smooth and stated they would reprocess the pureed foods.</p> <p>On 05/14/24 at 12:25 p.m., dietary aide #3 stated they processed foods for pureed diets until they appeared smooth.</p> <p>On 05/14/24 at 12:29 p.m., the dietary manager stated they tasted pureed foods to ensure they were a smooth consistency.</p> <p>On 05/17/24 at 12:34 p.m., the administrator stated they had provided the dietary department an educational power point about diet textures and had been monitoring the pureed foods prepared by the dietary staff.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to:</p> <ul style="list-style-type: none"> a. ensure scoops were not stored inside the bins of flour and corn starch for two of two bins observed; b. ensure foods stored in the refrigerator were labeled and dated for one of one walk in refrigerators observed; c. ensure the dish machine reached minimum specifications for sanitation for one of one dish machines observed; d. ensure the ice machine was maintained in a sanitary manner for one of two ice machines observed; e. ensure the proper use of hair restraints, including facial hair; f. ensure infection control was maintained when plating meals for one (the noon meal) of one meal service observed; and g. ensure kitchen equipment, surfaces, and floors were maintained in a sanitary manner. <p>The ADON identified 111 residents who received meals from the kitchen.</p> <p>Findings:</p> <p>The Food Preparation Guidelines policy, dated November 2017, read in part, .Food should be protected from contamination while being stored .</p> <p>The Ice Machine and Ice Storage Chests policy, dated January 2024, read in parts, .Ice machines .will be used and maintained to assure a safe and sanitary supply of ice .Our facility has established procedures for cleaning and disinfecting ice machines .which adhere to the manufacturer's instructions .</p> <p>The undated, Food Safety Requirements policy, read in part, .Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes .</p> <p>1. The Nutrition Services Visit, dated 03/02/24, read in part, .Areas for Corrective Action .Scoops inside flour bags .</p> <p>The Nutrition Services Visit, dated 04/02/24, read in part, .Areas for Corrective Action .Scoop stored in the flour bin .</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Nutrition Services Visit, dated 05/01/24, read in part, .Areas for Corrective Action/Recommendations . Flour and sugar scoops need to be placed in sealed bags when not in use .</p> <p>On 05/13/24 at 8:32 a.m., a large container with a bag of flour and a large container with a bag of corn starch was observed in the dry storage room. Scoops were observed inside the bag of flour and corn starch.</p> <p>On 05/14/24 at 12:30 p.m., scoops were observed inside the bag of flour and bag of corn starch inside the bins in the dry storage room.</p> <p>On 05/14/24 at 2:23 p.m., dietary aide #1 stated scoops were to be stored in zip top bags on top of the bins of flour and corn starch.</p> <p>On 05/14/24 at 2:33 p.m., the dietary manager stated they stored the scoops inside the flour and corn starch bins but should not store them in the bags.</p> <p>2. On 05/13/24 at 8:29 a.m., the walk in refrigerator was observed to contain an undated sheet pan of corn bread; three undated, uncovered, trays of dessert with whipped topping; two undated, uncovered pans of red gelatin; and an undated, unlabeled, zip top bag with five pieces of fish in a liquid.</p> <p>On 05/13/24 at 8:38 a.m., the dietary manager stated the items in the walk in refrigerator should be covered and dated. The dietary manager stated staff must have made the red gelatin last night, the dessert with whipped topping was from the weekend, and the cornbread was from Saturday. The dietary manager stated they had a problem with staff not covering or dating food items.</p> <p>3. The Dish Machine Temperature Log, dated March 2024, documented out of 93 opportunities to monitor the wash temperature, there were nine blanks and 76 times the documented temperature was less than 120 degrees F. The log documented out of 93 opportunities to monitor the rinse temperature, there were nine blanks and two times the documented temperature was less than 120 degrees F.</p> <p>The Dish Machine Temperature Log, dated April 2024, documented out of 90 opportunities to monitor the wash temperature, there were 16 blanks and 59 times the documented temperature was less than 120 degrees F. The log documented out of 90 opportunities to monitor the rinse temperature, there were 16 blanks.</p> <p>The Dish Machine Temperature Log, dated 05/01/24 through 05/13/24 at breakfast time, documented out of 37 opportunities to monitor the wash temperature, there were 32 times the documented temperature was less than 120 degrees F. The log documented out of 37 opportunities to monitor the rinse temperature there were three times the rinse temperature was less than 120 degrees F.</p> <p>On 05/13/24 at 8:44 a.m., the dish machine was observed with the dietary manager. The specifications on the label of the dish machine documented the minimum wash and rinse temperature was 120 degrees F. The dietary manager ran the dish machine. The wash temperature was observed to reach 100 degrees F and the rinse temperature was observed to reach 120 degrees F. The dietary manager stated they had recently had the dish machine serviced but was unaware the dish machine had not reached the minimum temperature.