STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375098	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care Center Midwest	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review and interview, the facility failed to provide evidence a resident representative was notified after the resident experienced a fall for one (#7) of three sampled residents reviewed for falls. The wound care nurse identified 57 residents resided in the facility. The Incidents by Incident Type reports, dated 11/14/24, documented 30 residents experienced a fall for the months of September, October, and November 2024. Findings: A Notification of Changes policy, dated 01/24, read in part, It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or representative .When a resident is mentally competent, his or her designated resident representative or family, as appropriate, should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident .Requirements for notification of resident, the resident representative, their physician .An accident involving the resident, which results in injury and has the potential for requiring physician interventions Resident #7 had diagnoses which included unspecified atrial fibrillation and cardiomyopathy. Resident #7's admission record, dated original admitted [DATE], documented Resident Representative #1 was their legal guardian and first emergency contact. A Quarterly Resident Assessment, dated 11/04/24, documented Resident #7 had moderate cognitive impairment. A General Note, dated 11/04/24 at 12:56 p.m., documented the nurse was called to Resident #7's room and found the resident on the floor with a CNA beside them. It documented the CNA reported the resident fell while trying to get out of their bed. It documented the resident suffered a bruise to their right rib. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Change in Condition Evaluation form, dated 11/04/24, documented Resident #7 had experienced a fall on 11/04/24 associated with no or minor injury. The resident representative notification section was blank. The form was signed by LPN #1 on 11/11/24. There was no documentation Resident #7's representative was notified of the 11/04/24 fall which resulted in bruising to their right rib. On 11/15/24 at 8:12 a.m., the DON stated surveyors did not have access to incident reports because they were not part of resident charts. On 11/15/24 at 8:13 a.m., the DON stated the facility completed incident reports under risk management when a resident experienced a fall. They stated each nurse had access to the risk management, but surveyors did not have access. On 11/15/24 at 10:48 a.m., Resident #7 stated they had experienced less than three falls in the facility. They stated staff would check them over to see if they were ok after a fall. The resident stated they had a significant other whom the facility would contact if they experienced a change in condition. On 11/15/24 at 10:55 a.m., LPN #1 stated when a resident experienced a fall, the physician, family, DON and ADON would be notified. LPN #1 stated when Resident #7 experienced a fall on 11/04/24, they had left a message for the family to call the facility back. They stated the notification would be documented in risk management where they documented the incident. LPN #1 stated it was not documented in the electronic record anywhere else other than under risk management for this fall.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review and interview, the facility failed to ensure: a. incident reports involving residents were accessible to the SA for two (#1 and #7); and b. resident records were complete and accurate for two (#1 and #7) of three sampled residents reviewed for falls. The wound care nurse identified 57 residents resided in the facility. The Incidents by Incident Type reports, dated 11/14/24, documented 30 residents experienced a fall for the months of September, October, and November 2024. Findings: An Accidents and Incidents policy, dated 01/24, read in part, Accidents/incidents may include .Fall .A thorough investigation and follow-up will be completed within five working days. A summary of the accident/incident will be documented .Accident/incident will have documentation initiated by the individual witnessing, made aware of or involved in the occurrence as soon as discovered or reported. An Incident investigation is not punitive in nature, but simply an accurate, objective account of an occurrence .Incident investigations are completed for the purpose of complying with State and Federal regulations requiring an investigation of unusual incident .All unusual occurrences will be reported immediately to the Manager/Supervisor on call and Incident documentation completed .Complete an Accident/Incident documentation if the accident/incident occurred to any of the following persons .resident .Obtain and record vital signs .Document final Incident Follow Up and summary .Document the occurrence in the Nurse's Notes of resident/patient. Document only objective facts such as .Date .Time .Person involved .Where accident/incident occurred .Who first noticed accident/incident .Where involved person positioned . Assistance given .Objective findings of physical examination .Names of persons notified .Interview affected person .witnesses .review medication regimen .Provide follow-up and resolution to the investigation .Record the disposition on the Incident documentation 1. Resident #1 had diagnoses which included unspecified anemia, tremor, and hypertension. A Summary for Providers note, dated 08/22/24, documented the reason for evaluation were falls. The Fall Scene Investigation report, dated 08/23/24, had blanks for number 27, 28, and 29 and the form was not signed by the person who completed it. The Fall Risk Evaluation