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	06/15/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, record review, and interview, the facility failed to ensure residents had access to the grievance procedure and file an anonymous grievance.The DON identified 61 residents resided in the facility.Findings:On 06/10/26 at 4:11 p.m., a tour of the facility was completed. There was no information regarding the facility's grievance procedure or location of grievance forms.On 06/15/26 at 9:44 a.m., CNA #1 with the DON's assistance located grievance forms in the copier room in an open cabinet on the wall by the DON's office.On 06/15/26 at 9:54 a.m., grievance forms were located in a file cabinet at the nurse's station. The cabinet had other facility forms. There was no information to show the grievance forms were located in the file cabinet. A policy titled Grievance Policy, dated 01/2024, read in part, The facility will inform residents orally and in writing of their right to make Complaints and Grievances and the process to do so during admission, readmission and the care planning process.On 06/15/26 at 9:45 a.m., the DON stated the copier room was not locked and residents had access to the grievance forms. The DON stated a resident in a wheelchair would not have access to the forms.On 06/15/26 at 9:46 a.m., CNA #1 stated they had not seen any posted grievance process in the facility.On 06/15/26 at 9:47 a.m., the social services director stated they were responsible for grievances in the facility.On 06/15/26 at 9:50 a.m., the social services director stated they could not locate the facility's grievance process or who the grievance official was in the admission agreement. On 06/15/26 at 9:52 a.m., the social services director stated they were not sure if a resident could file an anonymous grievance.On 06/15/26 at 9:54 a.m., the social services director stated the grievance forms were located in the copier room, in their office, and behind the nurse's station.On 06/15/26 at 9:58 a.m., the social services director stated the facility's grievance procedure was not posted.On 06/15/26 at 10:03 a.m., the administrator was unable to locate a posted facility grievance procedure.

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to:a. develop a comprehensive person-centered care plan, andb. include the resident and/or representative for care planning for 1 (#3) of 11 sampled residents whose care plans were reviewed.The administrator identified 61 residents resided in the facility.Findings:A policy titled Care Plan Process, revised 09/2019, read in part, When a resident is discharge return not anticipated, returns at a later date, the care plan must be re-written, and the dates must change.Every effort will be made to involve the resident and family or responsible party in the development, implementation, maintenance, and evaluation of the resident plan of care.A minimum data set entry for Resident #3, dated 03/27/26, was completed for Discharge Return Not Anticipated. A comprehensive care plan for Resident #3, dated 02/20/26, was canceled on 04/09/26 due to the resident's discharge.A minimum data set entry for Resident #3, dated 04/13/26, showed the resident was readmitted to the facility with diagnoses which included urinary tract infection, malignant neoplasm of duodenum, type 2 diabetes mellitus without complications, and chronic obstructive pulmonary disease. A care plan for Resident #3, dated 04/15/26, showed two care planned areas for nutrition and activities. The care plan did not address all the aspects of the resident's care. On 06/11/26 at 1:19 p.m., the unit director stated Resident #3 should have had a comprehensive care plan to address the needs of the resident after admission on [DATE], but did not.On 06/11/26 at 1:31 p.m., the social services director stated Resident #3's comprehensive care plan had not been developed to address all their needs.On 06/11/26 at 2:25 p.m., the social services director stated there should have been a care planning meeting for Resident #3 after admission on [DATE], but one had not been completed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide adequate supervision to prevent an elopement for 1 (#6) of 3 sampled residents reviewed for elopement. The DON identified two residents at high risk for elopement. Findings:A care plan for Resident #6, dated 11/01/24, showed the resident was an elopement risk. Interventions shown for elopement were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and or a book. A quarterly comprehensive assessment for Resident #6, dated 06/17/25, showed the resident was admitted to the facility on [DATE] with a diagnosis of dementia. The assessment showed Resident #6 had a brief interview for mental status score of 1, which indicated severe cognitive impairment. An incident report, dated 07/01/25, read in part, [Resident #6] was observed by a visitor sitting in the facility's south parking lot in a wheelchair. The visitor alerted staff of [Resident #6's] where abouts, the staff immediately went to [Resident #6] in the parking lot to bring [them] back into the facility. A nurse's note, dated 07/01/25, read in part, Patient [Resident #6] was found in the parking lot of the care center, patient was taken back in and assessed for