

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375553	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER Memory Care Center at Emerald		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 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>36191</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident was treated with dignity during dining for one (#20) of four sampled residents observed during two meals.</p> <p>The ADON identified 10 residents who required assistance with meals.</p> <p>Findings:</p> <p>The facility's, Activities of Daily Living (ADLs) policy, revised 01/2024, read in part, A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition .</p> <p>Resident #20 had diagnoses which included dementia.</p> <p>Resident #20's annual assessment, dated 03/12/24, documented they were dependent on staff for eating.</p> <p>On 05/09/24 at 8:45 a.m., RN #1 was observed feeding Resident #20, they got up from the table, Resident #20 had food remaining on her plate and went across the room to encourage another resident to eat. RN #1 came back to the table and assisted another resident to eat while Resident #20 was sitting at the table with a plate of food in front of them.</p> <p>On 05/09/24 at 8:49 a.m., Resident #6 was heard telling Resident #20 Take a bite, you can do it. No staff were observed at the table to feed Resident #20.</p> <p>On 05/09/24 at 8:50 a.m., Resident #20 was asked if they were hungry. They nodded their head up and down indicating yes.</p> <p>On 05/09/24 at 8:52 a.m., CNA #7 came to the table where Resident #20 was sitting. CNA #7 stated Resident #20 was finished eating. CNA #7 was made aware Resident #20 had nodded yes when asked if they were hungry. CNA #7 starting feeding Resident #20. Resident #20 was observed to eat the eggs being fed to them by the CNA.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/09/24 at 2:29 p.m., the ADON stated the staff should not have stopped feeding one resident and gone to assist another resident across the room. They stated during meal times they should have the nurse, CMA, CNA, and the float CNA on the unit to assist residents with eating.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 36191</p> <p>Based on record review and interview, the facility failed to ensure the resident's representative completed the resident's code status correctly and were offered the choice to formulate an advanced directive for two (#6 and #48) of three sampled residents reviewed for advanced directives.</p> <p>The administrator identified 56 residents who resided in the facility.</p> <p>Findings:</p> <p>The facility's Admission policy, revised 01/2024, read in part, The facility will review all advance directive information during the admission process to assure that the resident's wishes will be incorporated in the plan of care. The policy also read, The facility allows advance directive information to be given to the resident's representative at the time of admission if the resident is incapacitated, whether or not the resident has executed an advanced directive</p> <p>1. Resident #6</p> <p>A document titled, Advance Directive Code (Resuscitate) Status, dated 02/26/24, documented Resident #6's POA had initialed the resident was a full code and a DNR.</p> <p>Resident #6's Social Services Admission Data, dated 02/27/24, documented the resident was able to make their own decisions related to advanced care planning and did not have an advanced directive.</p> <p>On 05/08/24 at 4:10 p.m., the office assistant stated Resident #6 had a POA. They stated the resident's POA had incorrectly initialed both full code and DNR on the code status document. They stated Resident #6 was a full code. They stated they did not have documentation Resident #6 had been offered or declined the opportunity to formulate an advanced directive.</p> <p>On 05/08/24 at 5:15 p.m., the office assistant stated they did not ask any residents if they wanted information to formulate an advanced directive because of their dementia diagnoses.</p> <p>46216</p> <p>2. Resident #48 admitted to the facility on [DATE] with diagnoses which included Huntington's disease and unspecified dementia.</p> <p>On 05/07/24 at 2:55 p.m., the BOM was asked if Resident #48 had been offered the choice to formulate advanced directives.</p> <p>On 05/07/24 at 3:20 p.m., the BOM states no advanced directive on file for Resident #48.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>36191</p> <p>Based on observation, record review, and interview, the facility failed to ensure wheelchairs were clean and maintained in good repair for two (#1 and #25) of three sampled residents who were reviewed for wheelchair maintenance.</p> <p>The Administrator identified 56 residents who resided in the facility.</p> <p>Findings:</p> <p>The facility's Physical Environment: Space and Equipment policy, revised 01/2024, read in part, Inspection of resident care equipment will be completed routinely and as needed to maintain and ensure safe operating conditions.</p> <p>1. Resident #1's quarterly assessment, dated 04/10/24, documented they ambulated with a manual wheelchair and walker.</p> <p>On 05/06/24 at 11:24 a.m., Resident #1's wheelchair armrests were observed to be torn and had the yellow padding showing. The wheelchair was observed to be dirty.</p> <p>2. Resident #25's significant change assessment, dated 08/14/23, documented they ambulated with a manual wheelchair.</p> <p>On 05/06/24 at 12:17 p.m., Resident #25's wheelchair armrests were observed to be torn with the yellow padding showing. The wheelchair was observed to be dirty.</p> <p>On 05/08/24 at 2:35 p.m., the ADON stated the CNAs were responsible for notifying the nurse of the need for wheelchair maintenance and the nurse would notify maintenance. The ADON was shown the pictures and the wheelchairs for Resident #1 and #25. They stated they needed to be cleaned and the armrests needed to be repaired. They stated the wheelchair armrests could not be disinfected or cleaned properly because they were torn.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36191</p> <p>Based on record review and interview, the facility failed to implement their abuse policy related to:</p> <p>a. reporting allegations of abuse and/or neglect to the OSDH and investigating allegations of abuse and/or neglect for three (#6, #9, and #41) of five sampled residents who were reviewed for abuse allegations; and</p> <p>b. abuse training upon hire for seven (#1, 2, 3, 4, 5, 6, and #7) of 25 sampled employee files reviewed for abuse training.</p> <p>The administrator identified 56 residents who resided in the facility.