STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375416	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
First Shamrock Care Center	1415 South Main Street Kingfisher, OK 73750

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 - Some	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 residents were free from abuse for 2 (#1 and #5) of 6 sampled residents reviewed for abuse.The DON reported 44 residents resided in the facility. Findings:An undated facility policy titled Resident to Resident Abuse/Abuse Prohibition Policy read in part, The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion and mistreatment.1.A care plan for Res #1, dated 08/10/24, showed Resident #1 had a problem with agitation and aggressive behavior. Approaches included to separate from stressful situations, persons or places, understand triggers, observe for signs of frustration and intervene early.Res #1's annual assessment, dated 07/24/25, showed the resident's cognition was severely impaired. The assessment showed the resident had diagnoses which included non-Alzheimer's dementia, schizophrenia, depression, and anxiety. The assessment showed the resident had delusions; verbal behavioral symptoms directed toward others daily which put the resident at significant risk for physical illness or injury.A progress note, dated 08/13/25 at 3:46 p.m., showed Res #1 was witnessed by staff running up to Res #5, jumping up and as Res #1 came back down hit Res #5 near the neck/shoulder/head area. Residents were separated immediately and assessed. Res #1 had no injuries, Res #5 had slight redness noted behind their left ear. The progress note showed the doctor and DON were notified of the incident. 2.Res #5's annual assessment, dated 06/26/25, showed the resident had a BIMS score of 9 which indicated their cognition was moderately impaired. The assessment showed the resident had diagnoses which included schizophrenia, depression, and anxiety.On 08/20/25 at 1:28 p.m., Res #5 stated they felt safe in the facility, but was worried Res #1 would hit them again.On 08/21/25 at 9:48 a.m., the DON stated they were not aware of the incident. They stated an incident report should have been completed and reported to the OSDH.On 08/21/25 at 1:38 p.m., the ADON reported Res #1 continues on every 15 minutes checks.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report allegations of abuse to the Oklahoma State Department of Health for 1 (#1) of 6 sampled residents reviewed for abuse.The DON reported 44 residents resided in the facility. Findings:An undated facility policy titled Resident to Resident Abuse/Abuse Prohibition Policy, read in part, Administrator or DON will initiate an immediate investigation of alleged abuse at the time of occurrence, and document findings. Investigation will continue for a minimum of 72 hours. The administrator and/or designee will notify the Oklahoma State Department of Health within 24 hours, by fax or telephone, of an actual abuse. A report of the incident shall be mailed/faxed to OSDH within 5 working days of the incident.An undated resident face sheet showed Res #1 had diagnoses which included disorganized schizophrenia, major depressive disorder, anxiety disorder, dissociative and conversion disorder.An annual assessment, dated 07/24/25, showed Res #1's cognition was severely impaired. The assessment showed the resident had delusions; verbal behavioral symptoms directed toward others daily which put the resident at significant risk for physical illness or injury. The assessment showed the behavior significantly interfered with the resident's participation in activities and social interactions.A nurse note, dated 08/13/25 at 1:43 p.m., showed Res #1 was witnessed by staff running up behind Res #5, jumping up, and as Res #1 came back down, hit Res #5 near the neck/shoulder/head area. Residents were separated immediately and assessed. Res #5 had no injuries related to this incident. The doctor and DON were notified. Res #1 continued on every 15-minute checks.On 08/20/25 at 11:45 a.m., the ADON reported the incident should have been reported to the Oklahoma State Department of Health. On 08/21/25 at 9:48 a.m., the DON reported they were not notified of the incident. The DON reported the incident should have been reported the OSDH.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to conduct a thorough investigation after an allegation of resident-to-resident abuse for 1 (#1) of 6 sampled residents reviewed for abuse.The DON reported 44 residents resided in the facility.Findings: An undated facility policy titled Resident to Resident Abuse/Abuse Prohibition Policy, read in part, Administrator or DON will initiate an immediate investigation of alleged abuse at the time of occurrence, and document findings. Investigation will continue for a minimum of 72 hours.An undated resident face sheet showed Res #1 had diagnoses which included disorganized schizophrenia, major depressive disorder, anxiety disorder, dissociative and conversion disorder.An annual assessment, dated 07/24/25, showed the Res #1's cognition was severely impaired.A nurse note, dated 08/13/25 at 1:43 p.m., showed Res #1 was witnessed by staff running up behind Res #5, jumping up, and as Res #1 came back down, hit Res #5 near the neck/shoulder/head area. The residents were separated immediately and assessed. Res #5 denied any pain but had slight redness behind the left ear related to this incident. The doctor and DON were notified. Res #1 continued on every 15-minute checks.On 08/20/25 at 11:45 a.m., the ADON reported the incident should have had a thorough investigation completed.

