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 _____	08/26/2020

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.** 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 four (#2, #7, #8, and #9) of nine residents reviewed for infection control. The facility failed to: a) ~ Ensure staff members wore the appropriate personal protective equipment when caring for residents who were in quarantine. b) ~ Ensure staff used gloves/changed gloves/sanitized between resident care. c) ~ Ensure cross contamination did not occur during med pass. The facility identified 83 residents lived in the facility. Findings: The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: . Immediately before touching a patient . Before performing an aseptic task . Before moving from work on a soiled body site to a clean body site . After touching a patient or the patient's immediate environment . After contact with blood, body fluids, or contaminated surfaces . Immediately after glove removal . The Center for Disease Control guidance, titled Preparing for COVID-19 in Nursing Homes documented, .Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown .HCP (health Care Provider) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents . Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices .Perform and maintain an inventory of PPE in the facility .Identify health department or healthcare coalition contacts for getting assistance during PPE shortages .Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools .Make necessary PPE available in areas where resident care is provided .Facilities should have supplies of face masks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles) .Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room . 1. On 08/26/20 at 9:40 a.m., the surveyor observed a three drawer chest outside of the quarantine hall. The chest contained gloves, one washable gown, surgical masks, booties, and face shields. The surveyor put on personal protective equipment to enter the quarantine unit. There were closed doors and then a black plastic zippered barrier prior to entering the unit. Certified medication aid #1 was observed coming out of a resident room rolling an over bed table with a glass of water, an open cup with something white inside, a pulse ox, and a blood pressure cuff. She had a gown on and an N95 mask. She did not have a face shield or goggles on. She was wearing glasses. She did not take off her gown prior to leaving the resident's room. The certified medication aid rolled the over bed table halfway down the hall to the medication cart. She cleaned the pulse ox and blood pressure cuff. She obtained the next resident's medication and pushed the cart down the hall to the next resident's room. She wore the same gown and entered the room without wearing a face shield. She wore the same N95 mask into the room. She entered the resident's room rolling the over bed table with a medication cup with medication in it, two cups of water which were open to air, an open cup with something white inside, a pulse ox and a blood pressure cuff. She came out of the resident's room and did not remove her gown. She did not have a face shield or goggles on. The certified medication aide was asked if she knew what personal protective equipment should be worn when entering a resident's room, who was in quarantine. She stated she had not been changing gowns between residents. She stated there were no face shields or gowns on the hall. She stated she thought she was supposed to wear a face shield, a gown, a mask, and gloves. She was asked what was in the cup on her cart that contained something white. She stated those were cleaning wipes she had taken out of the container on the med cart so she did not bring the wipe container in and out of rooms. She was not observed getting a new cup with wipes when entering resident rooms to give medication. There were no supplies observed on the unit or outside resident rooms. There were no red bags observed in resident rooms. There were two boxes observed next to the black plastic zippered barrier. There were no red bags/bags in the boxes. One box contained soiled gowns and one box contained trash and soiled surgical face masks. At 10:00 a.m., certified nurse aid #1 was observed standing in the hall on the quarantine unit. She was asked if she knew what personal protective equipment should be worn when entering a resident's room, who was in quarantine. She stated she was supposed to wear a gown, gloves, face mask, and a face shield. She was asked if she was changing her personal protective equipment when she went in and out of resident rooms on the unit. She stated she had been told not to change her gown. She stated she was told to wipe off her gown with sani-wipes between residents. She stated she had not seen any face shields on the unit so she had not been using a face shield when caring for the residents. At 10:44 a.m., the assistant director of nursing was asked what personal protective equipment should be worn when caring for a resident in quarantine. She stated gloves, gown, mask, and eye protection. She stated they should change gloves, wash their hands, and clean their eye protection between each resident. She was asked about a certified medication aid who had entered two resident rooms, while passing medications, on the quarantine unit without changing her gown or wearing eye protection. The assistant director of nursing stated she did not think they had to change gowns between resident care. She stated the certified medication aid wore glasses and she thought that was sufficient eye protection. She was asked about personal protective equipment supplies on the unit. She stated they had just removed three drawer chests out of the unit and had placed one outside the unit for staff to put on before entering the quarantine unit. She was asked how staff were supposed to access supplies between resident care if there were no supplies inside the unit. She stated they would have to go out of the unit and