</p> <p>Findings:</p> <p>The facility's Abuse Neglect and Exploitation policy, revised 01/2024, read in part, Ensure that all alleged violations involving abuse .are reported immediately, but not later than two hours after the allegation is made.</p> <p>The policy also read, Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated The policy also read, Neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.</p> <p>The policy also read, Employee training .New employees should be educated on abuse, neglect, and exploitation during initial orientation. Annual education and training is provided to all existing employees. The policy also read, Investigation of Alleged Abuse, Neglect, and Exploitation .reports of abuse, neglect or exploitation occur, an investigation is immediately warranted.</p> <p>1. Resident #6 had diagnoses which included dementia and late on-set Alzheimer's Disease.</p> <p>A document titled, Grievance Log, dated 04/18/24, documented Resident #6 reported the staff on the night shift tried to smother them and pulled their call light out of the wall and placed it where they could not reach it. There was not an incident report submitted to the OSDH or documentation an investigation was conducted.</p> <p>On 05/10/24 at 11:43 a.m., the SSD stated they considered the grievance for Resident #6 on 04/18/24 an allegation of abuse and notified the administrator.</p> <p>On 05/10/24 at 11:45 a.m., the administrator stated they considered the statement made by the resident documented on the grievance log an allegation of abuse. They stated the nurse on the night shift had been on the unit and had written a statement. They stated they had not done an investigation or reported the incident to the OSDH because the nurse had been present during the time Resident #6 alleged the abuse happened.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #9 had diagnoses which included frontotemporal neurocognitive disorder.</p> <p>Resident #9's quarterly assessment, dated 11/28/23, documented the resident required substantial maximal assist with toileting, dressing, transferring, and was frequently incontinent of urine and bowel.</p> <p>Resident #9's care plan for ADLs, dated 09/12/23, documented the resident required one person assist for toileting, transferring, and personal hygiene.</p> <p>A document titled, Grievance Log, dated 01/05/24, documented there was not a CNA on the hall to provide care for Resident #9 until 5:00 a.m. and the resident had brown ringed (Dried urine on clothing or sheets.) the grievance log also documented the DON had disciplinary action against the aide who refused to help others.</p> <p>On 05/10/24 at 11:33 a.m., the administrator stated the SSD would notify them if they had received an allegation of neglect. The administrator was asked if they considered the grievance made for Resident #9 on 01/05/24 an allegation of neglect. They stated to some degree.</p> <p>On 05/10/24 at 11:40 a.m., the SSD stated they considered the grievance for Resident #9 on 01/05/24 an allegation of neglect and they notified the administrator and the DON.</p> <p>On 05/10/24 at 11:45 a.m., the administrator stated they did not believe the allegation of neglect on 01/05/24 documented on the grievance form had been submitted to the OSDH.</p> <p>On 05/14/24 at 2:25 p.m., the ADON stated brown ringed meant dried urine. They stated Resident #9 required assistance with incontinent care.</p> <p>46216</p> <p>3. Resident #41 admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, unspecified, dementia in other disease class, and bipolar disorder.</p> <p>An Incident Note, dated 12/24/23, documented, Resident standing at counter. Resident from [room number withheld] approached counter and this resident stepped closer to [Resident #15] while hitting [Resident #41] hand with [Resident #41] fist. [room number withheld] turned to walk away when this resident turned also. [room number withheld] stuck [Resident #15] foot out in front of [Resident #41] and at this same time pushed [Resident #41] from behind. Resident fell forward hitting [Resident #41] nose on the floor. Noted 0.2 x 0.1 cm laceration to [Resident #41] nose. Small amount of bleeding from nose. Cleaned area with normal saline. ROM WNL. Neuro checks initiated and WNL. One on one with this resident for 1 hr then assisted to bed. Called [family member], left message requesting return call. Notified DON and abd [sic] physician.</p> <p>No state reportables were located for the 12/24/23 incident.</p> <p>On 05/14/24 at 12:29 p.m., the ADON stated they were unable to locate state reportable for the 12/24/23.</p> <p>45583</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Employee #1, 2, 3, 4, 5, 6, and #7's personnel files were reviewed. The personnel files did not contain abuse training upon hire.</p> <p>On 05/10/24 at 10:39 a.m., HR stated they did not have information to show abuse training was received by the employee.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216</p> <p>Based on record review and interview, the facility failed to ensure an investigation was initiated for one (#13) of six resident sampled for abuse.</p> <p>The Administrator identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>A Abuse, Neglect and Exploitation policy, revised 1-2024, read in part, a. Respond to the needs of the resident and protect them from further incident (document), b. Notify the Director of Nursing and Administrator (document), c. initiate an investigation immediately.</p> <p>The policy also read, f. Contact the State Agency and the local Ombudsman office to report the alleged abuse.</p> <p>The policy also read, h. Monitor and document the resident's condition, including the response to medical treatment or nursing interventions, i. Document actions taken in steps above in the medical record.</p> <p>Resident #13 admitted to the facility on [DATE] with diagnoses of unspecified dementia, senile degeneration of the brain, and anxiety disorder, unspecified.</p> <p>A quarterly assessment dated , 03/13/24, documented the resident had moderately impaired cognition.</p> <p>A General Note, dated 05/08/23, documented, Resident was speaking to Physical Therapy and she states she is having her period and was needing some pads. Physical therapy spoke with skill Nurse and states this resident is having her period. Skilled Nurse and Physical therapy had this resident go into [Resident 13] room and look at the place where her bleeding was coming from. Resident has a place below her rectum that has a small amount of blood. Skilled Nurse notified Director of Nursing this resident has some bleed in the rectum vaginal area.