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 05/13/24 at 11:15 a.m., the maintenance supervisor stated they monitored the dish machine every Friday but would need to call the company for a service visit.</p> <p>4. On 05/13/24 at 8:57 a.m., the ice machine was observed with the maintenance supervisor. The deflector panel was observed to contain a red, orange, and brown substance when wiped with a white napkin. The maintenance supervisor stated the maintenance department was responsible to clean the ice machine and it was last cleaned in April 2024.</p> <p>5. The Nutrition Services Visit, dated 04/02/24, read in parts, .Areas for Corrective Action .All food service employees are wearing hats that do not completely restrain hair .</p> <p>On 05/13/24 at 8:29 a.m., dietary aide #1 and the dietary manager were observed in the kitchen preparing/serving the morning meal without facial hair restraints.</p> <p>On 05/14/24 at 11:55 a.m., the dietary manager and dietary aide #1 were observed to prepare the noon meal without facial hair restraints. Dietary aide #5 was observed with approximately four inches of hair hanging out of the back of their hair restraint. Dietary aide #4 was observed with approximately three inches of hair hanging out of the back of a stocking cap.</p> <p>On 05/14/24 at 12:04 p.m., dietary aide #1, dietary aide #4, and dietary aide #5 were observed to plate the noon meal without facial hair restraints.</p> <p>On 05/14/24 at 2:23 p.m., dietary aide #1 stated they always wore hair restraints. They stated they were not required to wear facial hair restraints if their beard was short. Dietary aide #1 stated their facial hair was long enough they should have worn a facial hair restraint.</p> <p>On 05/14/24 at 2:33 p.m., the dietary manager stated the dietary staff utilize hair restraints but did not know why the dietary staff had not covered their facial hair.</p> <p>On 05/17/24 at 12:34 p.m., the administrator stated the dietary staff were supposed to wear hair nets correctly and cover their facial hair as well.</p> <p>6. On 05/14/24 at 12:07 p.m., dietary aide #1 was observed to don gloves and touch plates, ladle handles, the counter top, styrofoam containers, tortillas, and chips with the same gloved hands throughout the noon meal service.</p> <p>On 05/14/24 at 12:09 p.m., dietary aide #4 was observed to don gloves and touch plates, the counter, ladle handles, tortillas, chips and shredded cheese with the same gloved hands throughout the noon meal service.</p> <p>On 05/14/24 at 12:14 p.m., the dietary manager was observed to don gloves and touch plates, ladle handles, a cloth towel, a package of tortillas, and chips with the same gloved hands throughout the noon meal service.</p> <p>On 05/14/24 at 12:15 p.m., dietary aide #3 was observed to don gloves and touch the counter top, ladle handles, tortillas, shredded cheese, shredded lettuce, and diced tomatoes with the same gloved hands throughout the noon meal service.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 05/14/24 at 12:35 p.m., dietary aide #6 was observed to don gloves and touch the fryer basket handles, plates, counter top, and oven doors then obtain cooked french fries from the fryer basket and obtained two slices of bread from a loaf with the same gloved hands.</p> <p>On 05/14/24 at 2:23 p.m., dietary aide #1 stated they did not know how they maintained infection control with meal service when they touched multiple items/surfaces then food with the same gloved hands. They stated they were supposed to use tongs.</p> <p>On 05/14/24 at 2:33 p.m., the dietary manager stated they should use utensils to maintain infection control during meal service.</p> <p>7. The Nutrition Services Visit, dated 03/02/24, read in parts, .The stainless steel counter and ice dispenser need to be cleaned .The drain and wall behind the drain for the dishwasher is starting to grow mold .</p> <p>The Nutrition Services Visit, dated 04/02/24, read in parts, .The stainless steel counter and ice dispenser need to be cleaned .The drain under the dish machine counter is heavily soiled and starting to grow mold . Action Plan .Recommend deep clean of drain under dish machine .</p> <p>On 05/13/24 at 8:32 a.m., the warmer oven, stove, stand mixer, under the dishwasher, under the serving counter, plate warmer, and deep fryer were observed to have a build up of a dark substance on the surfaces of the equipment. The floor in the kitchen was observed to have a sticky build up.</p> <p>On 05/14/24 at 12:43 p.m., the warmer oven, stove, stand mixer, under the dishwasher, the wall behind the dishwasher, under the serving counter, plate warmer, and deep fryer were observed to have a build up of a dark substance on the surfaces of the equipment. The floor in the kitchen was observed to have a sticky build up.</p> <p>On 05/14/24 at 2:23 p.m., dietary aide #1 was asked what the cleaning schedule was for the kitchen. They stated they did not have a schedule. Dietary aide #1 stated they usually just cleaned what they could.</p> <p>On 05/14/24 at 2:33 p.m., the dietary manager stated they had a cleaning list but the weekend shift had not completed the cleaning.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure garbage cans were available at the handwashing sink and garbage cans had lids in the kitchen.</p> <p>The ADON identified 111 residents who received meals from the kitchen.</p> <p>Findings:</p> <p>The Disposal of Garbage and Refuse policy, dated January 2024, read in part, .Garbage should be disposed of in refuse containers, which have plastic liners and lids .