form, dated 08/23/24, had no information filled out and was not signed by a staff member. There was no incident report provided to the surveyor for Resident #1's fall on 08/22/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A General Note, dated 08/24/24, read in part, Resident on shower chair washing off began to reach for faucet to turn off water then chair rolled back and [they] slid off of chair onto floor, D.O.N. and On call Physician notified . There was no incident report, change in condition evaluation, fall scene investigation report, fall risk evaluation, or pain evaluation documentation provided for Resident #1's fall on 08/24/24. The Monthly Falls Tracking form, dated 08/2024, documented Resident #1 experienced a non-injury fall on 08/22/24 and 08/24/24. There was an x in the column underlying chronic medical conditions and environmental issues for the 08/22/24 fall. There was an x in the column history of falls, underlying chronic medical conditions, and environmental issues for the 08/24/24 fall. The comments section for the 08/22/24 fall documented going to the bathroom and patient thinks (they) slipped on water. The comments section for the 08/24/24 fall documented [Resident #1] was sitting on the shower chair and reach for. There was no additional information in the comment section for the falls. On 11/14/24 at 9:52 a.m. a confidential interview was held. During the interview, it was reported Resident #1 had experienced a fall at the facility in the shower room with no staff present. On 11/14/24 at 1:16 p.m., the DON stated the information dated 08/23/24 was for Resident #1's fall on 08/22/24. They stated the fall had occurred at 11:16 p.m. on 08/22/24 and the nurse documented it as soon as they could. The DON acknowledged the fall risk evaluation form was not signed by anyone, but reported it was completed by LPN #4 who no longer worked at the facility. The DON stated they knew it was an unwitnessed fall without injury. They stated the resident reported water on the floor, but when the CNA was interviewed there was no water on the floor. On 11/14/24 at 1:23 p.m., the DON stated CNA #2 was present in the shower room when Resident #1 fell on [DATE]. On 11/14/24 at 1:28 p.m., CNA #2 stated they assisted Resident #1 with a shower on 08/24/24. They stated the resident was insistent they could do things themselves, however CNA #2 stated they explained to the resident staff had to be present in the shower. CNA #2 stated they assisted the resident into a shower chair and assisted the resident with completing a shower. CNA #2 stated they had pivoted to reach for a towel and Resident #1 reached to turn the water off. CNA #1 stated the water was already off, but when the resident had reached, they fell out of the shower chair onto the floor. They stated they called for the nurse who assessed the resident and got them off the floor. CNA #2 stated the resident did not experience an injury and staff kept close watch over them the rest of the shift. On 11/14/24 at 1:43 p.m., LPN #2 stated on 08/24/24 Resident #1 was taking a shower with the CNA present. LPN #2 stated they had stepped into the shower room at one point also because the CNA had to grab supplies. LPN #2 stated when the CNA returned, they left the shower room to complete an admission. They stated less than five minutes later, the CNA reported the resident had slipped while trying to turn off the shower. LPN #2 stated they assessed the resident who was on the floor in front of their shower chair. They stated the resident did not experience any injuries. LPN #2 stated the resident was embarrassed and stated it was their fault. LPN #2 stated the resident was their own responsible party and did not want family notified of the event. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/24 at 1:57 p.m., the DON was asked for Resident #1's IR for the 08/24/24 fall. The DON stated, That's all I have on that particular fall. They stated the nurse who was present was still employed at the facility. The DON stated the fall tracker had things they transcribed from the IR itself. The DON stated the IR was not part of the resident's chart and the surveyor was not permitted access to them. They stated the IR was what the facility used to investigate it. The DON referenced the general note dated 08/24/24. On 11/14/24 at 2:04 p.m., the DON stated the 08/24/24 general note did not documented who was present at the time of the fall, if the resident experienced any injuries, or any assessment completed on the resident. On 11/14/24 at 2:24 p.m., LPN #3 stated when a resident experienced a fall the nurse would complete a head to toe assessment to determine if there were any injuries. They stated they were not aware of any falls experienced on their shift by Resident #1. On 11/15 24 at 8:10 a.m., the DON stated when a resident experienced a fall, the nurse on duty would complete an assessment, provide first aide if needed, obtain vital signs, assist the resident back into a wheelchair if no major injury had occurred, and notify the physician and family. They stated neurological checks would be completed on any unwitnessed fall and staff would also complete 72 hour charting after a fall. The DON stated they encouraged staff to chart the information in a progress note. On 11/15/24 at 8:12 a.m., the DON stated the charge nurse would also complete an incident report. They stated surveyors were not permitted access to incident reports because they were internal and not part of residents' charts. On 11/15/24 at 8:13 a.m., the DON stated the facility completed incident reports under risk management when a resident experienced a fall. They stated each nurse had access to the risk management, but surveyors did not have access. On 11/15/24 at 8:15 a.m., the