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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to ensure a resident with exit seeking behaviors had care plan interventions to address and prevent elopement for 1 (#19) of 3 sampled residents reviewed for accidents. Resident #19 eloped through a facility window. The administrator identified 16 residents at risk for elopement. On 04/28/26, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure a resident with exit seeking behaviors had care plan interventions to address and prevent elopement resulting in Resident #19 eloping.On 04/28/26 at 6:43 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 04/28/26 at 6:53 p.m., the administrator was notified of the IJ situation and the IJ template was provided.On 04/29/26 at 3:02 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, Elopement policy and procedures reviewed and revised - signature 4.30.2026 at 12 PMResident #19 care plan was reviewed and revised at 9:36 pm and added new interventionsMedical Director notified IJ -7:50pmReviewed and updated elopement book - update 4.30.2026 12:55 pmAll resident's elopement observation updated - 9:35 pm, new residents elopement assessment completed on 37 residentsMedications reviewed with medical director no new orders - 8:00pm on resident # 19QAPI will monitor plan of removalFamily for resident #19 was notified at 8:03 pm for IJ/new interventions placedMaintenance walked parameter and checked all windows at 9:41pm for safety and will continue with daily monitoring for safety all residentsAll staff in serviced on elopement policy and procedures 7:15 pm in-service conducted by Administrator, corporate nurse consultant in-serviced the Administrator on elopement. A copy of the policy and procedures on elopement was placed on bulletin board for staff to review. Staff verbalized understanding of policy by question and answer and understood location of policy to review if any questions arise. Update inservice completed on missing employees 4.30.2026 12:55 pmAll residents' care plans were updated for elopement risk 9:50 pmReview and revised care plan policy and procedures and posted on bulletin boards 7:30pmMDS nurse in serviced over care plans policy and procedures 12:30 pm 04/29/26POR completed 04/30/2026 at 1:08 pm.On 04/30/26, the IJ was lifted when all components of the plan of removal had been verified as completed. Staff in various departments and shifts were interviewed regarding elopement policy and procedures and missing resident drill procedure. The MDS nurse was interviewed on the care plan policy and procedure for elopement risk residents. All staff interviewed were knowledgeable on the education and training provided. The plan of removal records including facility's elopement policy and procedure, elopement risk audit with updated care plans interventions, staff in-service with signatures to attest understanding of the training received, maintenance log for windows and door lock checks, posting of the elopement/care plan policy and procedure on the bulletin board, QAPI plan to monitor plan or removal, resident representative and provider notification were reviewed.The deficiency remained at a pattern with the potential for more than minimal harm that is not immediate jeopardy. Findings:A nursing admission assessment for Resident #19, dated 07/28/25, showed the resident wandered and their cognition was severely impaired.A wandering and elopement risk assessment for Resident #19, dated 07/28/25, showed four areas marked, Yes. The (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	assessment read in part, the resident is at risk if the answer to any question #3-#7 is yes. The areas marked yes on the assessment were placement in the facility, history of wandering, confusion and disorientation, and dementia. A wandering and elopement risk assessment for Resident #19, dated 01/29/26, showed two areas marked, Yes. The assessment read in part, the resident is at risk if the answer to any question #3-#7 is yes. The areas marked yes on the assessment were placement in the facility, and dementia. A quarterly assessment for Resident #19, dated 01/29/26, showed the resident had memory problems. The assessment did not show Resident #19 wandered. An elopment care plan for Resident #19, initiated 03/21/26, showed the resident was at risk for elopement. The care plan showed the resident had diagnoses which included unspecified schizophrenia and unspecified dementia, unspecified severity, with agitation. There was no documentation to show the resident had a care plan for wandering and elopement risk prior to 03/21/26.A nursing note for Resident #19, dated 03/21/26 at 7:04 p.m., showed the resident was sitting in Dietary Aide #2's truck. Resident #19 informed Dietary Aide #2 they were looking for their underwear and had them in their hands. Resident #19 became agitated because they did not want to be at the facility.A combined initial and final state reportable, incident date 03/21/26, showed Resident #19 was observed sitting in an employee's vehicle. The report showed the resident was an elopement risk and Resident #19 exited through a window of an empty room. The report showed the window was secured and the resident was placed on one on one with a staff member.On 04/28/26 at 1:08 p.m., LPN #1 stated Resident #19 had occasional exit seeking behaviors since admission to the facility.On 04/28/26 at 1:11 p.m., LPN #1 stated Dietary Aide #2 brought the resident to them and informed them the resident was sitting in their truck on 03/21/26. They stated the truck was in the back of the facility.On 04/28/26 at 1:28 p.m., the DON stated they were not sure how to determine from the elopement assessment if the resident was at risk for elopement. They stated they were not sure what question #3-#7 was on the elopement assessment.On 04/28/26 at 3:05 p.m., CNA #2 stated Resident #19 had behaviors of wanting to get out of the facility prior to the elopement incident. On 04/28/26 at 3:10 p.m., CNA #1 stated Resident #19 had exit seeking behaviors prior to the elopement incident. They stated the