</p> <p>A General Note, dated 05/08/23, documented, [NAME] Nurse practioner here and examined this resident and noted reddened bleeding area by vagina. She immediately contacted Dr. [name withheld] and Dr. [name withheld] states have her go to the Hospital and have her examined. [name withheld] DON notified family resident is going to Hospital for noted bleeding from the vaginal area. Paper work printed out and [name withheld] ambulance called for transport. [name withheld] notified [name withheld] Police department for Back up. Resident transported via ambulance with out complications. Resident being transported to [name withheld] Hospital.</p> <p>A EMS Patient Care Report, dated 05/08/23, read in part, PT is a 81 YOF with CC of vaginal bleeding. Upon arrival [facility] staff [name withheld] met EMS staff outside and stated that the PT quoted the boys touched me. [name withheld] states that PT is typically confused but [name withheld] was concerned about possible sexual assault.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Emergency Medicine Note, dated 05/08/23, read in part, She had originally said that people were touching her. The note also read, She has a very small less than a half a centimeter external labial laceration which currently does not have any active bleeding.</p> <p>A General Note, dated 03/28/24, documented, This nurse Obtained urine specimen via straight Cath d/t resident experiencing dysuria while going to the bathroom in the potty hat. A white thick milky foul odor smelling residue came from vagina and urethra. Resident expressed pain and discomfort in pelvic area during the Catherization. Social services notified and Gyno appt has been made. DON and family notified.</p> <p>A lab report, dated 04/01/24, documented positive result for Chlamydia and this is a reportable disease.</p> <p>A Progress Note, dated 04/08/24, read in part, I informed [name withheld] that [Resident #13] tested positive for Chlamydia. The progress note also read, I emphasized the importance of treatment completion but also to treat whomever her partner would have been during the time she had the infection. [name withheld] had stated that [Resident #13] is not sexually active that they are aware of, but [APRN] am concerned there is another resident that has either given or gotten Chlamydia from [Resident #13].</p> <p>An Infection Note, dated 04/08/24, documented Received a phone call from [name withheld], nurse practioner with [name withheld]. Requesting to speak with DON/ADON regarding test results. Reports resident was recently seen r/t pelvic pain and vaginal discharge, a vaginal swab was obtained at visit. NP reports the results of the vaginal swab were + for Chlamydia. NP gave orders to start resident on Doxycycline 100 mg BID x 7 days. Reports no follow up appointment/swab is necessary unless increased vaginal discharge or discomfort is noted. NP gave orders to begin isolation precautions until completion of ATB tx. Spoke with PCP Dr. [name withheld] agrees to current tx plan. Spoke with DON, regional RN, [name withheld] & administrator this matter. Spoke to resident's daughter via telephone, informed of lab results, precautions and treatment plan, verbalizes understanding and agreement with tx at this time. Staff educated on proper isolation precautions. Resident currently resting in room, denies pain or discomfort, in no apparent distress at this time. ATB ordered from preferred pharmacy, pending delivery at this time.</p> <p>On 05/08/24 at 9:00 a.m., The APRN stated that the STI could only be sexually transmitted. They stated Resident #13 did not appear abused, but Resident #13 had dementia and was in their own world and could be manipulated by whoever gave it to Resident #13.</p> <p>On 05/08/24 at 10:30 a.m., the ADON stated they did not have the investigation from last year. They stated they did not do the investigation of the recent STI.</p> <p>On 05/08/24 at 11:09 a.m., the Administrator stated they did not find anything about the 05/08/23 investigation. They stated they did not investigate the recent STI.</p> <p>05/08/24 at 11:10 a.m., the Administrator stated there was not any credible situation where anyone could have assaulted Resident #13 on a hall with all females. They stated it would be really difficult for someone to go into their quarters without being noticed.</p> <p>(continued on next page)</p>		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/08/24 at 11:11 a.m., the Administrator stated the facility employed a handful of male employees and a few that work at night and would work alone on the hall they were assigned. They stated to ensure no other residents were infected they could have tested everyone but they did not.		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>36191</p> <p>Based on observation, record review, and interview, the facility failed to ensure MDS assessments were accurate for one (#20) of two sampled residents reviewed for accuracy of documentation for limited range of motion on the MDS assessment.</p> <p>The ADON identified 10 residents who had limited range of motion and three residents who had contractures.</p> <p>Findings:</p> <p>Resident #20's annual assessment, dated 03/12/24, documented they had no impairment for limited range of motion to the shoulder, elbow, wrist, or hand.</p> <p>On 05/07/24 at 11:58 a.m., Resident #20's family member stated the resident's hand was contracted.</p> <p>On 05/09/24 at 8:54 a.m., Resident # 20's left hand was observed to be closed.</p> <p>On 05/09/24 at 9:07 a.m., CNA #7 stated Resident #20's hand was contracted.</p> <p>On 05/14/24 at 10:03 a.m., the ADON stated Resident #20's hand was contracted. They reviewed the MDS assessment and stated the assessment was filled out incorrectly. They stated the assessment documented no impairment in range of motion to upper extremities.</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>36191</p> <p>Based on observation, record review, and interview, the facility failed to develop a care plan for oxygen therapy for one (#6) of one sampled resident who received oxygen therapy and limited range of motion with contracture for one (#20) of two sampled residents who had limited range of motion.</p> <p>The ADON identified six residents who utilized oxygen, ten residents who had limited range of motion, and three residents who had contractures.</p> <p>Findings.</p> <p>The facility's Special Needs policy, revised 01/2024, read in part, Comprehensive care plans will be developed based on resident assessments, goals and preferences.</p> <p>1. Resident #6 had diagnoses which included acute respiratory failure with hypoxia.</p> <p>Resident #6's Monthly Physician's Orders, included oxygen 2 liters via nasal cannula continuously.