STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375499	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to implement their infection control program to prevent the potential spread of infection for six (#1, #2, #3, #4, #5, and #6) of seven sampled residents reviewed for infection control. The facililty failed to: a) Ensure staff completed hand hygiene as required. b) Ensure staff disinfected share equipment after use. c) Ensure staff used disposable gowns in resident quarantine rooms. There were 106 residents in the facility. Findings: The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes documented, .Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications . Hand Hygiene Guidance . Immediately before touching a patient . Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices . Before moving from work on a soiled body site to a clean body site on the same patient . After touching a patient or the patient's immediate environment . After contact with blood, body fluids, or contaminated surfaces . Immediately after glove removal . Environmental Cleaning and Disinfection . Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas . Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment . Use an EPA-registered disinfectant from List Nexternal icon on the EPA website to disinfect surfaces that might be contaminated with [DIAGNOSES REDACTED]-CoV-2. Ensure HCP are appropriately trained on its use . Gowns . Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use . 1. On 06/09/20 at 10:35 a.m., certified medication aide (CMA) #1 obtained the blood pressure (BP) of resident #1 using the wrist BP cuff device. The CMA left the resident's room and placed the BP cuff in his uniform top upper chest pocket. He used alcohol based hand sanitizer (ABHS) in the hallway and went into another resident's bathroom to assist the other resident. The CMA came out of the other resident's room and used ABHS. The CMA then took the BP cuff out of his right uniform pant pocket and walked down the hall to the front of the facility. At 10:43 a.m., he stated he had gotten some batteries for the BP cuff. He did not sanitize the BP cuff after resident use. 2. On 06/09/20 at 10:49 a.m., CMA #1 obtained the BP and pulse oxygen (ox) of resident #2. The CMA left the resident's room and placed the BP cuff and pulse ox meter on top of the medication cart. He did not clean/sanitize the BP cuff or the pulse ox meter. He did not sanitize his hands and then dispensed the medications for resident #2. He administered the medications to resident #2 on another hallway. On the quarantine hall (Blue Hall) multiple resident gowns were observed hung on hooks in each of the residents' rooms. The following observations were made on the quarantine hall. 3. On 06/09/20 on the quarandine hallway, CMA #2 put on a resident cloth gown. He entered the resident room of resident #3. The CMA administered the resident a medication. The CMA then removed his gloves, removed the gown, and hung the gown on a hook in the resident's room. The CMA dropped his glasses on the hallway floor while he removed the gown. He left the resident's room and picked up his glasses off the floor. He did not wash or sanitize his hands after removing his gloves, gown, or after he picked up his glasses off the floor. He walked down the hallway to the end of the hall. 4. On 06/09/20 at 11:50 a.m., CMA #2 walked out of a resident's room and placed a blue plastic tray onto the medication cart. There was a BP cuff, pulse ox meter, a pen, and thermometer on the tray. He did not sanitize the tray, the BP cuff, the pulse ox meter, or the thermometer. 5. On 06/09/20 at 11:58 a.m., licensed practical nurse (LPN) #1 carried a blue plastic tray and entered the room of resident #4. The LPN took a resident gown off a hook in the resident's room. The LPN with her right hand put the resident gown over her head, put her right arm in the gown, and then put her left arm in the gown. She placed the blue tray on the resident's overbed table. The LPN obtained the resident's finger stick blood sugar. She then held the plastic tray against her gown. She then removed the gown over her head, with one hand, while she held the tray. She hung the gown on a hook in the resident's room. She then removed her gloves. She left the resident's room. She did not wash or sanitize her hands after removing the gown or gloves. She placed the blue tray onto the treatment cart. She put on gloves and sanitized the glucometer that was on the tray and the blue tray. She did not sanitize the top of the treatment cart. Then set the tray back onto the treatment cart. 6. On 06/09/20 at 12:08 p.m., CMA #2 walked into the room of resident #5. The CMA put on a resident gown that had been hanging on a hook in the resident's room. He pulled gloves out of his uniform pants pocket and put them on. Certified nurse aide (CNA) #1 entered the resident's room and put on a gown that was hung on a hook in the resident's room and put on gloves. On 06/09/20 at 12:12 p.m., CNA #1 stated after resident care we hang the gowns on the hooks. She stated the gown was reused during the shift. She stated at the end of the shift the gowns were put in the isolation bag for the laundry. She stated the next shift would hang up clean gowns. The CNA stated the CNAs tried to use the third hook. CMA #2 stated he tried to use the corner hook for his gowns in the residents' rooms. They both stated they did not know which gowns the therapy staff members used. The CNA stated the staff did not know for sure what gown was theirs or if other staff members had worn the gowns. 7. On 06/09/20 at 12:22 p.m., LPN #1 took the BP cuff into the room of resident #6. At 12:25 p.m., after the LPN left the resident's room, she was asked how she knew which resident gown to put on in the residents' rooms. She stated staff had to remember where they had hung their gowns. The LPN put the BP cuff on top of the treatment cart and then back onto the blue plastic tray. The BP cuff was not sanitized after resident use. On 06/09/20 at 12:38 p.m., CMA #1 when asked stated he sanitized the BP cuff and pulse ox meter with alcohol wipes after each resident use. The CMA stated he washed his hands every third resident. The CMA stated he tried to sanitized his hands between each resident. On 06/09/20 at 12:47 p.m., CMA #2 stated he used alcohol wipes to sanitize the BP cuff. He stated he cleaned the BP cuff the first time he had used it but not the last two times used. On 06/09/20 at 2:53 p.m., the director of nursing (DON) stated the staff members were using the resident gowns to conserve the disposable gowns. She stated the facility had plenty of disposable gowns.

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

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.