resident would go to the exit door, attempt to put in codes, kick the door, and would set off the door alarms.On 04/28/26 at 5:17 p.m., MDS Coordinator #1 stated Resident #19's care plan did not have interventions for wandering. They stated the care plan should include wandering interventions if the wandering assessment showed the resident wandered.On 04/28/26 at 5:20 p.m., MDS Coordinator #1 stated they were not aware Resident #19 had exit seeking behaviors or tried to get out of the facility prior to the incident on 03/21/26.On 04/28/26 at 5:21 p.m., MDS Coordinator #1 stated they could have obtained information on resident behaviors from staff interviews.On 04/28/26 at 5:22 p.m., MDS Coordinator #1 stated staff interviews were not usually part of their process for care plan development or revision. They stated they may ask staff about medication refusal or activities of daily living. MDS Coordinator #1 stated if a resident had exit seeking behaviors, they should have care plan interventions.On 04/29/26 at 1:19 p.m., Dietary Aide #2 stated they were in the kitchen and looked out of the window and saw the resident had one foot inside the truck and another on the truck step. They stated they ran outside to the resident and brought them back inside. Dietary Aide #2 stated they informed the nurse the resident was in their truck. They stated it was around 7:00 p.m. because they were getting ready to leave for the day. Dietary Aide #2 stated the truck was parked behind the facility building close to the kitchen.On 04/29/26 at 1:23 p.m., Dietary Aide #2 stated they did not lock the truck, and the keys were in the truck in one of the compartments.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 observation, record review, and interview, the facility failed to:a. provide adequate supervision and a secure environment to prevent elopement for a resident with known exit seeking behaviors for 1 (#19). Resident #19 eloped through a facility window, andb. implement fall interventions for 1 (#3) of 3 sampled residents reviewed for accidents. An admission assessment for Resident #19, dated 07/28/25, showed the resident wandered and their cognition was severely impaired.A wandering and elopement risk assessment for Resident #19, dated 07/28/25, had four areas marked, Yes. The assessment read in part, the resident is at risk if the answer to any question #3-#7 is yes. The areas marked yes on the assessment were placement in the facility, history of wandering, confusion and disorientation, and dementia. A wandering and elopement risk assessment for Resident #19, dated 01/29/26, had two areas marked, Yes. The assessment read in part, the resident is at risk if the answer to any question #3-#7 is yes. he areas marked yes on the assessment were placement in the facility, and dementia. An elopement care plan for Resident #19, initiated 03/21/26, showed the resident was at risk for elopement. The care plan showed the resident had diagnoses which included unspecified schizophrenia and unspecified dementia, unspecified severity, with agitation. The care plan for Resident #19 did not show a concern for wandering and elopement risk prior to 03/21/26.A nursing note for Resident #19, dated 03/21/26 at 7:04 p.m., showed the resident was seated in a Dietary aide #2's truck. Resident #19 informed them they were looking for their underwear and had them in their hands. Resident #19 became agitated because they did not want to be at the facility.A combined initial and final state reportable form 283, with an incident date of 03/21/26, showed Resident #19 was observed to be seated in an employee's vehicle. The report showed the resident was an elopement risk and Resident #19 exited through a window of an empty room. The report showed the window was secured and the resident was placed on one on one with a staff member.On 04/28/26 at 1:53 p.m., the facility manager and the surveyor observed room [ROOM NUMBER] where Resident #19 exited the building. The window had a Plexi glass with a small, opened area along the vertical edge. The window could easily open when pushed gently. The door to the room was not locked.The facility manager identified 37 residents resided in the facility. The administrator identified 16 residents at risk for elopement.On 04/28/26, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide adequate supervision and a secure environment to prevent elopement for a resident with known exit seeking behaviors resulting in Resident #19 eloping.On 04/28/26 at 6:43 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On 04/28/26 at 6:53 p.m., the administrator was notified of the IJ situation and the IJ template was provided.On 04/29/26 at 3:02 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,Elopement policy and procedures reviewed and revised -signature 4.30.2026 at 12 pm to ensure a safe environment and reasonable measures to prevent elopement and how to recognize areas of concern and how/who to report tooResident #19 care plan was reviewed and revised at 9:36 pm added new interventionsMedical Director notified IJ -7:50 pmReviewed and updated elopement book - update 4.30.2026 12:55 pmAll resident's elopement observation updated - 9:35 pm, new residents elopement assessment completed on 37 residents -complete elopement observation when due and determine if resident is an elopement risk through dx physical state, mental state, interviews and review of nursing notes, clinician recommendations, behaviors and then update care plan accordingly to riskMedications reviewed with medical director no new orders-8:00 pm on resident #19QAPI will monitor plan of removalFamily for resident # 19 was notified at 8:03 pm by SSD about IJ status and new interventions placedMaintenance walked parameter and checked all windows at 9:41pm for safety and will continue with daily monitoring for safety all residents - Maintenance will secure (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	windows with screws to ensure windows do not operate. 