</p> <p>Resident #6's care plan did not document they utilized oxygen therapy, how often to change the nasal cannula, oxygen safety, or interventions.</p> <p>On 05/06/24 at 12:26 p.m., Resident #6 was observed in their room with oxygen at two liters via nasal cannula. An oxygen concentrator machine with a humidifier bottle and portable oxygen tank was observed in Resident #6's room.</p> <p>On 05/09/24 at 2:06 p.m., the MDS coordinator stated Resident #6's care plan should have included oxygen therapy. They stated the care plan did not document Resident #6 utilized oxygen or interventions for oxygen therapy.</p> <p>2. Resident #20</p> <p>Resident #20's care plan was reviewed and did not document they had limited range of motion or contracture to left hand and did not document interventions to prevent the contracture from worsening or how to provide care to the left hand with the contracture.</p> <p>On 05/07/24 at 11:58 a.m., Resident #20's family member stated the resident's hand was contracted. and they were not sure if they had a brace or splint for Resident #20's hand to prevent it from getting worse.</p> <p>On 05/09/24 at 8:54 a.m., Resident # 20's left hand was observed to be closed, there was not a splint or brace in Resident #20's hand.</p> <p>On 05/09/24 at 9:07 a.m., CNA #7 stated Resident #20's left hand was contracted. They stated they at times put a rolled wash cloth in Resident #20's hand.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Memory Care Center at Emerald		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 North Hickory Street Claremore, OK 74017	

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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>On 05/14/24 at 10:03 a.m., the ADON stated Resident #20's left hand was contracted. They stated the care plan did not document Resident #20's hand was contracted or interventions to prevent it from worsening.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216</p> <p>Based on record review and interview, the facility failed to include a care plan regarding isolation for one (#13) of 19 sampled resident reviewed for care planning.</p> <p>The Administrator identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>A Care Plan Process policy, revised 09/2019, read in part, The plan of care must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and social well-being. The policy also read, Maintains care plans on a current status. The policy also read, Aid in preventing or reducing declines in the residents's functional status and/or functional levels.</p> <p>Resident #13 admitted to the facility on [DATE] with diagnosis which included unspecified dementia, senile degeneration of brain, anxiety disorder, unspecified.</p> <p>An Infection Note dated 04/08/24, documented, nurse practioner gave orders to begin isolation precautions until completion of antibiotic treatment.</p> <p>There was no documentation on the care plan of isolation/isolation precautions.</p> <p>On 05/10/24 at 11:05 a.m., the MDS coordinator stated no, isolation is not on Resident #13's care plan.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 46216</p> <p>Based on record review and interview, the facility failed to ensure neurological checks were completed after a fall with head injury for one (#41) of four sampled residents reviewed for accident hazards.</p> <p>The Administrator identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>An Accidents/Neuro Checks policy, revised 1-24, read in part, The purpose of this procedure is to provide guidelines for a neurological assessment. The policy also read, Neurological assessments are indicated. The policy also read, Following an unwitnessed fall. The policy also read, Following a fall or other accident/injury involving head trauma.</p> <p>Resident #41 admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, unspecified, dementia in other disease class, and bipolar disorder.</p> <p>Resident #41's significant change assessment documented the resident had severe cognitive impairment.</p> <p>An Incident Note, dated 12/24/23, documented, Resident standing at counter. Resident from [room number withheld] approached counter and this resident stepped closer to [Resident #15] while hitting [Resident #41] hand with [Resident #41] fist. [room number withheld] turned to walk away when this resident turned also. [room number withheld] stuck [Resident #15] foot out in front of [Resident #41] and at this same time pushed [Resident #41] from behind. Resident fell forward hitting [Resident #41] nose on the floor. Noted 0.2 x 0.1 cm laceration to [Resident #41] nose. Small amount of bleeding from nose. Cleaned area with normal saline. ROM WNL. Neuro checks initiated and WNL. One on one with this resident for 1 hr then assisted to bed. Called [family member], left message requesting return call. Notified DON and abd [sic] physician.</p> <p>An Incident report, dated 02/25/24, documented, Residents and staff were on back patio for afternoon activities. Staff called this nurse back out to patio at approximately [2:00 p.m.] to observe resident lying on concrete, crying, with plant hanger tangled between feet and blood coming from above right eye. Head to toe assessment revealed laceration just above right eye with copious amounts of bright red drainage. Neuro monitoring initiated, findings consistent with baseline. Hypotension noted with B/P: 85/47, additional V/S WNL including T:98, P:59, O2: 98% on RA and R: 18. Resident exhibits signs of pain including guarding grimacing crying out and agitation. Staff assisted residents back into building. RN supervisor cleansed wound and applied gauze with pressure. This nurse contacted Dr. [name withheld] and received order to send resident out to hospital for further evaluation and treatment. 911 emergency line contacted for transport followed by [family member], DON and Admin. Resident exited building with EMT x 2 enroute to [hospital name withheld] at approximately [2:30 p.m.]</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 - Few</p>	<p>No neuro sheets were located it Resident #41's chart.</p> <p>On 05/14/24 at 1:58 p.m., The ADON state if a fall was unwitnessed or if resident had an injury involving the head, the staff should start neuros</p> <p>On 05/14/24 at 12:29 p.m., the ADON stated they were unable to locate neuro sheets for the 12/24/23 and 02/25/25 incidents.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>36191</p> <p>Based on observation, record review, and interview, the facility failed to ensure oxygen tubing was labeled, dated, and changed per facility policy for one (#6) of one sampled resident who was observed for oxygen therapy.