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	05/06/2026

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 - Immediate jeopardy to resident health or safety 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 protect a resident's right to be free from physical abuse for 1 (#19) of 3 sampled residents reviewed for abuse. Resident #19 was physically abused by another resident. A review of an undated facility video monitoring showed Resident #20 attempted to grab a TV remote from the table where Resident #19 was. Resident #19 grabbed the remote and held onto it. Resident #20 continued attempts to take the remote from Resident #19 standing over them. Resident #19 asked Resident #20 several times not to touch it and to get away from them. Resident #19 was cussing at Resident #20 as they persisted at their approached. Resident #19 asked Resident #20 if they wanted their (curse word withheld) beat and stood up from their sitting position. Resident #20 responded, Yes, whip my [curse word withheld]. Resident #20 swung and hit Resident #19 on their face. CNA #4 stated from the dining area Hey stop it, both of you stop. CNA #4 was walking into the common area from the dining area with a cart. Resident #19 told Resident #20 to get away from them but Resident #20 moved closer to Resident #19 and Resident #19 took a couple steps back. Resident #20 punched Resident #19 several times on the face causing them to fall to the floor. CNA #4 was within view and called Resident #19 by their name.CNA #4 did not attempt to de-escalate the physical altercation between the two residents.A behavior care plan for Resident #19, initiated 08/05/25, showed the resident was at risk for verbal and physical behaviors. The care plan showed the resident had diagnoses which included unspecified schizophrenia and unspecified dementia, unspecified severity, with agitation.A nursing note for Resident #19, dated 03/31/26 at 8:42 p.m., showed the resident had a skin tear to the left bridge of their nose and left inner cheek. The note showed Resident #20 hit Resident #19 on their face.On 04/30/26 at 9:56 a.m., CNA #4 stated they had not received abuse in-service training after the incident on 03/31/26.On 04/30/26 at 2:09 p.m., the facility manager stated they reviewed video footage which showed CNA #4 continued to pass snacks after they witnessed the physical altercation and Resident #19 on the floor. The facility manager stated it took about 10 to 15 minutes before the nurse on duty was notified of the physical altercation between the residents.On 04/30/26 at 2:15 p.m., the facility manager stated they had not completed abuse in-service training for all staff after the incident.The facility manager identified 37 residents resided in the facility.On 04/30/26, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to protect a resident's right to be free from physical abuse resulting in Resident #19 sustaining facial injury to their face.On 04/30/26 at 2:55 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 04/30/26 at 3:17 p.m., the administrator was notified of the IJ situation and the IJ template was provided.05/01/26 at 3:52 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,Medical Director notified of IJ F600 via electronic no new orders obtained 4.30.2026 3:34 PMNotified family member via phone call of IJ F600 of #19 4.30.2026 4:59 PMNotified family member via phone call of IJ F600 of #20 4.30.2026 5:10 PMAbuse and neglect clinical protocol reviewed 4.30.2026 4:13 PMMeasures for Abuse and neglect created for all staff on 4.30.2026 4:47 PMRevised on 5.1.2026 11:18 AMMeasures for Abuse and Neglectle[sic] Resident on Resident, Resident on StaffScene safe observe environmentIf unable to (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	intervene safely notify 911 for assistanceAttempt to safely intervene or stop an altercation verbal commandsIf unable to stop notify 911 for assistanceAttempt to deescalate verbally and notify other staff for assistanceAll staff regardless their title in the facility should attempt these measures and then ensure separation and nurse notification immediatelyStaff regardless their title in the facility will remain within viewing and listening distance and safely attempt to continue separation of individuals, if possible redirect from area and or redirect other residents also.Nurse will follow abuse and neglect clinical protocol.1:1 will be initiated for minimum of 72 hours and to restart if new altercation occurs.After 72 hour 1:1 monitoring is completed transition to initiating Q [every] 15 minute checks for minimum of 72 hoursNursing Home Abuse Prevention & Response Policy reviewed and revised 4.30.2026 4:50 PMIn service held with all staff on abuse and neglect clinical protocol, Nursing Home Abuse Prevention and Response Policy, and new measures for abuse and neglect abuse. Understanding with question and answer and acknowledgement of these items 4.30.2026 7:06 PMNursing Home Abuse Prevention and Response Policy, Abuse and neglect clinical protocol and measures for abuse and neglect abuse posted to bulletin