4:15pm update maintenance written log and initialedAll staff in serviced on elopement policy and procedures 7:15 pm in-service conducted by Administrator, corporate nurse consultant in-serviced the Administrator on elopement. A copy of the policy and procedures on elopement was placed on bulletin board for staff to review. Staff verbalized understanding of policy by question and answer and understood location of policy to review if any questions arise. Update inservice completed on missing employees 4.30.2026 12:55 pmAll residents' care plans were updated for elopement risk 9:50pmReviewed care plan policy and procedures and posted on bulletin boards 12:55 pm. Educated MDS nurse on this policy and procedure 12:30 pmPOR completed on 04/30/2026 at 1:08pm.On 04/30/26, the IJ was lifted when all components of the plan of removal had been verified as completed. Staff in various departments and shifts were interviewed regarding elopement policy and procedures and missing resident drill procedure. The MDS nurse was interviewed on the care plan policy and procedure for elopement risk residents. All staff interviewed were knowledgeable on the education and training provided. The plan of removal records including facility's elopement policy and procedure, elopement risk audit with updated care plans, staff in-service with signatures to attest understanding of the training received, maintenance log for windows and door lock checks, posting of the elopement/care plan policy and procedure on the bulletin board, QAPI plan to monitor plan or removal, resident representative and provider notification were reviewed. Observation of secured windows was completed. room [ROOM NUMBER] was locked and not in use.The deficiency remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy. Findings: 1. On 04/28/26 at 1:53 p.m., the facility manager and the surveyor observed room [ROOM NUMBER] where Resident #19 exited the building. The window had a Plexi glass with an open area along the vertical edge. The window could easily open when pushed gently. The door to the room was not locked. A nursing admission assessment for Resident #19, dated 07/28/25, showed the resident wandered and their cognition was severely impaired. A wandering and elopement risk assessment for Resident #19, dated 07/28/25, had four areas marked, Yes. The assessment read in part, the resident is at risk if the answer to any question #3-#7 is yes. The areas marked yes on the assessment were placement in the facility, history of wandering, confusion and disorientation, and dementia. A wandering and elopement risk assessment for Resident #19, dated 01/29/26, had two areas marked, Yes. The assessment read in part, the resident is at risk if the answer to any question #3-#7 is yes. The areas marked yes on the assessment were placement in the facility, and dementia. A quarterly assessment for Resident #19, dated 01/29/26, showed the resident had memory problems. An elopement care plan for Resident #19, initiated 03/21/26, showed the resident was at risk for elopement. The care plan showed the resident had diagnoses which included unspecified schizophrenia and unspecified dementia, unspecified severity, with agitation. The care plan did not show a concern for wandering and elopement risk prior to 03/21/26. A nursing note for Resident #19, dated 03/21/26 at 7:04 p.m., showed Resident #19 was sitting in a Dietary Aide #2's truck. Resident #19 informed Dietary Aide #2 they were looking for their underwear and had them in their hands. Resident #19 became agitated because they did not want to be at the (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility. A combined initial and final State reportable, incident date 03/21/26, showed Resident #19 was observed sitting in an employee's vehicle. The report showed the resident was an elopement risk and Resident #19 exited through a window of an empty room. The report showed the window was secured and the resident was placed on one on one with a staff member. On 04/27/26 at 9:31 a.m., Resident #19 denied trying to leave the facility. They stated they would like to live in their own apartment. On 04/28/26 at 1:02 p.m., LPN #1 stated they cared for Resident #19 since they were admitted to the facility. They stated the resident went in and out of other rooms and was oriented to self. On 04/28/26 at 1:08 p.m., LPN #1 stated Resident #19 had occasional exit seeking behaviors since admission to the facility. On 04/28/26 at 1:11 p.m., LPN #1 stated the Dietary Aide #2 brought the resident to them and informed them the resident was sitting in their truck on 03/21/26. They stated the truck was in the back of the facility. LPN #1 stated the window had tape on it and must have come off. On 04/28/26 at 1:18 p.m., LPN #1 stated Resident #19 continued to have exit seeking behaviors after the elopement incident on 03/21/26. On 04/28/26 at 1:28 p.m., the DON stated they were not sure how to determine from the elopement assessment if the resident was at risk for elopement. They stated they were not sure what question #3-#7 was on the elopement assessment. On 04/28/26 at 1:44 p.m., the facility manager stated they did not have documentation to show in-service on elopement was provided to staff. On 04/28/26 at 1:46 p.m., the facility manager stated a review of the facility's video monitoring showed Resident #19 entered room [ROOM NUMBER] on the day of the incident. On 04/28/26 at 1:50 p.m., the facility manager stated residents could get out of the window in room [ROOM NUMBER] and any other windows in the facility. On 04/28/26 at 1:54 p.m., the administrator stated the window in room [ROOM NUMBER] was not secured and a resident could elope. On 04/28/26 at 2:57 p.m., the facility manager stated they no longer had the video footage of the Resident entering room [ROOM NUMBER]. They stated during the investigation the resident was seen on video electronic monitoring device entering room [ROOM NUMBER] around 6:30 p.m. and was found in the truck around 7:10 p.m. On 04/28/26 at 2:59 p.m., the facility manager stated at the time of the incident, the window in room [ROOM NUMBER] was Plexi glass taped with two boards. They stated after the incident they had secured the window with silicone