injuries i [sic] have contacted PCP [name withheld] and daughter [name withheld] about elopement from facility. An elopement in-service document, dated 07/01/25, showed staff were educated about the elopement policy and how to prevent and respond to an elopement. An elopement risk assessment, dated 07/01/25, showed Resident #6 was reassessed for elopement risk post elopement. A review of an elopement risk binder, located at the nurse's station, showed two residents at risk for elopement. A review of the facility's Quality Assurance and Performance Improvement agenda, dated 09/24/25, showed the facility met and discussed Resident #6's elopement and potential elopement of other residents. On 06/11/26 at 9:50 a.m., CNA #3 stated they had received training on elopement prevention and response. On 06/11/26 at 10:03 a.m., CMA #2 stated they had received training on elopement prevention and response. On 6/11/26 at 11:19 a.m., LPN #1 stated Resident #6 followed a family outside in July of 2025. They stated the resident was found unharmed in the parking lot by a visitor. LPN #1 stated Resident #6 was brought inside and assessed, and an elopement in-service was completed.On 06/11/26 at 11:46 a.m., the DON stated Resident #6 was alert and oriented to self only when they eloped. They stated the activity director had excused themselves from the front lobby for approximately 10-15 minutes while Resident #6 had been sitting up front. Upon returning to the front lobby Resident #6 was not present. The DON stated a visitor came inside and alerted the facility that Resident #6 was sitting outside in their wheelchair. They stated the resident was brought back inside, assessed, and physician and family were notified. The DON stated Resident #6 was unharmed. They stated the resident's care plan was updated, and staff was educated on elopement. On 06/12/26 at 9:57 a.m., the DON stated residents were assessed for elopement risk on admission and with any changes. They stated only Resident #6 had been reassessed for elopement risk following their elopement. The DON stated to ensure safety from elopement for all other residents, the facility placed a sign on the door stating that no visitor may let anyone out with them and updated the elopement binder.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to administer intravenous medication as ordered for 1 (#2) of 4 sampled residents reviewed for medication administration.The DON identified 61 residents resided in the facility and one resident received intravenous medication.Findings:A policy titled Medication Administration and General Guidelines, dated 2021, read in part, Medications are administered as prescribed.A physician's order for Resident #2, dated 06/05/26, showed ampicillin sodium (antibiotic medication) injection. Use two grams intravenously every six hours due to cellulitis for 10 Days.A 06/2026 treatment administration record showed the 12:00 p.m. dose of ampicillin was not administered on the 06/06/26. The record showed to see nurse's notes.A nursing note for Resident #2, dated 06/06/26 at 6:23 p.m., showed the ampicillin order was on the medication administration record but then switched to the treatment administration record.On 06/10/26 at 6:44 p.m., LPN #2 stated they did not administer the intravenous ampicillin medication because it did not alert the nurse to administer the medication at 12:00 p.m. LPN #2 stated the medication should have been transcribed under the treatment record so nurses would have been alerted to give it.On 06/11/26 at 1:15 p.m., the DON stated medications were transcribed into the electronic health system and administered as ordered. The DON stated they were aware of the missed medication for Resident #2.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide laboratory services as ordered by a physician for 1 (#1) of 3 sampled residents reviewed for laboratory services. The DON identified 61 residents resided in the facility. Findings:A facility policy titled Laboratory Services and Reporting, revised 02/03/23, read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law.A physician's order for Resident #1, dated 05/28/26, showed the resident was to have a CBC and CMP drawn weekly on Sundays.A review of Resident #1's electronic medical record did not show any results for a CBC or CMP on (Sunday) 05/31/26 or (Sunday) 06/07/26.An admission assessment for Resident #1, dated 06/04/26, showed the resident was admitted to the facility on [DATE] with diagnoses which included polycythemia vera (a blood cancer that causes the bone marrow to produce too many red blood cells), and surgical aftercare of the gastrointestinal system.On 06/11/26 at 1:56 p.m., LPN #5 stated the nurses entered laboratory orders into their laboratory provider's website and the provider would obtain blood draws from residents in the facility. LPN #5 stated they could not find any CBC or CMP results for Resident #1 in their system.On 06/11/26 at 2:04 p.m., the DON stated Resident #1 was to have a CBC and CMP completed weekly on Sundays, but they did not see the results in the system. On 06/11/26 at 2:18 p.m., the DON stated the facility nurse did not enter the CBC or CMP orders, so Resident #1 had missed their laboratory draws on (Sunday) 05/31/26 and (Sunday) 06/07/26.