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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375135 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/17/2024 |
| NAME OF PROVIDER OR SUPPLIER Emerald Care Center Southwest LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 5600 South Walker Oklahoma City, OK 73109 | |

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) |
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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>48344</p> <p>Based on observation and interview, the facility failed to ensure ADL assistance was provided in a timely manner for one (#7) of four resident call lights observed for staff assistance in a timely manner.</p> <p>The administrator identified 51 residents resided in the facility.</p> <p>Findings:</p> <p>The Call Lights: Accessibility and Timely Response-Physical Environment policy, dated 01/24, read in part, . All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified .</p> <p>A Nursing Admission Data Collection dated 05/16/24, documented Resident #7 had functional limitation on both lower extremities and they required one person substantial max assist for bed mobility.</p> <p>On 05/17/24 at 5:23 a.m., two call lights were observed on hall 200.</p> <p>On 05/17/24 at 5:41 a.m., LPN #2 and RN #1 were observed at the nurse's station while the call lights were on. Both call lights on hall 200 were not answered at this time.</p> <p>On 05/17/24 at 5:46 a.m., LPN #2 answered one of the call lights on hall 200. Resident #7's call light was not answered.</p> <p>On 05/17/24 at 5:51 a.m., CNA #1 walked past Resident #7's room. The call light was not answered.</p> <p>On 05/17/24 at 5:52 a.m., LPN #2 answered Resident #7's call light. The resident informed LPN #2 they needed assistance to get off the bed pan. LPN #2 informed the Resident they would get help and walked out. The call light was left on.</p> <p>On 05/17/24 at 5:55 a.m., CNA #1 and CNA #2 walked past Resident #7's room. The Resident did not receive assistance at this time. The call light was still on.</p> <p>On 05/17/24 at 6:01 a.m., CNA #1 walked past Resident #7's room. The call light was not answered.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 05/17/24 at 6:05 a.m., CNA #5 answered Resident #7's call light. The Resident informed CNA #5 they needed assistance to get off the bed pan. CNA #5 informed the Resident they would be back to assist. CNA #5 turned off the Resident's call light and walked out of the room.</p> <p>On 05/17/24 at 6:09 a.m., CNA #1 and CNA #5 went to assist Resident #7 off the bed pan. Urine was noted in the bed pan.</p> <p>On 05/17/24 at 6:10 a.m., Resident #7 told CNA #1 and CNA #5 they had a broken back in three places and had been on the bed pan for so long. CNA #5 apologized to the resident.</p> <p>On 05/17/24 at 6:18 a.m., CNA #1 stated they should answer call lights within five to 10 minutes.</p> <p>On 05/17/24 at 6:22 a.m., CNA #1 stated they were not aware Resident #7's call light was on. They stated they became aware of the Resident's call light when CNA #5 requested assistance to help care for the Resident.</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>45583</p> <p>Based on observation, record review, and interview, the facility failed to administer pain and nausea medication as ordered in a timely manner for one (#6) of three sampled residents reviewed for medication administration.</p> <p>The Administrator identified 65 residents resided in the facility.</p> <p>A Medication Administration and General Guidelines policy, read in part, Medications are administered in accordance with written orders of the attending physician.</p> <p>A physician's order dated 05/13/24, documented Norco 10-325 mg every 6 hours as needed for pain.</p> <p>A physician's order dated 05/13/24, documented Ondansetron 4 mg every 6 hours as needed for n/v.</p> <p>Review of Resident #6 MAR did not document the administration of prn pain nor nausea medications.</p> <p>Resident #5 had diagnosis which included senile degeneration of the brain and dysphagia.</p> <p>On 05/17/24 at 5:46 a.m., Resident #6 was observed during incontinent care to slightly moan when moved and to vomit at the end of care.</p> <p>On 05/17/24 at 5:49 a.m., the residents roommate, Resident #5, whom was also the residents family representative, requested CNA #1 to ask for the resident to have medication for pain and nausea.</p> <p>On 05/17/24 at 6:24 a.m., Resident #6 stated they had not yet received their medication. They stated they were still in pain and were unable to rate the pain.</p> <p>On 05/17/24 at 6:26 a.m., Resident #5 stated they were still waiting on the medication. CNA #1 was in the room.</p> <p>On 05/17/24 at 7:19 a.m., observed LPN #1 at the medication cart outside the residents room preparing medication for an unknown resident. They stated they were working as a CMA that day.</p> <p>On 05/17/24 at 8:29 a.m., Resident #5 stated Resident #6 received their medication about 45 minutes prior.</p> <p>On 05/17/24 at 8:45 a.m., LPN #1 was asked if they had been informed of Resident #6 requesting medication. They stated, No.</p> <p>On 05/17/24 at 8:45 a.m., unable to locate the charge nurse for Resident #6.</p> <p>On 05/17/24 at 8:46 a.m., the DON was asked to check if Resident #6 had received any medication that morning. They stated the 7-11 am meds had been given by the CMA and that no PRN medication had been given.</p> <p>(continued on next page)</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>On 05/17/24 at 8:52 a.m., the DON and Administrator were made aware of the medication request made for Resident #6 at 05:49 a.m.</p> <p>On 05/17/24 at 9:13 a.m., LPN #1 stated they had given Resident #6 Norco and Zofran at 7:01 a.m., and that they were informed of the residents request at 6:30 a.m. They stated that when asked earlier they had thought of the wrong resident.</p> <p>On 05/17/24 at 11:00 a.m., LPN #3 stated an acceptable time frame for administration of prn pain medication was 20 minutes for mild to moderate pain and 5-7 minutes for moderate to severe pain. They stated an acceptable time frame for administration of a prn nausea medication was to be given immediately. The LPN #3 further stated a resident waiting an hour for nausea and pain medication was absolutely not acceptable.</p> <p>Resident #6 received their requested medications over an hour after it was requested.</p> |