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	12/18/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an advance directive acknowledgment form had been completed for 2 (#2 and #11) of 23 sampled residents reviewed for advance directives. The administrator identified 112 residents resided in the facility. Findings:A policy titled Advance directive policy and procedure, dated 01/2024, read in part, Upon admission, identify if the resident has an advanced directive and if not, determine if the resident wishes to formulate an advanced directive.All advanced directive document copies will be obtained and located in the resident chart.1.A physician's order, dated 12/09/24, showed Resident #2 was a full code. An order summary report, dated 12/16/25, showed Resident #2 admitted to the facility on [DATE]. There was no advanced directive acknowledgment form located in the medical record. 2.A physician's order, dated 09/08/25, showed Resident #11 was a full code.An order summary report, dated 12/16/25, showed Resident #11 admitted to the facility on [DATE]. There was no advanced directive acknowledgement located in the medical record. On 12/16/2025 at 1:42 p.m., the admission director stated they did not have the acknowledgements because they were waiting for the families to provide.

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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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a fall with major injury was reported to the OSDH for 1 (#97) of 3 sampled residents reviewed for falls.The administrator identified 112 residents resided in the facility. Findings:A document titled Long Term Care Reportable Incidents - Regulatory Requirements, dated 06/28/22, read in part, All reports to the Department shall be made within twenty-four (24) hours of the reportable incident unless otherwise noted .The facility shall report to the Department incidents that result in: fractures, injury requiring treatment at a hospital, a physician's diagnosis of closed head injury or concussion, or head injuries that require more than first aid.A November 2025 medication administration record showed Resident #97 was taking Warfarin Sodium 4mg (a blood thinner) every Monday, Wednesday, Thursday, Friday, Saturday, and Sunday. Resident #97 was taking Warfarin Sodium 2mg every Tuesday.A Nurse's Note, dated 12/01/25, read in part, Head to toe assessment completed and found bleeding from frontal area of forehead and on the left side of [their] skull. The nurse's note showed Resident #97 was sent to the emergency room via ambulance for a fall.A Neurosurgery Consult Progress Note, dated 12/02/25, read in part, [Resident #97] with atrial fibrillation on Warfarin who was reported to have a ground level fall at [their] facility today. The progress note showed Resident #97 had diagnoses of a T12 (thoracic 12th vertebrae) fracture and bilateral subdural hematomas.A MDS [minimum data set], dated 12/05/25, showed Resident #97 was admitted to the facility on [DATE] with diagnoses to include atrial fibrillation, heart failure, and thrombophilia (a blood disorder that causes one to be prone to blood clots).On 12/17/25 at 1:01 p.m., the ADON was asked who was responsible for reporting incidents to OSDH. They stated anything other than abuse would be themselves or the DON. The ADON was asked for the incident report pertaining to Resident #97's fall on 12/01/25.On 12/17/25 at 1:06 p.m., the DON stated Resident #97's fall on 12/01/25 was not a reportable incident. They stated, [They] received no stitches or anything, no major injury. The DON was asked if a T12 fracture and bilateral subdural hematomas were considered a major injury. They stated, No, because [they] were discharged with no treatment recommendations. The facility's incident reporting policy was requested from the DON.On 12/17/25 at 1:20 p.m., the DON showed the document regarding LTC reportable incidents. They stated, We go by Chapter 675 [Federal Regulations for LTC facilities] and I should've reported it.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interview, the facility failed to perform annual nurse aide competency reviews for two (CNA #3 and CNA #4) of 2 sampled employee files reviewed for annual competencies.The administrator identified 112 residents resided in the facility. Findings:1.An undated staff roster showed CNA #4 was hired on 10/13/23. There was no documentation an annual competency review was completed for 2025.2.An undated staff roster showed CNA #3 was hired on 04/17/24. There was no documentation an annual competency review was completed for 2025.On 12/17/25 at 10:13 a.m., the HR director was asked for annual competencies for CNA #3 and CNA #4. The HR director stated, We may not have them. We try to get them done, but sometimes we don't.On 12/17/25 at 10:23 a.m., the HR director stated, We do not have reviews for those two CNAs. We will have them completed in January or February. A policy for annual competencies was requested and the HR director stated they did not have one.