DON stated risk management triggered forms when staff completed the incident report. They stated a change in condition, fall risk evaluation, fall scene investigation, and pain would trigger. They stated all four forms would meet what was required on an incident report form. The DON stated the fall scene investigation gave a description like an incident report. They stated it provided how the resident was found and what happened. They stated the fall summary triggered them as to why the resident fell getting to the root cause. On 11/15/24 at 8:17 a.m., the DON stated on the fall scene investigation form number 27 would document what caused the fall, 28 would documented the conclusion of the investigation and what the facility could do to prevent the next fall, and 29 would document the care plan or updates nurse aides could do. The DON reviewed Resident #1's form dated 08/23/24 and stated the nurse had not completed the form. On 11/15/24 at 8:19 a.m., the DON explained the blank fall risk evaluation form for Resident #1 dated 08/23/24, was supposed to evaluate cognition, history of falls, how they ambulated, whether they were continent, their gait, high risk for falls, and asked questions on the resident's health and assistance they needed. The DON stated there were no forms completed for Resident #1's 08/24/24 fall. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/15/24 at 8:21 a.m., the DON stated the facility used the change in condition form to document the resident's finger sticks and any behaviors. They stated a change in condition form was not completed for Resident #1's 08/24/24 fall. The DON stated when they spoke to the nurse they did not know they were supposed to complete the forms. On 11/14/24 at 8:25 a.m., the DON was asked to review the facility's incident report policy and explain where the above four referenced forms were in the policy. The DON stated the forms were not listed in there specifically. The DON was asked how staff would know what to fill out. They stated when staff completed the risk management, at the bottom of the incident report it would have at least one to four forms to fill out. The DON stated the four forms would populate to the resident's chart. 2. Resident #7 had diagnoses which included unspecified atrial fibrillation and cardiomyopathy. Resident #7's admission record, dated original admitted [DATE], documented Resident Representative #1 was their legal guardian and first emergency contact. A Quarterly Resident Assessment, dated 11/04/24, documented Resident #7 had moderate cognitive impairment. A General Note, dated 11/04/24 at 12:56 p.m., documented the nurse was called to Resident #7's room and found the resident on the floor with a CNA beside them. It documented the CNA reported the resident fell while trying to get out of their bed. It documented the resident suffered a bruise to their right rib. It documented vital signs 147/63 pulse 75, oxygen saturation 97, and pain was zero. A Change in Condition Evaluation form, dated 11/04/24, documented Resident #7 had experienced a fall on 11/04/24 associated with no or minor injury. It documented yes to the question are these the most recent vital signs taken after the change in condition occurred: blood pressure 166/105 dated 11/11/24, most recent pulse 75 dated 11/11/24, most recent respiration 18 dated 10/30/24, most recent temperature 97.4 dated 10/30/24, most recent oxygen saturation 97 percent dated 10/30/24. Under the section functional status evaluation the vital signs area was blank. It documented the primary care clinician was notified on 11/04/24 at 10:00 a.m. The resident representative notification section was blank. The form was signed by LPN #1 on 11/11/24. A Fall Scene Investigation report, effective date 11/11/24, documented Resident #7 slipped and experienced a fall to the floor. It documented a statement from the CNA who observed and/or assisted the resident during the three hours prior to the fall to re-create the life of the resident before the fall. The box documented N/a and the following box documented a first name for the CNA. The form was signed by LPN #1 on 11/11/24. The Monthly Falls Tracking form, contained multiple different month/dates, documented Resident #7 experienced a fall on 11/04/24. The sections activity prior to fall, fall resulted in injury, injury type, treatment location, injury detail description, post fall evaluation components and comments were all blank. There was no incident report provided to the surveyor for this fall. On 11/15/24 at 8:12 a.m., the DON stated surveyors did not have access to incident reports because they were not part of resident charts. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/15/24 at 10:10 a.m., the DON stated the facility did not have a policy for state surveyor access to medical records or complete and accurate records. They stated risk management was internal. The DON stated everything the incident reports consisted of were in the fall tracker. On 11/15/24 at 10:48 a.m., Resident #7 stated they had experienced less than three falls in the facility. They stated staff would check them over to see if they were ok after a fall. The resident reported they had a significant other whom the facility would contact if they experienced a change in condition. On 11/15/24 at 10:55 a.m., LPN #1 stated when a resident experienced a fall, the physician, family, DON and ADON would be notified. LPN #1 stated when Resident #7 experienced a fall on 11/04/24, they had left a message for the family to call the facility back. They stated the notification would be documented in risk management where they documented the incident. LPN #1 stated it was not documented in the electronic record anywhere else other than under risk management for this fall.