board 4.30.2026 6:18 PMQAPI will monitor plan of removal 4.30.2026 5:30 PMSafe surveys completed for 5.1.2026 10:00 AMNew inservice for revised Measures for abuse and neglect, nursing home abuse prevention & response policy, and Abuse and Neglect - clinical protocol with all staff 5.1.2026 POR [plan of removal] completed 5.1.2026 1:31 PM.On 05/05/26, the IJ was lifted, effective 05/01/26, when all components of the plan of removal had been verified as completed. Staff in various departments and shifts were interviewed regarding facility measures for abuse and neglect, abuse policy, and clinical protocol. All staff were knowledgeable on the education and training provided. The plan of removal records including facility's measures for abuse, abuse and neglect policy and clinical protocol, staff in-service training, safe surveys, QAPI monitor plan of removal, and resident representatives' notifications were reviewed.The deficiency remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy. Findings:A review of an undated facility video monitoring showed Resident #20 attempted to grab a TV remote from the table where Resident #19 was. Resident #19 grabbed the remote and held onto it. Resident #20 continued attempts to take the remote from Resident #19 standing over them. Resident #19 asked Resident #20 several times not to touch it and to get away from them. Resident #19 was cussing at Resident #20 as they persisted at their approached. Resident #19 asked Resident #20 if they wanted their (curse word withheld) beat and stood up from their sitting position. Resident #20 responded, Yes, whip my (curse word withheld). Resident #20 swung and hit Resident #19 on their face. CNA #4 stated from the dining area Hey Stop it, both of you stop. CNA #4 was walking into the common area from the dining area with a cart. Resident #19 told Resident #20 to get away from them but Resident #20 moved closer to Resident #19 and Resident #19 a couple steps back. Resident #20 hit Resident #19 several times on the face causing them to fall to the floor. CNA #4 within view and called Resident #19 by their name. CNA #4 did not attempt to deescalate the physical altercation between the two residents.1. A behavior care plan for Resident #19, initiated 08/05/25, showed the resident was at risk for verbal and physical behaviors. The care plan showed the resident had diagnoses which included unspecified schizophrenia and unspecified dementia, unspecified severity, with agitation.A quarterly assessment for Resident #19, dated 01/29/26, showed the resident had memory problems.A nursing note for Resident #19, dated 03/31/26 at 8:42 p.m., showed Resident #19 had a skin tear to the left bridge of their nose and left inner cheek. The note showed Resident #20 hit Resident #19 on their face and caused Resident #19 to fall.An initial State reportable form 283, dated 03/31/26, showed Resident #20 punched Resident #19 multiple times in the face and caused them to fall to the floor and they had a difficult time standing.On 04/30/26 at 9:48 a.m., CNA #4 stated they were in the dining room when they heard a verbal altercation between resident #19 and Resident #20. They stated they did not know what was said. CNA #4 stated when they came into the common area they saw Resident #19 swing at Resident #20. They instructed both residents to back away from each other and they did. CNA #4 stated they turned (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	around to continue passing snacks. CNA #4 stated they heard a commotion behind them and next thing they saw was Resident #19 on the floor.On 04/30/26 at 9:56 a.m., CNA #4 stated they had not received abuse in-service training after the incident on 03/31/26.On 04/30/26 at 10:00 a.m., CNA #4 stated if they were to witness a resident-to-resident altercation, they were to separate them, make sure the residents were safe, report to the charge nurse, and provide a witness statement.On 04/30/26 at 10:01 a.m., CNA #4 stated they could have called another staff to lay eyes on the residents and ensure the residents were separated.On 04/30/26 at 2:09 p.m., the facility manager stated they reviewed video footage where CNA #4 continued to pass snacks after they witnessed the physical altercation and Resident #19 on the floor. The facility manager stated it took about 10 to 15 minutes before the nurse on duty was notified of the physical altercation between the residents.On 04/30/26 at 2:15 p.m., the facility manager stated they had not completed abuse in-service training for all staff after the incident.2. A quarterly assessment for Resident #20, dated 01/28/26, showed the resident had diagnoses which included anxiety and Huntington's disease. The assessment showed the resident's cognition was intact with a brief interview for mental status score of 14.On 04/27/26 at 9:46 a.m., Resident #20 stated they wanted the remote to change the channel on the TV and Resident #19 told them to, get the [curse word withheld] out. They stated they tried to grab the remote from the resident and Resident #19 hit them, so they hit Resident #19 back.