</p> <p>The ADON identified six residents who received oxygen therapy.</p> <p>Findings:</p> <p>The facility's, Special Needs policy, revised 01/2024, read in part, To address special needs, this facility will provide the necessary care and treatment .consistent with professional standards of practice.</p> <p>Resident #6 had diagnoses which included acute respiratory failure with hypoxia.</p> <p>Resident #6's Monthly Physician's Orders, included oxygen 2 liters via nasal cannula continuously.</p> <p>On 05/06/24 at 12:26 p.m., Resident #6 was observed in their room. The oxygen tubing hooked up to the oxygen concentrator was not dated.</p> <p>On 05/09/24 at 9:15 a.m., Resident #6 was observed in the dining room wearing the oxygen nasal cannula hooked up to the portable oxygen tank. The oxygen tubing was dated 03/29/24. CNA #7 observed the date on the tubing and verified the date.</p> <p>On 05/09/24 at 9:25 a.m., the nasal cannula hooked up the oxygen concentrator was observed hanging from the regulator and was discolored and undated. The humidifier bottle was out of water and had water stains on the bottle.</p> <p>On 05/09/24 at 9:27 a.m., RN #1 stated the oxygen tubing hooked up to the concentrator was not dated. RN #1 stated the tubing was supposed to be changed weekly. They stated they did not know why the oxygen humidifier was out of water. RN #1 stated the oxygen tubing and humidifier were not dated.</p> <p>On 05/09/24 at 9:58 a.m., the ADON was shown pictures of the nasal cannula and the humidifier bottle. They stated the nasal cannula was dirty. They stated the humidifier bottle needed to be changed. The ADON stated the oxygen tubing and humidifier bottle should be changed weekly and the tubing should be dated with the date it was changed. They stated the humidifier bottle should not run out of water. The DON stated it was the nurse's responsibility to change the tubing and humidifier bottle and ensure it had water.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36191</p> <p>Based on observation, record review, and interview, the facility failed to ensure sufficient staff</p> <p>a. was available to provide incontinent care for one (#9) of one sampled resident who required incontinent care;</p> <p>b. was available to provide supervision during meals for one (#46) of two sampled residents who required supervision with meals; and</p> <p>c. was available to provide a licensed staff member on a 24 hour basis.</p> <p>The ADON identified 40 residents who required assistance with incontinent care, 10 residents who required assistance with meals, and 56 residents who resided in the facility.</p> <p>Findings:</p> <p>1. Resident #9 had diagnoses which included frontotemporal neurocognitive disorder.</p> <p>Resident #9's care plan for ADLs, dated 09/12/23, documented the resident required one person assist for toileting, transferring, and personal hygiene.</p> <p>Resident #9's quarterly assessment, dated 11/28/23, documented the resident required substantial maximal assist with toileting, dressing, transferring, and was frequently incontinent of urine and bowel.</p> <p>A schedule, dated 01/04/24, documented there were no CNAs assigned to work on the Burgundy hall on night shift.</p> <p>A document titled, Grievance Log, dated 01/05/24, documented there was not a CNA on the hall to provide care for Resident #9 until 5:00 a.m. and the resident had brown ringed (Dried urine stain on linen or clothing.) the grievance log also documented the DON had disciplinary action against the aide who refused to help others.</p> <p>On 05/14/24 at 2:25 p.m., the ADON stated the schedule did not reflect a staff member had been assigned to the burgundy hall. The ADON was asked what brown ringed meant from the grievance log. They stated brown ringed meant dried urine. They stated Resident #9 required assistance with incontinent care every two hours. The ADON stated the CNA from green hall should have assisted the nurse with the residents' care needs on burgundy hall. The ADON stated they were not working at the facility at the time of the grievance and based on the documentation it looked like the aide from green hall refused to assist with resident care on the burgundy hall.</p> <p>2. Resident #46 had diagnoses which included extrapyramidal and movement disorder, anxiety, and dementia.</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>Resident #46's care plan for ADLs dated 01/11/24 , documented they required set up and supervision with meals.</p> <p>A nurse's note, dated 04/12/24, at 1:32 p.m., documented Resident #46 only ate if they were fed. Resident #46 ate 100% of their breakfast and lunch when they were fed.</p> <p>A nurse's note, dated 04/14/24, at 2:12 p.m., documented Resident #46 required some attention towards feeding and Resident #46 would eat if fed.</p> <p>On 05/09/24 at 8:25 a.m., during breakfast observation, RN #1 and CNA #7 were observed assisting residents with eating. CMA #1 was observed administering medications in the dining room. There were no staff members feeding or sitting with Resident #46 to encourage them to eat and not wander from the dining area.</p> <p>On 05/09/24 at 8:25 a.m., Resident # 46 was observed chewing their food and walking around unit. The residents breakfast was in a bowl, scrambled eggs, a biscuit in one bowl, a bowl of oatmeal, a cup juice and milk.</p> <p>On 05/09/24 at 8:26 a.m., CNA #7 cued Resident #46 to come and eat from across the dining room.</p> <p>On 05/09/24 at 8:29 a.m., Resident # 46 was observed walking to their room. There was no staff with Resident #46.</p> <p>On 05/09/24 at 8:31 a.m., Resident # 46 came out of room and went into another residents room. CNA#7 went to get Resident #46 and encouraged resident to go back to the dining area and eat her breakfast.</p> <p>On 05/09/24 at 8:39 a.m., Resident #46 continued to ambulate around unit and come and get bites of food. The staff did not stay with Resident #46 during the meal to ensure the resident stayed in the dining area and was encouraged to eat.</p> <p>On 05/09/24 at 9:04 a.m., CNA #7 stated Resident #46 ate their bacon, oatmeal, a few bites of their eggs and half of their biscuit.</p> <p>On 05/09/24 at 2:07 p.m., the MDS coordinator stated the care plan documented to provide supervision with meals. They stated a staff member should be next to Resident #46 during meals to provide supervision and prompt the resident to eat.</p> <p>On 05/09/24 at 2:29 p.m., the ADON stated Resident #46 required cuing and supervision with meals. The ADON stated the staff should be seated next to Resident #46 to cue the resident to eat and ensure they do not get up and leave the dining table. The ADON stated the CNA, nurse, float CNA, CMA should assist with meals to ensure each resident is provided supervision and assistance with meals.