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident was administered a medication as ordered by the physician for 1 (#124) of 6 sampled residents reviewed for medication administration.The administrator identified 112 residents resided in the facility. Findings:An admission assessment, dated 11/12/25, showed Resident #124 was admitted to the facility on [DATE] with a diagnosis of thrombocytopenia, a deficiency of platelets in the blood. A Physician's Order, dated 11/14/25, showed Resident #124 was prescribed eltrombopag olamine oral tablet, (a platelet stimulating agent), 50mg tablet by mouth at bedtime for thrombocytopenia.A medication administration record, dated November 2025, showed Resident #124 was not administered eltrombopag olamine oral tablet on 11/14/25.A Nurse Note, dated 11/14/25, read in part, Pharmacy won't dispense.A medication administration record, dated November 2025, showed Resident #124 was not administered eltrombopag olamine oral tablet on 11/15/25.An Incident Report, dated 11/14/25, was received by the Oklahoma State Department of Health on 12/08/25. The incident report read in part, It was reported to the administrator that [Resident #124] did not receive medication (eltrombopag olamine) for two days (11/14 and 11/15.) The medication was received on 11/14/2025 and was locked in the narcotic box on the medication cart.A Nurse Note, dated 11/15/25, read in part, Waiting on delivery.A Witness Statement, dated 12/04/25 and signed by CMA #1, read in part, There was a medication for [Resident #124] that I could not find. I must have overlooked it.An email, dated 12/04/25, from CMA #2 to the ADON read, I do not recall if said medication was given.A document titled Notification of Nurse Aide/Nontechnical Service Worker Abuse, Neglect, Mistreatment, Misappropriation of Property, dated 12/08/25, showed CMA #2 was terminated from the facility in part due to not administering Resident #124's medication on 11/14/25.On 12/16/25 at 2:28 p.m., CMA #1 was asked what the process was when a medication was listed on the medication administration record but not found on the cart. CMA #1 stated they would look for the medication, call pharmacy to check on the delivery, and would notify the nurse that the medication was not in the building. CMA #1 was asked to recall the missed medications for Resident #124 on 11/15/25. They stated, I looked everywhere for it and couldn't find it. [Resident #124's family member] wanted medications right then, so I just marked it as not in the building. CMA #1 was asked what they should have done differently. They stated, I should have called [ADON].On 12/16/25 at 3:13 p.m., the ADON was asked what the process was when a medication could not be found in the building. They stated the medication aides were to notify the nurse and the nurse was to notify the physician. The ADON was asked if CMA #2 still worked for the facility. They stated no, the medication error led to CMA #2's termination. The ADON stated they counted Resident #124's medication with CMA #2, so they were not sure why CMA #2 did not give the medication on 11/15/25.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure pharmacy recommendations for adding hold parameters to blood pressure medications were followed for 1 (#11) of 5 sampled residents reviewed for unnecessary medication. The administrator identified 112 residents resided in the facility. Findings: A policy titled Drug Regimen Review-With Consultant Agreement only, dated 2021, read in part, Drug Regimen Review consists of reviewing and analyzing prescribed medication therapy and medication use, including nursing documentation of medication ordering and administration.Findings and recommendations are reported to the Administrator, Director of Nursing, the Primary Physician, and the Medical Director, where appropriate.Nursing personnel provide a written response to the review within two weeks after the report is received. A physician's order, dated 09/05/25, showed nifedipine extended release (blood pressure medication) 24 hour 30 mg at bedtime for blood pressure. The order did not have parameters for administration. A Director of Nursing Report (pharmacy recommendation), dated 09/17/25, showed nifedipine order needed hold parameters. A physician's order, dated 09/19/25, showed amlodipine besylate (blood pressure medication) 5 mg one time a day. The order did not have parameters for administration. A Director of Nursing Report (pharmacy recommendation), dated 10/08/25, showed amlodipine order needed hold parameters. A physician's order dated, 11/25/25, showed amlodipine besylate 10 mg one time a day for hypertension. The order did not have parameters for administration. An order summary report, dated 12/16/25, showed Resident #11 had diagnosis which included hypertension. On 12/17/25 at 12:47 p.m., the DON stated they were responsible for the pharmacy reviews. The DON stated they gave those that the physician needed to see, to the physician, and then put the order in the electronic record if needed. On 12/17/25 at 12:48 p.m., the DON reviewed the request on 09/17/25 for the nifedipine and Resident #11's medication list and stated they must have missed it. On 12/17/25 at 12:50 p.m., the DON reviewed the request on 10/08/25 for the amlodipine and Resident #11's medication list and stated they must have missed it. The DON stated they both did not have parameters and they should have.