tape. On 04/28/26 at 3:05 p.m., CNA #2 stated Resident #19 had behaviors of wanting to get out of the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility prior to 03/21/26. They stated after the incident, the resident would wait at the front door exit seeking and would go into rooms to see if the window was open. On 04/28/26 at 3:07 p.m., CNA #3 stated Resident #19 tried to leave the facility and had kicked the glass of the front door attempting to get out a week ago. They stated the resident tried to follow people out of the door. On 04/28/26 at 3:10 p.m., CNA #1 stated Resident #19 had exit seeking behaviors prior to the elopement incident. They stated the resident would go to the exit door, attempt to put in codes, kick the door, and would set off the door alarms. On 04/28/26 at 3:14 p.m., Hospitality Aide #1 stated they had seen Resident #19 at the front door exit seeking and tried to follow people out after the elopement incident. On 04/29/26 at 1:19 p.m., Dietary Aide #2 stated they were in the kitchen and looked out of the window and saw the resident had one foot inside the truck and another on the truck step. They stated they ran outside to the resident and brought them back inside. Dietary Aide #2 stated they informed the nurse the resident was in their truck. They stated it was around 7:00 p.m. because they were getting ready to leave for the day. Dietary Aide #2 stated the truck was parked behind the facility building close to the kitchen. On 04/29/26 at 1:23 p.m., Dietary Aide #2 stated they did not lock the truck and keys were in the truck in one of the compartments. On 04/29/26 at 1:33 p.m., Dietary Aide #2 stated they did not receive an in-service on elopement after the incident. 2. On 05/06/26 at 1:14 p.m., Resident #3 was observed to lie awake in a low positioned bed. No fall mat was observed in the room. Resident #3 was observed as unable to communicate well when greeted. On 05/06/26 at 1:25 p.m., CNA #5 was observed to enter the room of Resident #3 and locate the fall mat, when asked. CNA #5 was observed to look around the room several minutes, before they located the fall mat. The fall mat was found to be folded behind the resident's bed. Resident #3 was observed to be awake lying in bed during this time. An undated policy titled Falls and Fall Risk, Managing, read in part, The staff, with input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. A quarterly assessment for Resident #3, dated 02/05/26, showed the resident required substantial/maximal assistance for lying to sitting on the side of the bed and to go from sitting to standing. The assessment showed the resident required supervision or touching assistance for walking. A progress note for Resident #3, dated 04/05/26, showed the resident had a fall incident at the facility and was found to lie on the floor adjacent to the bed with abrasions to the nose, right forehead, and right shoulder. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A care plan for Resident #3, dated 04/05/26, showed the resident had a focus for being at risk for falls and had an intervention of a fall mat at the bedside in place. A fall observation document for Resident #3, dated 04/05/26, showed the resident had diagnoses which included vascular dementia with agitation, Alzheimer's disease, disorganized schizophrenia, restlessness and agitation, and expressive language disorder. The document showed the resident had a mental status/level of consciousness that was disoriented x3 (not oriented to person, place, and time) with diminished safety awareness. The document showed the current care plan needed to be continued to address Resident #3's needs. Resident #3 was given a fall risk score of 14, which indicated a high risk for falls. On 05/06/26 at 1:22 p.m., CNA #5 stated they had taken care of Resident #3 and the resident had interventions of a fall mat at bedside and lowered bed due to being a fall risk. On 05/06/26 at 1:27 p.m., CNA #5 stated the fall mat was not where it was supposed to be when they had entered the room of Resident #3 to help prevent future falls for the resident.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. Based on observation and interview, the facility failed to ensure contact information for filing a complaint with the State Agency was available to the residents.The facility manager identified 37 residents resided in the facility. Findings:On 04/28/26 at 10:12 a.m., both resident halls, both nurses' stations, and the main living area were observed. There was no information regarding filing a complaint with the State agency.On 04/28/26 at 10:03 a.m., a confidential interview was held with the resident council group. The resident council group was asked if they had been informed of their rights and given information on how to formally complain to the State about the care they were receiving. They stated, No.On 04/28/26 at 10:20 a.m., the administrator stated the information on how to formally file a complaint with the State Agency was not posted at this moment.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based observation and interview, the facility failed to post notice of the availability of past State survey results in areas of the facility that were prominent and accessible to the public.The facility manager identified 37 residents resided in the facility. Findings: On 04/28/26 at 10:12 a.m., both resident halls, both nurses' stations, and the main living area were observed. There was no posted information on where the past State survey results were located. On 04/28/26 at 10:15 a.m., the administrator showed the location of the past State survey results. The binder was to the right of the facility entrance door.On 04/28/26 at 10:03 a.m., a confidential interview was held with the resident council group. The resident council group stated they did not know where to locate past State survey results.On 04/28/26 at 10:16 a.m., the administrator stated a sign was posted to show location of past State survey results, but it was taken down by a resident. They stated they were not sure when it was removed by the resident.

