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 _____	08/05/2020

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 14 (#1 through #14) of 14 sampled residents. The facility failed to: a) Ensure washable isolation gowns were not worn by multiple staff members to provide care to residents and were not worn between residents. b) Ensure residents medications for administration were not carried into multiple resident rooms. c) Ensure the staff washed their hands between resident care while administering medications. d) Ensure crates with resident food snacks were not stored on the floor and staff disinfected the crate before putting the them on a table. e) Ensure residents wore face masks when out of their rooms on the memory unit. f) Ensure residents who ate in a dining area were social distanced during meals. g) Ensure a specimen cup that held sanitizer was not taken out of a quarantine (isolation) room; and h) Ensure residents were monitored for all possible COVID-19 symptoms as required. The facility identified 99 residents lived in the facility. Findings: The Center for Disease Control guidance titled, Preparing for COVID-19 in Nursing Homes documented, HCP (health care providers) should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others . Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room . Actively monitor all residents upon admission and at least daily for fever (T.100.0 F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions . Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0 F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 . Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection. Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any with new symptoms . Implement aggressive social distancing measures (remaining at least 6 feet apart from others): Cancel communal dining and group activities, such as internal and external activities. Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene . If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 . 1. On 08/04/20 at 10:21 a.m., on the 400 hall, yellow gowns were hanging just inside the doorway in the residents' rooms. This hall was not the quarantine (isolation) or COVID positive halls. At 10:25 a.m., certified nurse aide (CNA) #1 was asked about the yellow gowns that were hanging in the residents' rooms. She stated the gowns were for the staff members to put on after going into the residents' rooms to provide care to the residents. She was asked was there one gown in the room to wear while providing care to the two residents. She stated no there was two gowns in the residents' rooms to provide care to both residents. She stated the position of the hanging gowns was in reference to the resident's beds. She stated there was one gown per resident. She stated multiple staff members wore the same gowns to provide care to residents. She stated the gowns were washable. She was asked how often the gowns were washed. She did not know how often the gowns were washed. On 08/04/20 at 12:22 p.m., CNA #1 took a meal tray into the room of resident #13. The CNA then put on a yellow isolation gown that had been hanging by the room door. She reentered the resident's room area, assisted the resident to sit up on the side of the bed. The CNA then without washing her hands hung the yellow isolation gown back up by the door and exited the room. On 08/05/20 during an interview which started at 12:15 p.m., with the administrator, director of nursing (DON), and assistant director of nursing (ADON), they were asked why washable isolation gowns were hung in the residents' rooms on the 400 hall and worn by multiple staff members to provide care to the residents. The administrator stated the staff were not supposed to be using the gowns. She stated the gowns had been taken down multiple times. The DON stated staff had been told and educated multiple times not to use the gowns. 2. On 08/04/20 at 10:28 a.m., certified medication aide (CMA) #1 was observed in a yellow isolation gown and holding a blue tray, to come out of resident #4's room area and go into the room area of resident #1. The CMA did not wash/sanitize her hands between residents. At 10:32 a.m., the CMA walked out of the room of resident #4 and #1 with the yellow isolation gown on. She then walked back into the residents' room, took the yellow isolation gown off with one hand, hung the gown up with one hand, as she was holding the blue tray. She did not wash/sanitize her hands. She exited the room and immediately entered room of residents #5 and #6 holding the same blue tray. She did not wash/sanitize her hands. She put on a yellow isolation gown. The CMA entered the room area of resident #5 with the blue tray. At 10:37 a.m., the CMA came out of side of the room of resident #5 and then without washing/sanitizing her hands entered the room side for resident #6. The CMA walked out of the room side for resident #6 and stated she had one glove. She went into the bathroom washed her hands, put on gloves, and re-entered the side of the room of resident #6. At 10:39 a.m., she exited the side of the room of resident #6 she was holding a blue tray. The CMA went into the bathroom and then came out of the bathroom without the blue tray. The CMA took off and hung the yellow isolation gown up on the hall on the right side of the room door. She went back into the bathroom, washed her hands, and exited the room with the blue tray. The CMA's glasses were on the tray. At 10:44 a.m., the CMA verified she had worn the gowns in the rooms of all four of the residents. She stated she should have changed her gowns between residents. She stated she had fluids and medications on the blue tray for all four of the residents. She stated she was not supposed to do that and was trying to catch up on her medication pass as it had been a busy morning. She stated she had held the blue tray when she went into the residents' rooms. She stated she had washed the blue tray with soap and water when she went into the bathroom and washed her hands. She stated she usually wiped the blue tray down with alcohol wipes. 3. On 08/04/20 at 11:03 a.m., a brown plastic crate was on the floor, in the hallway, outside of resident room [ROOM NUMBER]. The crate had individually packaged cereals, apple sauces, crackers, and snack packs. On 08/04/20 at 12:46 p.m., on the quarantine hall, a black crate lined with a plastic bag was on the floor in the hallway. The crate had individual sized servings of applesauce and fruit juices. CNA #3 was asked what was in the crate. She stated it was resident snacks and the crate was not usually on the floor. She stated it was usually on the table and she pointed to a table beside the crate. At 12:47 p.m., LPN entered the quarantine hall, picked up the crate and without cleaning/sanitizing the crate put the crate on top of the table. On 08/05/20 during at 12:15 p.m., the administrator, DON, and ADON, were asked why the crates which held residents' snacks were on the floor. The administrator stated the crates should be on the tables provided on the halls. 4. On 08/04/20 at 11:09 am., CMA #2 was at a medication cart she was wearing a cloth mask. The CMA was asked if she was wearing a cloth mask. She stated, yes. She stated, the masks had two filters in the mask as she felt more comfortable that way. On 08/04/20 at 11:45 a.m., CNA #2 was wearing a cloth mask. The CNA was asked if she was wearing a cloth mask. She stated yes and there were two filters in the mask. On 08/05/20 during an interview which started at 12:15 p.m., with the