</p> <p>The Nutrition Services Visit, dated 03/02/24, read in parts, .Areas for Corrective Action .No lids on large trash cans .Action Plan .Keep lids on all trash cans .</p> <p>The Nutrition Services Visit, dated 04/02/24, read in parts, .Areas for Corrective Action .No lids on large trash cans .Action Plan .Keep lids on all trash cans .</p> <p>On 05/13/24 at 8:29 a.m., a garbage can was not observed to be at the handwashing sink. Three large barrel-type garbage cans, without lids, were observed across from the handwashing sink near the stove, at the service line, and in the food preparation area.</p> <p>On 05/14/24 at 11:50 a.m., a garbage can was not observed to be at the handwashing sink. Three large barrel-type garbage cans, without lids, were observed across from the handwashing sink near the stove, at the service line, and in the food preparation area.</p> <p>On 05/15/24 at 9:37 a.m., the dietary manager stated they utilized the large barrel-type garbage cans but they did not have lids. The dietary manager stated they needed to order a small garbage can for the handwashing sink and lids for the large garbage cans.</p> <p>On 05/17/24 at 12:34 p.m., the administrator stated the dietary department had lids for the garbage cans and the dietary staff had been told to utilize them.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474</p> <p>Based on observation, record review, and interview, the facility failed to ensure an effective pest control program in resident rooms, the dining room, and the kitchen.</p> <p>The DON identified 114 residents who resided in the facility.</p> <p>Findings:</p> <p>The Pest Control Program policy, dated January 2024, read in part, .Facility will maintain an effective pest control program that eradicates and contains common household pests .</p> <p>The Maintenance Request Log, dated 03/06/24, documented Resident #7 complained there had been a roach in their bed and pest control was contacted.</p> <p>The Maintenance Request Log, dated 03/10/24, documented roaches were observed in room [ROOM NUMBER] and pest control was contacted.</p> <p>The Maintenance Request Log, dated 03/30/24, documented ants in room [ROOM NUMBER]. The response was documented as done.</p> <p>The Maintenance Request Log, dated 03/31/24, documented ants in room [ROOM NUMBER]. The response was documented as done.</p> <p>The Maintenance Request Log, dated 03/31/24, documented ants in room [ROOM NUMBER] and pest control was contacted.</p> <p>The Maintenance Request Log, dated 04/04/24, documented roaches in room [ROOM NUMBER].</p> <p>The Maintenance Request Log, dated 04/19/24, documented roaches in bathroom of room [ROOM NUMBER].</p> <p>The Maintenance Request Log, dated 04/24/24, documented roaches were seen in the serving window in the dining room. The response was documented as done.</p> <p>The Maintenance Request Log, dated 05/06/24, documented ants in room [ROOM NUMBER] and pest control was contacted.</p> <p>The Maintenance Request Log, dated 05/08/24, documented ants in room [ROOM NUMBER] and room [ROOM NUMBER] and pest control was contacted.</p> <p>The Maintenance Request Log, dated 05/11/24, documented ants in room [ROOM NUMBER] and pest control was contacted.</p> <p>The Maintenance Request Log, dated 05/13/24, documented ants in room [ROOM NUMBER] and pest control was contacted.</p> <p>(continued on next page)</p>		

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 05/17/2024
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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/13/24 at 9:54 a.m., Resident #357 stated there were pests in the kitchen and they had seen pests running across the tables in the dining room.</p> <p>On 05/13/24 at 10:23 a.m., ants were observed on the window sill and on the bedside table in room [ROOM NUMBER].</p> <p>On 05/13/24 at 1:59 p.m., Resident #26 and a family member stated they had observed small roaches in the facility.</p> <p>On 05/14/24 10:06 a.m., Resident #26 stated they had seen pests in the dining room.</p> <p>On 05/14/24 at 12:39 p.m., a roach was observed crawling on the floor and went under the stove in the kitchen.</p> <p>On 05/14/24 at 2:23 p.m., dietary aide #1 stated they had observed roaches in the kitchen. They stated pest control had sprayed but they had still seen them fall from the air vents in the past.</p> <p>On 05/14/24 at 2:33 p.m., the dietary manager stated they had talked with the maintenance supervisor about the roaches in the kitchen. They stated they needed to take everything out of the kitchen and exterminate after they deep cleaned.</p> <p>On 05/17/24 at 12:20 p.m., the maintenance supervisor stated the food vendor was bringing the roaches into the facility in the cardboard boxes. They stated they had a plan in place to treat the kitchen and had seen fewer pests since changing pest control companies. They stated the pest control company had a policy against treating pests in the resident rooms. They stated they have had roaches in the kitchen off and on since November 2023. They thought it had gotten better until they observed a roach last week. The maintenance supervisor stated the dietary staff were not completing their nightly cleaning.</p> <p>On 05/17/24 at 12:34 p.m., the administrator stated they utilize a pest control company monthly and as needed. They stated they needed to keep things cleaner in the kitchen to assist in ridding the facility of pests.</p> <p>41873</p>		