</p> <p>3. A document titled, Incident Report Form, dated 05/12/24, documented the facility was without a licensed nurse for 3.5 hours due to the nurse scheduled to work the 7:00 p.m. shift to 7:00 a.m. shift had called in.</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 05/13/24 at 1:30 p.m., Resident #1's family member stated they had pushed the call light for assistance at 6:48 p.m. on 05/12/24, and it had not been answered by the time they left at 7:30 p.m. They stated they lowered the resident's bed, and placed the resident's fall mat by their bed before they left. The family member stated they believed the facility did not have enough staff on 05/12/24.</p> <p>On 05/13/24 at 4:17 p.m., the ADON stated the administrator had filled out an incident report and reported the facility had not had a licensed nurse on 05/12/24 for 3.5 hours. They stated they had volunteered to cover the 3.5 hours but were advised they were needed on 05/13/24. The ADON stated the nurses who had been working the day shift left the facility on [DATE] without a licensed nurse to replace them. They stated the nurse from their sister facility on campus had been available for emergencies.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>45583</p> <p>Based on record review and interview, the facility failed to ensure licensed nurse, and certified nurse aides received competency/skills checks for four (LPN #1, CNA # 2, CNA #3, and CNA #4) of five employee files reviewed for competency/skills checks.</p> <p>The administrator identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>A Nursing Services and Sufficient Staff policy, dated 02/23, read in part, It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The policy also read, The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for resident's needs as identified through resident assessments and described in the plan of care. The policy also read, The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for resident's needs, as identified through resident assessments, and described in the plan of care.</p> <p>1. LPN #1 was hired on 12/13/23. Review of the employee file for LPN #1 did not reveal a competency/skills check had been completed.</p> <p>2. CNA #2 was hired on 09/02/23. Review of the employee file for CNA #2 did not reveal a competency/skills check had been completed.</p> <p>3. CNA #3 was hired on 09/05/23. Review of the employee file for CNA #3 did not reveal a competency/skills check had been completed.</p> <p>4. CNA #4 was hired on 11/29/23. Review of the employee file for CNA #3 did not reveal a competency/skills check had been completed.</p> <p>On 05/10/24 at 11:58 a.m., the ADON stated they did not have the skills check offs for CNA #2, 3, 4, and LPN #1. They were asked if they did annual skills check offs. They stated, We should be.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583</p> <p>Based on record review and interview the facility failed to ensure:</p> <ul style="list-style-type: none"> a. the services of an RN was available in the facility eight hours daily seven days a week, and b. there was a RN designated as full time DON. <p>The administrator identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>A Nursing Services and Sufficient Staff policy, read in part, .Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours, 7 days a week.</p> <p>A document of in and out time punches for April 1st, 2024 through May 5th, 2024 documented RN #1's shifts worked as follows:</p> <ol style="list-style-type: none"> 1. 04/05/24 12.37 hours worked. 2. 04/06/24 12.17 hours worked. 3. 04/18/24 17.70 hours worked. 4. 04/19/24 12.65 hours worked. 5. 04/25/24 12.48 hours worked. 6. 04/29/24 12.23 hours worked. 7. 05/03/24 12.42 hours worked. <p>A document of in and out time punches for April 1st, 2024 through May 5th, 2024 documented RN #2's shifts worked as follows:</p> <ol style="list-style-type: none"> 1. 04/12/24 8.77 hours worked. 2. 04/13/24 8.97 hours worked. 3. 04/14/24 8.85 hours worked. 4. 04/20/24 9.03 hours worked. 5. 04/21/24 13.18 hours worked. <p>(continued on next page)</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. 04/28/24 13.07 hours worked.</p> <p>7. 05/04/24 8.52 hours worked.</p> <p>8. 05/05/24 7.05 hours worked.</p> <p>These shifts did not overlap.</p> <p>A document of in and out time punches for April 1st, 2024 through April 18th, 2024 documented the previous DON's did not have time punches for the days as follows:</p> <ol style="list-style-type: none"> 1. April 4th, 2024 = PTO 2. April 5th, 2024 = PTO 3. April 8th, 2024 = PTO 4. April 9th, 2024 = PTO 5. April 10th, 2024 = PTO 6. April 11th, 2024 = PTO 7. April 18th, 2024 = PTO <p>There were 37 total days the facility had been without a designated DON and there were 14 days with no RN coverage; with some coverage being the DON; from April 1st to May 5th 2024 when requested RN punch details from the facility.</p> <p>On 05/06/24 at 9:47 a.m., the Administrator stated that currently the DON position was vacant and had been for two weeks. They stated they did not have anyone and the ADON was at the [NAME]. The Administrator further stated they did not have RN coverage every day since the previous DON left. They stated they only have two RN's, one prn and one part time.</p> <p>On 05/08/23 at 2:23 p.m., the ADON stated they did not have an RN coverage's as the DON coverage.</p> <p>On 05/14/24 at 9:43 a.m., the ADON stated the facility did not have an RN to serve as the DON on a full time basis.</p> <p>On 05/14/24 at 9:50 a.m., the ADON verified after looking at the punch details for both RN's on staff, that they Did not have RN coverage for all the days not listed on the punch details and that the DON may have covered some. Verified no daily RN coverage.</p>		

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NAME OF PROVIDER OR SUPPLIER Memory Care Center at Emerald		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 North Hickory Street Claremore, OK 74017	