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and interview, the facility failed to follow the dietician approved menu for 3 of 3 meal services observed.The administrator identified 112 residents who received their meals from the kitchen. One resident received nutrition and hydration solely through a feeding tube. Findings:On 12/15/25 at 12:15 p.m., serving of the lunch meal was observed. The lunch meal consisted of meatballs, mashed potatoes with gravy, boiled mix vegetables, and yellow cake with cream cheese frosting.On 12/16/25 at 11:45 a.m., preparation of the lunch meal was observed. The lunch meal consisted of kielbasa sausage, mashed potatoes, creamed corn, and Jello.On 12/16/25 at 4:50 p.m., a sample dinner tray was provided from the kitchen per request. The dinner meal consisted of beef pot pie, boiled squash, cornbread, and peach cake.A Food Preparation Guidelines policy, dated 11/2017, read in part, The cook, or designee, should prepare menu items following the facility's written menus and standardized recipes.A Week 3 facility menu, dated 2025 through 2026, showed residents would be served sliced ham, crispy cubed sweet potatoes, seasoned greens, cornbread, and chocolate cream pie for Monday's lunch meal on 12/15/25.A Week 3 facility menu, dated 2025 through 2026, showed residents would be served glazed meatloaf, red roasted potatoes, southern green beans, honey kissed roll, and gelatin parfait for Tuesday's lunch meal on 12/16/25.A Week 3 facility menu, dated 2025 through 2026, showed residents would be served tuna melt sandwich, steak fries, mixed green salad, and apple crisp for Tuesday's dinner meal on 12/16/25.On 12/15/25 at 10:50 a.m., cook #1 stated the food service director had instructed them to prepare meatballs for lunch. They stated sometimes the food service supervisor would change the menu at the last minute, but was not sure why. [NAME] #1 stated they thought it had to do with not having enough quantity of food items to prepare the meal on the written menu.On 12/16/25 11:50 a.m., the food service director was asked why the lunch meal listed on the written menu had not been prepared. The food service director stated they decided on an alternative lunch meal due to not having all the food items available to prepare the meal listed on the written menu.On 12/16/2025 at 1:21 p.m., during a resident council meeting, the residents stated the menus that have been posted were often not the menus that were served.On 12/16/25 at 5:02 p.m., the administrator stated they were not aware the written menus were not being followed. They stated the kitchen staff should have all the food items required to ensure the meals are followed daily according to the dietician approved menus.On 12/17/2025 at 9:55 a.m., the dietician stated the written menus should have been followed per regulations. They stated the food service director had not made them aware of the changes in the menu this week.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interview, the facility failed to ensure food served from the kitchen was attractive and palatable for 1 of 1 test trays obtained. The administrator identified 112 residents who received their meals from the kitchen. One resident received nutrition and hydration solely through a feeding tube.Findings:On 12/16/25 at 4:50 p.m., a dinner tray was sampled for palatability. The dinner meal consisted of beef pot pie, boiled squash, cornbread, and peach cake. The meal was observed as one large scoop of mixed vegetables and ground beef topped with slightly browned biscuits. The scoop of pot pie was surrounded by water and pieces of squash. The pieces of squash were mushy in texture and bland to taste. The water from the boiled squash had soaked into the biscuit topping for the pot pie. The biscuit topping was soggy in consistency and bland in taste.A Food Preparation Guidelines policy, dated 11/2017, read in part, Food should be palatable, attractive, and at the proper temperature, as determined by the type of food, to ensure resident's satisfaction and meet individual needs.Resident council meeting minutes, dated November 2025, showed residents were concerned the food was not being cooked properly and seemed to be getting worse. The minutes showed the residents felt their dietary concerns were not being addressed.Resident council meeting minutes, dated December 2025, showed residents were concerned the food was not being cooked properly and seemed to be getting worse. The minutes showed the residents felt their dietary concerns were not being addressed.On 12/15/25 at 11:49 a.m., Resident #29 stated they ate most of their meals in their room. They stated the food never tasted good and the vegetables were always mushy.On 12/15/25 at 12:08 p.m., Resident #22 stated the food was bad and the facility rarely offered alternatives.On 12/15/2025 at 1:46 p.m., Resident #62 stated the food served at the facility was not good. They stated the food was never appetizing in appearance. Resident #62 stated the vegetables were always served mushy and the food was either too salty or too bland in taste.On 12/16/25 at 1:21 p.m., during a resident council meeting, the residents voiced concerns regarding the palatability of the meals served. On 12/16/25 at 5:02 p.m., the administrator was shown the sample dinner tray and asked to sample the meal. The administrator stated the meal tasted ok. They stated they would rate the meal 5/10 for taste and appearance. They stated the food service director had already left the facility for the day.On 12/17/25 at 9:25 a.m., the food service director was made aware of the dinner meal observations. The food service director stated they felt the meals they served were appetizing and palatable. They stated the residents complained the meals were seasoned too much or not enough making it difficult to prepare tasty meals consistently.