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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.The facility manager identified 37 residents resided in the facility. Findings:On 04/28/26 at 10:12 a.m., both resident halls, both nurses' stations, and the main living area were observed. There was no information regarding the facility's grievance procedure or location of grievance forms. The grievance personnel information was posted.On 05/06/26 at 1:37 p.m., the facility grievance binder was reviewed. There were no grievances.A Grievance Policy, dated 11/28/16, read in part, The facility will provide a mechanism for filing a grievance/complaint without fear of retaliation and/or barriers of service; will provide residents, resident representatives and others information about the mechanisms and procedure to file a grievance.On 04/28/26 at 10:03 a.m., a confidential interview was held with the resident council group. The resident council group stated they did not know how to file a grievance.On 04/28/26 at 10:20 a.m., the administrator stated the grievance procedure was not posted at the moment.

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	375416	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure RN coverage for 8 consecutive hours seven days a week.The facility manager identified 37 residents resided in the facility. Findings: An RN coverage policy, reviewed 01/01/26, read in part, Nurse staffing in nursing homes has a substantial impact on the quality of care and outcomes that residents experience.Facilities are responsible for ensuring they have an RN providing services at least 8 consecutive hours a day, 7 days a week.The facility must designate a registered nurse (RN) to serve as the DON on a full-time basis. A Punch Audit Report, dated 11/01/25 through 04/26/26, showed no RN hours for 10/01/25 through 10/03/25 10/06/25 through 10/15/25, 10/18/25 through 10/19/25, 10/21/25, 10/25/25 through 10/26/25, 10/28/25, 11/01/25 through 11/02/25, 11/06/25 through 11/09/25, 11/13/25, 11/27/25, 12/04/25, 12/08/25, 12/11/25, 12/22/25, 12/25/25, and 12/31/25. On 04/29/26 at 10:08 a.m., the business office manager stated between October 1st and October 14th, the facility had no RN coverage. They stated there was no RN coverage on any of the above dates.On 04/30/26 at 9:56 a.m., the facility manager stated the facility was without a DON from 09/18/25 through 10/14/25.

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	375416	A. Building B. Wing	05/06/2026

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation and interview, the facility failed to ensure an extended menu with portion sizes was available for use during one of one meal service observed.The facility manager identified 37 residents who received meal services from the kitchen. Findings:On 04/27/26 at 7:50 a.m., a facility extended menu was requested during entrance conference.On 05/05/26 at 8:23 a.m., [NAME] #1 was observed to put a 5-ounce scoop of scrambled eggs on two plates.On 05/05/26 at 8:27 a.m., [NAME] #1 was observed to put 4-ounce spoon of scrambled eggs on three plates.On 05/05/26 at 9:02 a.m., the administrator brought a box to the surveyors and was observed to shift through the paper items. There was no extended menu in the box.On 05/05/26 at 6:56 a.m., [NAME] #1 stated the breakfast menu was biscuit and gravy, hash brown, scrambled eggs, and cold cereal.On 05/05/26 at 8:28 a.m., [NAME] #1 stated the proper portion size should be 4-ounces of scrambled eggs.On 05/05/26 at 9:06 a.m., the administrator stated the facility did not have an extended menu at this time.On 05/05/26 at 10:07 a.m., [NAME] #2 stated they were not told about portion sizes for serving.On 05/06/26 at 2:36 p.m., the registered dietitian stated they were responsible for reviewing and signing off on the regular menu and not the creation of menus.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to ensure a resident was not administered a psychotropic medication without adequate indications for its use and received gradual dose reductions for 1 (#4) of 5 sampled residents reviewed for unnecessary medications.The RNC identified 28 residents were prescribed psychotropic medications. Findings: An undated EHR facesheet for Resident #4 showed the resident had diagnoses which included vascular dementia (severe) with psychotropic disturbances, depression, and an anxiety disorder due to known physiological condition. A facility policy titled Policy on Unnecessary Drugs, dated 01/01/99, read in part, All medications prescribed to residents must be based on an individual assessment of each resident's clinical condition, needs, and goals of care. Medications must be regularly reviewed to determine their continued necessity and appropriateness.A discontinued medication order, dated 02/17/25, showed Resident #4 had received an order for Invega Sustenna (an antipsychotic) 78 mg once a month for the first time for the diagnosis of vascular dementia (severe) with psychotic disturbances. There were no records found that this medication had been prescribed prior to this date. A quarterly assessment, dated 06/17/25, showed Resident #4 did not have potential indicators of psychosis which included hallucinations and delusions. The assessment showed the resident did not have a diagnosis of schizophrenia. The assessment showed Resident #4 received antipsychotics on a routine basis and a GDR was not attempted, because the physician documented it as clinically contraindicated. A medication regimen review document, dated 09/03/25, showed a GDR was requested by the pharmacist for Invega Sustenna 78mg once a month, but was not completed. Invega Sustenna is used primarily to