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216</p> <p>Based on record review and interview, the facility failed to ensure antipsychotic medications were ordered with an appropriate diagnoses for one (#5) of five sampled residents reviewed for unnecessary medications.</p> <p>The ADON identified 23 residents were prescribed psychotropic medications.</p> <p>Findings:</p> <p>Resident #5 admitted to the facility on [DATE] with diagnoses that included unspecified dementia and general anxiety disorder.</p> <p>A Physician's Order, dated 09/20/22, documented aripiprazole tablet 5 mg by mouth one time a day for unspecified dementia with behavioral disturbance.</p> <p>On 05/14/24 at 9:52 a.m., the ADON stated schizophrenia, bipolar, and depression where appropriate diagnoses for aripiprazole.</p> <p>On 05/14/24 at 9:53 a.m., the ADON stated that dementia to their knowledge was not an appropriate diagnosis for aripiprazole.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>45583</p> <p>Based on observation, record review, and interview, the facility failed to ensure menus were followed for one of one meal preparation and service observed.</p> <p>The ADON identified all 56 residents received their meals from the kitchen.</p> <p>Findings:</p> <p>A Menus and Adequate nutrition policy, dated 01/2024, read in part, The purpose of this policy is to assure menus are developed and prepared, based on reasonable efforts, to meet resident choices and reflect the resident's nutritional, religious, cultural, and ethnic needs, while using established guidelines and considering resident preferences. The policy also read, The facility will ensure that menus, The policy also read, Be followed; The policy also read, All residents have the right to make their own personal dietary choices.</p> <p>On 05/06/24 at 9:59 a.m., Cook #1 stated the lunch menu was chicken paprikash, egg noodles, squash, and mixed fruit.</p> <p>The menu was observed and it documented the noon meal was to have been chicken paprikash, buttered egg noodles, squash medley, melon cubes, and beverage.</p> <p>On 05/06/24 at 1:25 p.m., Cook #1 was observed telling another staff member they would bring Resident #5 their food. Cook #1 stated they did not have time to make their food. That resident wanted sandwich meat and cheese roll up.</p> <p>On 05/06/24 at 1:43 p.m., there were five residents that did not receive the butter noodles. Cook #1 stated what was left was stuck to the pan and stated they were going to bring back bread.</p> <p>There was not enough noodles stuck to the pan to have fed 5 more residents.</p> <p>On 05/06/24 at 1:43 p.m., there was no observation of dessert. Cook#1 stated they did not have time to make it and would make when they got back to the kitchen.</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>45583</p> <p>Based on observation and interview, the facility failed to ensure proper food service sanitation, cleaning and storage requirements were followed.</p> <p>The ADON identified all 56 residents who resided at the facility received food from the kitchen.</p> <p>Findings:</p> <p>An undated, Sanitation of Dining and Food Service Areas policy, read in part, The Dining Service staff will uphold sanitation of the dining areas. The policy also read, All staff will be trained on the frequency of cleaning. The policy also read, Staff will be held responsible for all cleaning tasks.</p> <p>An undated Sanitizing and Disinfectant Solutions policy, read in part, Bleach solution should be at a concentration of greater than or equal to 50 to 100 ppm.</p> <p>An undated Food Storage(Dry, Refrigerated, and Frozen) policy, read in part, All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded.</p> <p>On 05/06/24 at 9:50 a.m., a tour of the kitchen was conducted. The following observations were made.</p> <ul style="list-style-type: none"> a. Cook #1 did not have on a beard guard and had a full beard, b. one opened bag of an orange block of cheese with no date label, c. five packs of boiled eggs in a box. The box did not have a date label of when opened, d. one plastic container almost empty of cheese with no date label, e. one opened bag of mozzarella cheese with no date label, f. one block of butter in a box with no date label on the box when opened, g. one gallon of half empty milk with no date label of when opened, h. one box with three bags of liquid eggs with no date label when opened, i. one opened box of bacon with no date label when opened, j. one jar of almost empty ranch dressing with no date label when opened, <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>k. a red/pink drinking cup with a lid and draw was observed on the bottom shelf next to a box of plastic ware. The metal shelf had black and white substance/debris on it(see photo),</p> <p>l. there were two toasters covered with brown and black crumb substance/debris on both the black trays they were sitting on and on the metal shelves they were stored on(see photo),</p> <p>m. there was black, brown and white debris/substance on the bottom of the metal shelf that stored the pots and pans(see photo).</p> <p>On 05/06/24 at 9:56 a.m., the Cook #1 stated they were not sure and had to brush up on the policy and procedure was for hair nets. They stated they did not have on a beard guard because they were waiting for them to be ordered and had not been instructed on what to do until they arrived.</p> <p>On 05/06/24 at 10:16 a.m., Cook #1 stated the policy and procedure for food storage/labeling was to pull the oldest to the front and label/date when ordered and when arrived.</p> <p>On 05/06/24 at 10:21 a.m., Cook #1 stated that none of the items listed from the refrigerator were dated and did not know why. They acknowledged the crumbs on the toaster and shelf and stated it was not clean. They stated the kitchen was swept and mopped every night and the shelves were cleaned every Wednesday.</p> <p>On 05/06/24 at 10:25 a.m., Cook #1 observed the debris wiped from the shelf of the pots and pans and stated it was dirt.</p> <p>On 05/06/24 at 11:24 a.m., follow up observation found the following.</p> <p>n. black substance splattered on the wall and along the trim around the sink area where the dishes were washed(see photo),</p> <p>o. the low temp dishwasher never reached above 100 degrees(see photo),</p> <p>p. the three sink sanitizer compartment never reached above 10 ppm.</p> <p>On 05/06/24 at 11:25 a.m., Dietary Aide #1 stated the black substance on the wall around the sink next to the dishwasher was black mold. They stated they knew it was because they would scrub it and it would come off then came back. They stated they reported to Food Service Director.</p> <p>On 05/06/24 at 11:52 a.m. the dishwasher was run again for the fourth time and the temperature still under 100 degrees. (see photo for temperature gauge requirement). They stated when that happens they let the Food Service Director know and they call to get it fixed. They stated that they still continue to use it because it takes months to get someone out to fix it. They were to set up the three compartment sink for usage after lunch.