come back in. 2. On 08/25/20 at 11:25 a.m., licensed practical nurse #1 was observed to put on gloves check resident #7's finger stick blood sugar. She removed her gloves after cleaning the glucometer and put on new gloves. She checked resident #2's finger stick blood sugar and cleaned the glucometer and removed her gloves. She did not sanitize her hands. She was asked when she should change gloves and sanitize/wash her hands. She stated she always changed her gloves but she waited to wash or sanitize her hands until after two residents finger stick blood sugars had been checked. At 12:15 p.m., certified medication aid #2 was observed to give resident #8 medication. She did not wear gloves and after giving resident #8 her medication she did not sanitize/wash her hands. She went to the medication cart. She texted on her phone, touched the computer, and opened the med cart and obtained resident #9's medication. She did not put on gloves or sanitize her hands. She gave the resident his medication, pulled his mask up over his nose, and raised his geri-chair up. She went to the sink and washed her hands. Certified medication aid #2 was asked when she should wear gloves when providing resident care. She stated she did not know. She stated the rules changed all of the time. She was asked when she should sanitize/wash her hands. She stated she sanitized/washed her hands after giving medications to three residents. On 08/26/20 at 10:44 a.m., the assistant director of nursing was asked when staff should change their gloves and sanitize/wash their hands when providing resident care. She stated staff should change their gloves and sanitize/wash their hands between each resident. 3. On 08/26/20 at 9:40 a.m., the surveyor observed a three drawer chest outside of the quarantine hall. The chest contained gloves, one washable gown, surgical masks, booties, and face shields. The surveyor put

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) on personal protective equipment to enter the quarantine unit. There were closed doors and then a black plastic zippered barrier prior to entering the unit. Certified medication aid #1 was observed coming out of a resident room rolling an over bed table with a glass of water, an open cup with something white inside, a pulse ox, and a blood pressure cuff. She had a gown on and an N95 mask. She did not have a face shield or goggles on. She was wearing glasses. She did not take off her gown prior to leaving the resident's room. The certified medication aid rolled the over bed table halfway down the hall to the medication cart. She cleaned the pulse ox and blood pressure cuff. She obtained the next resident's medication and pushed the cart down the hall to the next resident's room. She wore the same gown and entered the room without wearing a face shield. She wore the same N95 mask into the room. She entered the resident's room rolling the over bed table with a medication cup with medication in it, two cups of water which were open to air, an open cup with something white inside, a pulse ox and a blood pressure cuff. She came out of the resident's room and did not remove her gown. She did not have a face shield or goggles on. The certified medication aide was asked if she knew what personal protective equipment should be worn when entering a resident's room, who was in quarantine. She stated she had not been changing gowns between residents. She stated there were no face shields or gowns on the hall. She stated she thought she was supposed to wear a face shield, a gown, a mask, and gloves. She was asked what was in the cup on her cart that contained something white. She stated those were cleaning wipes she had taken out of the container on the med cart so she did not bring the wipe container in and out of rooms. She was not observed getting a new cup with wipes when entering resident rooms to give medication. There were no supplies observed on the unit or outside resident rooms. There were no red bags observed in resident rooms. There were two boxes observed next to the black plastic zippered barrier. There were no red bags in the boxes. One box contained soiled gowns and one box contained trash and soiled surgical face masks. At 10:00 a.m., certified nurse aid #1 was observed standing in the hall on the quarantine unit. She was asked if she knew what personal protective equipment should be worn when entering a resident's room, who was in quarantine. She stated she was supposed to wear a gown, gloves, face mask, and a face shield. She was asked if she was changing her personal protective equipment when she went in and out of resident rooms on the unit. She stated she had been told not to change her gown. She stated she was told to wipe off her gown with sani-wipes between residents. She stated she had not seen any face shields on the unit so she had not been using a face shield when caring for residents. At 10:44 a.m., the assistant director of nursing was asked what personal protective equipment should be worn when caring for a resident in quarantine. She stated gloves, gown, mask, and eye protection. She stated they should change gloves, wash their hands, and clean their eye protection between each resident. She was asked about a certified medication aid who had entered two resident rooms, while passing medications, on the quarantine unit without changing her gown or wearing eye protection. The assistant director of nursing stated she did not think they had to change gowns between resident care. She stated the certified medication aid wore glasses and she thought that was sufficient eye protection. She was asked about personal protective equipment supplies on the unit. She stated they had just removed three drawer chests out of the unit and had placed one outside the unit for staff to put on before entering the quarantine unit. She was asked how staff were supposed to access supplies between resident care if there were no supplies inside the unit. She stated they would have to go out of the unit and come back in.