manage schizophrenia and schizoaffective disorders. Resident #4's PMHNP responded, a reduction in the medication would likely worsen behavior.A nursing progress note, dated 10/08/25, showed Resident #4 had received new medication orders from their psychiatric provider for Invega Sustenna 156 mg once a month. Prior to this order, all previous Invega Sustenna orders were for 78 mg. A psychiatry services note, dated 11/03/25, showed Resident #4's mood was stable during the assessment and the resident's sporadic shouting during the day was correlated to pain. The note showed the resident had a diagnosis of schizophrenia and the treatment plan for the diagnosis included Invega Sustenna 156 mg/mL.There was no documentation found the resident had been assessed for schizophrenia prior to Resident #4's diagnosis and treatment.A nursing progress note, dated 11/10/25, showed Invega Sustenna had been administered to Resident #4's right deltoid. A physician's order, dated 11/10/25, showed Resident #4 had an active order for Invega Sustenna 156 mg/mL once a day on the 10th of the month. The medication order did not have an end date listed. The record showed the medication was given for the diagnosis of vascular dementia (severe) with psychotic disturbances. A medication administration record, dated 03/01/26 through 03/31/26, showed Resident #4 had been administered Invega Sustenna 156 mg/mL on the 10th of the month.A medication administration record, dated 04/01/26 through 04/30/26, showed Resident #4 had been administered Invega Sustenna 156 mg/mL on the 10th of the month.There was no documentation found that a gradual dose reduction had been attempted for Invega Sustenna any of the times it was prescribed. On 05/05/26 at 11:57 p.m., the PMHNP stated they did not diagnose Resident #4 with schizophrenia and followed through with the previous provider's orders. They stated they did not know who diagnosed Resident #4 with schizophrenia and the resident's behaviors had been stable for a while. The PMHNP stated vascular dementia with psychotic disturbance was not an appropriate diagnosis for the administration of Invega Sustenna and a diagnosis of schizophrenia would be required.On 05/05/26 at 1:08 p.m., CNA #5 stated Resident #4 had behaviors of hollering out loud and grinding teeth, but the behaviors did not happen often. CNA #5 stated the behaviors occurred when the resident needed something or was uncomfortable.On 05/05/26 at 1:24 p.m., the facility manager stated a comprehensive assessment was required for a psychotropic medication if a new provider (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	took over care. They stated the medication Invega Sustenna should be used for treatment for the diagnosis the psychiatry services had prescribed it for, which was schizophrenia.On 05/05/26 at 2:02 p.m., the facility manager stated Resident #4's admission records did not have a diagnosis of schizophrenia and would have to see where it came from. The facility manager could not find documentation of a schizophrenia assessment completed for Resident #4.On 05/06/26 at 4:39 p.m., the medical director stated they did not know why Resident #4's EHR showed they were being prescribed Invega Sustenna for dementia and would have to discuss this with the psych provider. They stated they did not know if a GDR had been attempted for this medication or of any assessments done by any providers to diagnose Resident #4 with schizophrenia.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to inform a resident or their representative of the risk, benefits, and alternative treatment options prior to giving psychotropic medications for 1 (#4) of 5 sampled residents whose clinical records were reviewed for unnecessary medications.The RNC identified 28 residents were prescribed psychotropic medications. Findings:The undated clinical record facesheet showed Resident #4 had diagnoses which included vascular dementia (severe) with psychotic disturbance, depression, and an anxiety disorder due to known physiological condition (history of).The facility's medication consent form binder from 2025 was reviewed. A consent form dated 05/05/25 for clozapine 75 mg four times a day for Resident #4 was found. There was no other documentation the resident or the resident's representative had been informed of the risks and benefits of the use of other psychotropic medications, treatment alternatives/options, and the choice of treatment the resident preferred before receiving the psychotropic medications. A physician's order for Resident #4, dated 06/02/25, showed the resident was to receive clozapine (an antipsychotic) 75 mg four times a day.A physician's order for Resident #4, dated 06/17/25, showed the resident was to receive buspirone (an anxiolytic) 15 mg twice a day.A physician's order for Resident #4, dated 10/12/25, showed the resident was to receive citalopram (an antidepressant) 20 mg once a day.A physician's order for Resident #4, dated 11/10/25, showed the resident was to receive Invega Sustenna (an antipsychotic) 156 mg/mL once a day on the 10th of the month.A review of the nursing progress notes for Resident #4, from the past year, did not show Resident #4 or their representative had been informed about any psychotropic medications or treatment alternatives.On 05/05/26 at 11:09 a.m., the facility manager stated that if an antipsychotic consent form for a specific medication was not in the binder, then the facility did not have one for Resident #4.On 05/05/26 at 1:24 p.m., the facility manager stated if a resident or their representative were informed of the psychotropic medications or alternative treatments, then it would be in the nursing progress notes.