</p> <p>On 05/06/24 at 12:16 a.m., observed the three compartment sink observed. The hot water coming out of the faucet was 88 degrees. Dietary Aide #1 stated that when the dishwasher is running then the hot water comes out cool then warms up when the dishwasher stopped.</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 05/06/24 at 12:29 p.m., the three compartment sink sanitization was too low at 10 ppm. They stated they never had that happen before and were to contact the Administrator. They also stated that they would have scrubbed the dishes well with washing them.</p> <p>On 05/06/24 at 12:38 p.m., the three compartment sink sanitization was again too low at 10 ppm. The blender used to prepare the mechanical soft and puree food was washed in the dishwasher that had not reached temperature.</p> <p>On 05/06/24 at 12:52 p.m., observed Maintenance supervisor in the kitchen dishwasher area.</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>36191</p> <p>Based on record review and interview, the facility failed to explain the arbitration agreement in a manner the resident representative could understand for one (#21) of three sampled residents who entered into a binding arbitration agreement.</p> <p>The administrator identified 25 residents who had entered into a binding arbitration agreement.</p> <p>Findings:</p> <p>A document titled, Voluntary Arbitration Agreement, dated 04/08/24, documented Resident #21's family member signed the agreement.</p> <p>On 05/09/24 at 8:08 a.m., Resident #21's representative was asked if they understood the arbitration agreement they signed. The family member stated they did not realize what they were signing. They stated they did not realize they were giving up their right to have litigation in court. They stated they were stressed out and signing a lot of paperwork. The family member stated the facility went over the paper work so fast, they guessed they should have paid more attention. They stated they were not told they could withdraw from the agreement within 30 days of signing the agreement.</p> <p>On 05/10/24 at 9:31 a.m., the SSD stated an arbitration agreement was agreeing to have a mediator first to solve a dispute before they tried anything else. The SSD stated the resident or resident representative could still solve a dispute in court after they signed the arbitration agreement. The SSD was asked how they explained the arbitration agreement to the residents or resident representatives. They stated they let them read the paper work and ask questions. They stated they kept it short and simple. The SSD was asked if they explained to them they had 30 days to rescind the agreement and were giving up their right to go to court. They stated no. They stated they emailed the agreement to the resident representative and told the families to reach out if they had any questions.</p> <p>On 05/10/24 at 10:30 a.m., the administrator stated the facility should be considering the family and the stress they are under when they are signing the paperwork for admission.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>36191</p> <p>Based on observation, record review, and interview, the facility failed to ensure oxygen tubing was stored in a manner to prevent cross contamination for one (#6) of one sampled resident who was observed for oxygen therapy.</p> <p>The ADON identified six residents who received oxygen therapy.</p> <p>Findings:</p> <p>Resident #6 had diagnoses which included acute respiratory failure with hypoxia.</p> <p>Resident #6's Monthly Physician's Orders, included oxygen 2 liters via nasal cannula continuously.</p> <p>On 05/06/24 at 12:26 p.m., Resident #6 was observed in their room. The nasal cannula oxygen tubing hooked up to the portable oxygen tank was observed lying on the floor.</p> <p>On 05/09/24 at 9:15 a.m., Resident #6 was observed in the dining room wearing the oxygen nasal cannula that was hooked up to the portable oxygen tank.</p> <p>On 05/09/24 at 9:25 a.m., the nasal cannula hooked up the oxygen concentrator was observed hanging from the regulator and was discolored. The humidifier bottle was out of water and had water stains on the bottle.</p> <p>On 05/09/24 at 9:58 a.m., the ADON was shown pictures of the nasal cannula and the humidifier bottle. They stated the nasal cannula was dirty, and should not have been stored on the floor or the regulator. They stated the humidifier bottle needed to be changed.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>36191</p> <p>Based on observation and interview, the facility failed to ensure emergency call cords were long enough to be reached by the residents if they were lying on the floor in the shower for two (#44 and #56) of two residents who were able to independently shower.</p> <p>The ADON identified 12 residents who would have the cognitive ability to utilize the call light.</p> <p>Findings:</p> <p>1. Resident #44</p> <p>On 05/06/24 at 10:30 a.m., CNA #8 stated Resident #44 was able to shower themselves independently. They stated they assisted them with gathering the shower supplies.</p> <p>On 05/06/24 at 12:36 p.m., Resident #44's bathroom was observed. The emergency call cord in the bathroom was next to the toilet and not within reach of the shower.</p> <p>On 05/08/24 at 2:39 p.m., the ADON stated Resident #44 should be provided stand by assistance in the shower to stay on task. The ADON stated Resident #44 would not be able to reach the call light if they fell in shower.</p> <p>On 05/09/24 at 11:10 a.m., Resident #44 was shown the call cord in their bathroom and was asked if they knew what the cord was for next to their toilet. Resident #44 stated the cord was for emergencies and they knew how to pull the cord.</p> <p>On 05/09/24 at 11:13 a.m., the ADON stated Resident #44 had the cognitive ability to use the call light.</p> <p>2. Resident #56</p> <p>On 05/06/24 at 12:38 p.m., Resident #56's bathroom was observed the emergency call cord was next to the toilet and was not within reach of the shower.</p> <p>On 05/06/24 at 12:40 p.m., CNA #3 stated Resident #56 did not like anyone in the bathroom while they were in the shower. They stated they would get the towels and soap for the resident to shower. CNA #3 stated Resident #56 was not provided supervision while they were taking a shower.</p> <p>On 05/08/24 at 2:40 p.m., the ADON stated Resident #56 was able to shower themselves and they liked their own space. The ADON stated the staff should stay in the resident's room while the resident was in the shower. They stated the staff would be within a few feet of the resident to give them privacy and space during the shower.</p> <p>On 05/09/24 at 11:13 a.m., the ADON stated #56 had the cognitive ability to use the call light.</p>		