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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 ensure a resident's care plan was updated to include an intervention related to aggressive behaviors for 1 (#1) of 6 sampled residents reviewed for care plans.The DON reported 44 residents resided in the facility.Findings: An undated resident face sheet showed Res #1 had diagnoses which included disorganized schizophrenia, expressive language disorder, restlessness and agitation.A care plan, initiated 08/10/24, showed Res #1 had agitation and aggressive behavior with no new interventions added to the care plan since 08/10/24.An annual assessment, dated 07/24/25, documented Res #1s cognition was severely impaired. The assessment showed the resident had delusions; verbal behavioral symptoms directed toward others daily which put the resident at significant risk for physical illness or injury. The assessment showed the behaviors significantly interfered with the resident's participation in activities and social interactions.A nurse note, dated 08/13/25 at 1:43 p.m., showed Res #1 was witnessed by staff running up behind Res #5, jumping up, and as Res #1 came back down, hit Res #5 near the neck/shoulder/head area. The residents were separated immediately and assessed. Res #5 denied pain but had slight redness behind left ear related to the incident. The doctor and DON were notified. Res #1 continued on every 15-minute checks.On 08/20/25 at 11:45 a.m., the ADON reported the care plan should have been reviewed/revised with new interventions added.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on record review and interview, the facility failed to ensure antipsychotic medications were administered as ordered for a serious mental illness for 1 (#1) of 6 sampled residents reviewed for behaviors. The DON reported 44 residents resided in the facility.Findings:An undated face sheet showed Res #1 had diagnoses which included disorganized schizophrenia, vascular dementia, major depressive disorder, and anxiety. A care plan, dated 08/10/24, showed Res #1 had a problem with psychotropic drug use, had an active diagnosis of schizophrenia and required anti psychotic medications. Interventions included the nurse would monitor and report side effects/behaviors to the physician.A physician order, dated 05/04/25, showed Uzedy (an antipsychotic) suspension 125mg/0.35ml; 1 injection subcutaneous once a day every 28 days for disorganized schizophrenia. A treatment administration record, dated 06/01/25 - 06/30/25, showed a missed injection on 06/01/25.An annual assessment, dated 07/24/25, documented Res #1s cognition was severely impaired. The assessment showed the resident had delusions; verbal behavioral symptoms directed toward others daily which put the resident at significant risk for physical illness or injury. The assessment showed the behaviors significantly interfered with the resident's participation in activities and social interactions.A mental health progress note, dated 08/04/25, read in part, Res #1's condition deteriorated significantly after nursing staff overlooked his monthly injection. Despite receiving the missed dose on July 22nd and being prescribed hydroxyzine [an antihistamine] 25mg every 6 hours as needed, the patient continued to exhibit physical aggressive behavior toward other residents. By July 28th, there was no improvement in the patient's condition. A 7-day course of Risperidone 0.5mg twice daily was initiated as a bridge to stabilize the patient and return them to their therapeutic levels.On 08/20/25 the ADON reported the injection was overlooked and they now have a board in their office to ensure it did not happen again.