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	375416	A. Building B. Wing	05/06/2026

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interview, the facility failed to ensure a baseline care plan was developed within 48 hours of admission for 1 (#4) of 12 sampled residents whose care plans were reviewed.The facility manager identified 37 residents resided in the facility. Findings: An undated policy titled Care Plans - Baseline, read in part, To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission.A significant change assessment, dated 06/17/25, showed Resident #4 had diagnoses which included anxiety, vascular dementia (severe) with psychotropic disturbance, depression, acute and chronic respiratory failure with hypoxia, and an original admission date of 12/03/24, and a reentry date of 05/30/25.Review of the electronic health record did not show a baseline care plan was developed for Resident #4.On 05/05/26 at 1:24 p.m., the facility manager stated they could not find the baseline care plan for Resident #4, which meant there was not one for them.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure a clinical rationale from the physician was provided on a gradual dose reduction request for a antidepressant and an antipsychotic for 1 (#37) of 5 sampled residents who were reviewed for unnecessary medications.The facility manager identified 37 residents resided in the facility. Findings:A Policy on Unnecessary Drugs, dated 01/01/1999, read in part, To ensure that residents in the long-term care facility are prescribed medications based on their clinical needs, avoiding unnecessary drugs that could lead to adverse effects, interactions, or diminished quality of life.Criteria for Identifying Unnecessary Drugs: Lack of a documented clinical indication for the medication.Documentation will include the rationale for continuing, discontinuing, or adjusting any medication, as well as discussions with the resident or their representative.A significant change assessment, dated 11/06/25, showed Resident #37 was severely impaired in cognition for decision making, had diagnoses of dementia and psychotic disorder, and received an antidepressant and antipsychotic medication.A Medical Director Report, dated, 08/06/25 showed a gradual dose reduction request for haloperidol (an antipsychotic medication) 10 mg at bedtime and fluoxetine (an antidepressant medication) 20 mg once a day. The drug regimen review did not show a physician response to the gradual dose reduction request.An Expanded DRR [drug regimen review] report, dated 02/04/26, showed a gradual dose reduction request for haloperidol 10 mg at bedtime and fluoxetine 20 mg once a day. The drug regimen review did not show a physician response to the gradual dose reduction request.On 05/06/26 at 1:39 p.m., the regional nurse consultant stated the February and August gradual dose reduction requests had not been addressed by the medical director or by psychiatric services.

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	375416	A. Building B. Wing	05/06/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure water was not utilized to puree foods for 1 of 1 breakfast meal observed.Cook #1 identified one resident on a pureed diet resided in the facility. Findings:On 05/05/26 at 7:54 a.m., [NAME] #1 was observed to place two hash brown patties in a blender. [NAME] #1 was observed to add an unmeasured amount of hot water to the blender and puree the hash browns.On 05/05/26 at 8:06 a.m., [NAME] #1 was observed to add a 5-ounce scoop of scrambled eggs to the blender. [NAME] #1 was observed to add an unmeasured amount of hot water to the blender and puree the scrambled eggs.On 05/05/26 at 8:12 a.m., [NAME] #1 was observed to place one and a half biscuit in a blender. [NAME] #1 was observed to add an unmeasured amount of hot water to the blender and puree the biscuits.On 05/05/26 at 7:56 a.m., [NAME] #1 stated they did not know how much water they added to the hash browns. They stated they just added water to food items until it was pureed.On 05/05/26 at 10:07 a.m., [NAME] #2 stated they used a half cup of hot water to puree food items. They stated if the puree became too thin, they added thickener.On 05/06/26 at 2:33 p.m., the registered dietitian stated staff were not supposed to use plain water for pureed foods.

