

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/14/2024
NAME OF PROVIDER OR SUPPLIER  Emerald Care Center Midwest		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 Parklawn Drive Midwest City, OK 73110	

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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>45462</p> <p>Based on record review and interview, the facility failed to ensure a resident's critical post discharge medical equipment was ordered and received in a timely manner for one (#1) of two sampled residents whose discharge planning process was reviewed.</p> <p>The DON identified 65 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #1 was admitted to facility on 04/17/24 with diagnoses that included Parkinsonism, traumatic subdural hematoma, and depression.</p> <p>A 'Notice of Medicare Non-Coverage', was signed by Resident #1 on 04/29/24.</p> <p>A Nursing Progress Note, written 05/02/24, documented Resident #1 was discharged home with family.</p> <p>A Physician's Progress Note, submitted to the DME company, read in parts, .Without a wheelchair, the patient has a higher risk of morbidity or mortality in [their] attempts to complete [their] MRADLs . It was not signed by NP #1 nor submitted to the DME company until 05/09/24.</p> <p>A prescription for billing and dispensing of a standard wheelchair for Resident #1 was not signed by NP #1 nor submitted to the DME company until 05/09/24.</p> <p>There was no documentation in Resident #1's clinical record that any attempts were made to ensure Resident #1's wheelchair was ordered prior to their discharge from the facility.</p> <p>There was no documentation in Resident #1's clinical record that any attempts were made to follow up with Resident #1 or their family to ensure the wheelchair was received after it was ordered on 05/09/24.</p> <p>On 06/12/24 at 1:15 p.m., Resident #1's family member stated they still did not have a wheelchair for the resident and, despite leaving several messages for Social Services Dir., they never got a call back.</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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/13/24 at 9:44 a.m., Social Services Dir. was asked if post discharge medical equipment had been ordered for Resident #1 prior to their discharge from facility. They stated yes it had but they had failed to document any attempts and had shredded all related documents. Social Services Dir. was asked if any attempts were made to follow up with Resident #1 or their family to ensure they received the wheelchair once it was ordered on 05/09/24. They stated, Once the DME company said they were delivering it, I took a vacation and I didn't think anymore of it. Social Services Dir. was asked when does the facility's responsibility to the discharged resident end. They stated, After everything is in place.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462</b></p> <p>Based on record review and interview, the facility failed to administer medications and treatments in a timely manner for two (#4 and #5) of six residents reviewed for receiving medications and treatments for scabies.</p> <p>The DON identified 65 residents resided in the facility.</p> <p>Findings:</p> <p>1. A Physician's Order for Resident #4, dated 05/29/24, read in parts, .Ivermectin Oral Tablet 3mg .give 7 tablets by mouth one time only for rash .</p> <p>Pharmacy Manifest #2761767, dated 05/31/24, documented Ivermectin 3mg tabs (7 tabs) were delivered to the facility on [DATE] at 7:20 p.m. and received by LPN #1.</p> <p>A printout of the medication administration history for Resident #4 documented Ivermectin 3mg tabs (7 tabs) were not administered until 06/06/24 at 3:58 p.m.</p> <p>There was a lapse of 140.25 hours (5 days and 20.25 hours) between the time Resident #4's medication was delivered to the facility and when it was administered.</p> <p>2. A Physician's Order for Resident #5, dated 06/11/24, read in parts, .Permethrin External Cream 5% .Apply to body-neck down topically one time only for rash for 2 Days .leave on for 8 hours and then shower .</p> <p>Pharmacy Manifest #2790737, dated 06/11/24, documented Permethrin Cream 5% was delivered to the facility on [DATE] at 7:09 p.m. and received by LPN #1.</p> <p>June 2024 MAR documented Permethrin Cream 5% treatment was not administered until 06/13/24 at 1:38 a. m.</p> <p>There was a lapse of 30.5 hours (1 day and 6.5 hours) between the time Resident #5's medication was delivered to the facility and when the resident received treatment.</p> <p>On 06/14/24 at 11:05 p.m., the ADON was asked to review the Physician's Orders and medication administration documents for Resident #4 and Resident #5 mentioned above. After reviewing the documents, they acknowledged the medication for Resident #4 and the treatment for Resident #5 were not administered in a timely manner.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>45462</p> <p>Based on record review and interview, the facility failed to administer treatment as ordered for one (#5) of six sampled residents reviewed for receiving medication or treatment for scabies.</p> <p>The DON identified 65 residents resided in the facility.</p> <p>Findings:</p> <p>A Physician's Order, dated 06/11/24, read in parts, .Permethrin External Cream 5% .Apply to body-neck down topically one time only for rash for 2 Days .leave on for 8 hours and then shower .</p> <p>June 2024 MAR documented Permethrin Cream 5% was administered on 06/13/24 at 1:38 a.m.</p> <p>On 06/14/24 at 9:20 a.m., Resident #5 was asked if Permethrin Cream 5% had been applied to their body for a second time during the previous night and if they had been showered this am. Resident #5 stated, No, they only did it that one time. Resident #5 was asked if they still had itching or a rash. They stated yes and showed left arm and left chest to this surveyor. Several red, raised areas were observed on Resident #5's left arm and chest.</p> <p>On 06/14/24 at 9:28 a.m., CNA #1 was asked if Resident #5 had received a shower this morning to remove medication applied during the night. They stated the treatment was done on Wednesday night and Resident #5 was showered on Thursday morning. CNA #1 was asked if the treatment was done again last night. They stated no we were not told that it had been.</p> <p>On 06/14/24 at 11:05 a.m., the ADON was asked to review Resident #5's order for Premethrin Cream 5% and their June 2024 MAR. After review, the ADON acknowledged the treatment was not done for two days as prescribed.</p>