

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/14/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview, the facility failed to ensure a resident was free from verbal abuse for 1 (#3) of 3 sampled residents reviewed for abuse. The admissions coordinator identified 72 residents resided in the facility. Findings: A policy titled Abuse, Neglect, and Exploitation, dated 11/17/24, read in part, Residents must not be subject to abuse by anyone. A quarterly comprehensive assessment for Resident #3, dated 05/23/26, showed they had a brief interview for mental status score of 14, which indicated they were cognitively intact. An incident report for Resident #3, dated 06/03/26, showed Resident #3 requested a peanut butter and jelly sandwich at lunch because they were not satisfied with the way their hamburger was cooked. The dietary manager yelled at Resident #3 stating, [They] should have asked for an alternative an hour ago! No, I won't make [them] a sandwich! The incident report showed another staff member intervened and Resident #3 received their peanut butter and jelly sandwich. Resident #3 took the sandwich to their room and cried. The dietary manager was immediately suspended pending the investigation and once verbal abuse was substantiated, they were terminated. A review of the abuse investigation for Resident #3 showed a sample of residents were asked to identify any experience with abuse in the facility. There were no additional reports of abuse. An in-service sign-in sheet, dated 06/05/26, showed all staff were educated on the facility's abuse policy and protocols. An Employee Status Report, dated 06/08/26, showed the dietary manager last worked on 06/03/26 and was terminated on 06/08/26. A quality assurance meeting agenda, dated 06/08/26, showed the quality assurance team met to discuss verbal abuse and measures to prevent future occurrence. On 07/13/26 at 12:10 p.m., CMA #1 stated they had not witnessed or heard any abuse and if they had, they would notify the DON or administrator immediately. They stated they were educated on abuse recently but could not recall the exact date. On 07/13/26 at 12:43 p.m., Resident #3 stated they remembered a cook was mean to them and made them cry. They could not remember the details. On 07/13/26 at 1:00 p.m., CNA #4 stated they were educated on abuse recently and often. They stated they had not witnessed or heard abuse and would report to DON or administrator immediately. On 07/13/26 at 2:21 p.m., the social services director stated they witnessed the dietary manager raising their voice at Resident #3 because they asked for an alternative at lunch time. They stated Resident #3 was tearful and they informed the dietary manager they would not speak to a resident in that manner. The social services director stated the dietary manager was immediately suspended and then terminated. They stated residents were asked about any potential abuse they may have experienced and there were no additional findings of abuse of any kind. The social services director sent their report into adult protective services who visited the facility shortly afterward and did their own investigation. On 07/14/26 at 9:00 a.m., CMA #2 stated they were educated on abuse routinely in the facility. On 07/14/26 at 10:44 a.m., CNA #3 stated they had not witnessed any abuse, but would report to charge nurse, administrator, or DON. They stated they were educated on abuse several times but did not recall specific dates.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 375135
		If continuation sheet Page 1 of 2

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to revise a care plan to include fall interventions for 1 (#3) of 3 sampled residents reviewed for fall interventions. The admissions coordinator identified 72 residents resided in the facility. Findings: A Fall Protocols Policy, dated 03/08/19, read in part, Residents experiencing an actual fall will have the following interventions: The care plan will be revised for any new fall prevention interventions. A care plan for Resident #3, dated 02/16/26, showed they were at risk for falls and would receive visual rounding from staff. The care plan showed Resident #3 would receive physical therapy or occupational therapy as needed. There were no additional fall interventions. An after visit summary for Resident #3, dated 05/03/26, showed they were seen in the emergency department for diagnoses of a closed head injury, contusion of the hip, and cervical strain sustained from a fall. On 07/13/26 at 12:37 p.m., LPN #1 stated the charge nurse would complete a fall data collection report after a resident had fallen. LPN #1 stated they could not locate any documentation for Resident #3's fall. On 07/13/26 at 2:30 p.m., the MDS coordinator stated they added fall interventions to care plans based on the fall data collection report. They stated all falls received interventions in the resident's care plan. The MDS coordinator stated they did not revise Resident #3's care plan to include a fall intervention for the fall on 05/03/26.		