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	375416	A. Building B. Wing	05/06/2026

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and interview, the facility failed to have effective administration who utilized its resources effectively and efficiently to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident. The facility administration failed to:a. provide adequate supervision and a secure environment to ensure residents at risk for elopement had not eloped for 1 (#19) of 16 sampled residents at risk for elopement. Resident #19 was at risk for wandering and elopement. The care plan for Resident #19 did not show a concern for wandering and elopement risk prior to 03/21/26. Dietary Aide #2 stated they found Resident #19 in their truck. A combined initial and final state reportable form 283, incident date of 03/21/26, showed Resident #19 was observed seated in an employee's vehicle. The report showed the resident was an elopement risk. The report showed Resident #19 exited through a window of an empty room. MDS Coordinator #1 stated they were not aware the resident had exit seeking behaviors.b. protect resident's right to be free from physical abuse for 1 (#19) of 3 sampled residents reviewed for abuse. A review of an undated facility video monitoring showed Resident #20 punched Resident #19 several times on the face causing them to fall to the floor. Resident #19 had facial injuries. CNA #4 did not attempt to de-escalate the physical altercation between the two residents. CNA #4 stated they had not received abuse in-service training after the incident on 03/31/26. 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. The facility manager stated they had not completed abuse in-service training for all staff after the incident.c. ensure an extended menu with portion sizes was available for use during one of one meal service observed. [NAME] #1 was observed to put a 5-ounce scoop of scrambled eggs on two plates and they changed the serving size to 4 ounce spoon of scrambled eggs on three plates. [NAME] #1 stated the proper portion size should be 4 ounces. [NAME] #2 stated they were not told about portion sizes for serving. The administrator stated the facility did not have an extended menu at this time.d. ensure RN coverage for 8 consecutive hours seven days a week. A Punch Audit Report, dated 11/01/25 through 04/26/26, showed no RN hours for 10/01/25 through 10/03/25 10/06/25 through 10/15/25, 10/18/25 through 10/19/25, 10/21/25, 10/25/25 through 10/26/25, 10/28/25, 11/01/25 through 11/02/25, 11/06/25 through 11/09/25, 11/13/25, 11/27/25, 12/04/25, 12/08/25, 12/11/25, 12/22/25, 12/25/25, and 12/31/25. The BOM stated between October 1st and October 14th, the facility had no RN coverage. They stated there was no RN coverage on any of the above dates.The facility manager identified 37 residents resided in the facility. Findings: Please refer to CMS form 2567 at F600, F689, F727, and F803 for evidence details. The Quality Assurance Improvement Plan policy, revised 07/28/25, read in part, Our purpose is to provide excellent quality resident/patient care and services. Quality is defined as meeting or exceeding the needs, expectations and requirements of the patients cost-effectively while maintaining good resident/patient outcomes and perfections of patient care.The Administrator/Assistant Administrator ensures that the quality program is adequately resourced.On 05/06/26 at 3:58 p.m., the administrator stated they tried to be at the facility atleast 20 hours a week but occasionally did not meet the requirement due to having other facilities.On 05/06/26 at 4:07 p.m., the administrator was asked if there was a lack of oversight in the administration of their facility. They stated, Yes.

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	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

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on record review and interview, the facility failed to ensure the medical director verified the appropriateness of an antipsychotic medication for 1 (#4) of 5 sampled residents reviewed for unnecessary medications.The facility manager identified 37 residents resided in the facility. Findings:A review of an undated EHR facesheet for Resident #4 showed the resident had diagnoses which included vascular dementia (severe) with psychotropic disturbances, depression, and an anxiety disorder due to known physiological condition. A physician's order, dated 11/10/25, showed Resident #4 had an active order for Invega Sustenna (antipsychotic medication) 156 mg/mL once a day on the 10th of the month. Invega Sustenna is used primarily to manage schizophrenia and schizoaffective disorders. The record showed the medication was prescribed for the diagnosis of vascular dementia (severe) with psychotic disturbances. A quarterly assessment, dated 06/17/25, showed Resident #4 did not have potential indicators of psychosis which included hallucinations and delusions. The assessment showed the resident did not have a diagnosis for schizophrenia. A psychiatry services note, dated 11/03/25, showed Resident #4 had a diagnosis of schizophrenia and the treatment plan for the diagnosis included Invega Sustenna 156 mg/mL. There was no documentation found the resident had been assessed for schizophrenia prior to Resident #4's diagnosis and treatment.On 05/05/26 at 11:57 p.m., the PMHNP stated they did not diagnose Resident #4 with schizophrenia and followed through with the previous provider's orders. They stated they did not know who diagnosed Resident #4 with schizophrenia and the resident's lashing out behaviors had been stable for a while. The PMHNP stated vascular dementia with psychotic disturbance was not an appropriate diagnosis for the administration of Invega Sustenna and a diagnosis of schizophrenia would be needed.On 05/06/26 at 4:39 p.m., the medical director stated they oversaw the medications the psych services were prescribing and appropriate medication was ordered for the diagnosis. They stated they went over the indications for the use of psychotropic medications for residents on a monthly basis. They stated they signed off on all medications for the facility. The medical director stated they did not know why Resident #4's EHR showed they were prescribed Invega Sustenna for dementia and would have to discuss with the psych provider. They stated they did not know the psych notes showed Resident #4 was prescribed Invega Sustenna for schizophrenia. The medical director stated they did not know where to find the psych notes for the facility's residents. They stated they did not know if a GDR had been attempted for this medication or of any assessments done by any providers to diagnose Resident #4 with schizophrenia. The medical director stated they did not recall the black box warning for Invega Sustenna because they did not usually prescribe this medication.