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) administrator, DON, and ADON, the administrator stated she thought the cloth masks were ok if they had filters. 5. On 08/04/20 at 11:38 a.m., there were six residents sitting in the memory unit TV area without face masks on. No staff members were heard to ask/encourage the residents to wear facial masks. At 11:43 a.m., licensed practical nurse (LPN) #1 was asked why the residents did not have face masks on their faces. She stated, that they had never been told to put a face mask on the residents. On 08/05/20 during an interview which started at 12:15 p.m., with the administrator, DON, and ADON, were asked why the residents in the memory unit were not wearing face masks when out of their rooms. The DON stated, she thought it would agitate the residents to wear the masks and they would try. 6) On 08/04/20 at 11:57 a.m., in the memory unit resident #7 was seated across a round table from resident #8 to eat their noon meals. The residents were not seated at least six feet apart from one another while eating. CNA #2 assisted resident #7 with her meal. The two residents' meals were served in square Styrofoam 'to go' containers. When the tops of the resident's food containers were opened the container tops were approximately three to four inches apart from each other. Residents' #9 and #10 were seated at a circular table across from one another for the noon meal. The residents were not seated at least six feet apart from one another while eating. The two residents meals were served in square Styrofoam 'to go' containers. When the tops of the resident's food containers were open the container tops were approximately three to four inches apart from each other. Residents' #11 and #12 were seated at a square table across from one another for the noon meal. The residents were not seated at least six feet apart from one another while eating. The two residents meals were served in square Styrofoam 'to go' containers. When the tops of the resident's food containers were open the container tops were approximately four inches apart from each other. On 08/04/20 at 12:05 p.m., LPN #1 was asked if the six residents that were eating together at the three different tables were six feet apart from one another. She stated, probably not. The LPN was asked why the residents' were not seated six feet apart. She stated, she had not really ever thought about it. CMA #3 stated, it would be hard as the residents had dementia. The LPN was asked should the staff at least attempt to social distance the residents. She stated, yes. On 08/05/20 during an interview which started at 12:15 p.m., with the administrator, DON, and ADON, they were asked why the residents in the memory unit were not social distanced while eating. The DON stated, they would need to add more tables to the unit. 7) On 08/04/20 at 12:58 p.m., CMA #4 entered the room of resident #14 and obtained the resident's blood pressure (BP) (with a wrist BP cuff), pulse ox, and temperature. After obtaining the resident's vital signs. The CMA wiped the pulse ox and thermometer and took them to the resident's bathroom. The CMA exited the bathroom, removed his shoe protectors, gown, and gloves. He went into the bathroom and turned the water on. He exited the room with the thermometer, wrist BP cuff, the pulse ox, and a specimen cup with a green lid. He placed the specimen cup on top of the medication cart. At 1:03 p.m., CMA #4 was asked what he had used when he wiped the BP cuff, thermometer, and pulse ox. He stated the sanitizer on gauze 4x4s in the specimen cup. He was asked where he had placed the specimen cup when he was in the residents' room. He stated on the resident's bedside table, then into the resident's bathroom to clean the BP cuff, thermometer, and the pulse ox, and then placed on the top of the medication cart. On 08/05/20 during an interview which started at 12:15 p.m., with the administrator, DON, and ADON, they were asked what was the process for sanitizing the thermometer, pulse ox, and BP cuff after resident use. The DON stated, to sanitize the equipment before leaving the resident's room after resident use. 8) On 08/05/20 residents' 07/2020 electronic records were reviewed for the monitoring of possible COVID-19 symptoms (besides the residents temperatures and pulse ox) for residents #1, #2, and #3. There were multiple days and/or times that there was no documentation of the monitoring of possible COVID-19 symptoms (besides the residents temperatures and pulse ox) on the residents' treatment monitoring sheets and/or in the nurses progress notes. Theses records were reviewed with the DON. Resident #2 was admitted to the hospital on [DATE]. There was documentation on the 07/2020 treatment monitoring sheet that the resident was assessed for possible COVID-19 symptoms five times after the resident was admitted to the hospital. Resident #3 was admitted to the hospital on [DATE]. There was documentation on the 07/2020 treatment monitoring sheet that the resident was assessed for possible COVID-19 symptoms two times after the resident was admitted to the hospital. On 08/05/20 during an interview which started at 12:15 p.m., with the administrator, DON, and ADON, they were asked how often the residents needed to be monitored for possible symptoms of COVID-19. The DON stated twice in 24 hours and the residents' temperatures were taken three times a day. They were asked why the residents were not being monitored that frequently and were shown some of the blanks on the residents' treatment monitoring sheets. The DON stated, she thought the assessments were being done but the nurses were just not documenting the assessments.