STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER Edmond Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 39 East 33rd Street Edmond, OK 73013	

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 48344 Based on record review and interview, the facility failed to provide medical record to a resident's representative upon request for one (#3) of one sampled resident reviewed for medical records. The Administrator identified 80 residents resided in the facility. Findings: An Access to Personal and Medical Records policy, revised 05/17, read in part, .Access to the resident's personal and medical records will be provided to the resident within 1 week .of his or her request .The resident .may grant others the right to access the resident's records if such request is made in writing and identifies the information that is to be released and to whom the information is to be released . Resident #3 had diagnoses which included bipolar and schizophrenia. An AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF PROTECTED HEALTH INFORMATION form, dated 02/20/24, documented Resident #3 signed the release of their medical records to their representative. On 03/06/24 at 12:58 p.m., the Administrator stated they were not aware Resident #3's family had requested medical records. They stated it takes a week for the release of medical records. On 03/06/24 at 1:04 p.m., the Medical Records stated Resident and the Resident's representative requested medical records during their care plan meeting on 02/20/24. They stated they compiled the medical records and sent them to legal the next day. On 03/06/24 at 1:10 p.m., the Administrator stated corporate informed them they released the medical records to the Resident's representative on the request form. On 03/06/24 at 1:50 p.m., the Administrator provided an email correspondence dated 03/06/24. It documented unsuccessful attempts to contact the person on the request form regarding the medical record pick up. They were unable to provide documentation on the release of the medical records prior to 03/06/24.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 48344 Based on record review and interview, the facility failed to ensure a resident was not involuntarily discharged for one (#2) of three sampled residents reviewed for involuntary discharge. The Administrator identified 80 residents resided in the facility. Findings: A Transfer or Discharge Documentation policy, revised 12/16, read in part, .Should the resident be transferred or discharged for any of the following reasons, the basis for the transfer or discharge will be documented in the resident's clinical record by a physician .The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident .The following information will be communicated to the receiving facility or provider .Resident representative information including contact information . A Transfer or Discharge, Emergency policy, revised 08/18, read in part, .Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures .Notify the representative (sponsor) or other family member . Resident #2 had diagnoses which included dementia, schizoaffective disorder, and bipolar. A progress note, dated 12/01/23, read in part, Resident experiencing increased delusions religious in nature . received order to transfer to geri psych for further eval, treatment, and stabilization. Resident #2's discharge assessment return anticipated, dated 12/01/23, documented the Resident had an unplanned discharge to an inpatient psychiatric facility. Resident #2's medical record was reviewed for documentation regarding their transfer on 12/01/23 and the reason the Resident did not return to the facility. No such documentation was found. On 03/05/24 at 1:30 p.m., the Administrator stated Resident #2 was transferred to [hospital name withheld] on 12/01/23 due to behaviors. They stated Resident #2 went to a sister facility on 12/15/23 upon discharge from the hospital. On 03/05/24 at 1:41 p.m., the Administrator stated Resident #2 did not return to the facility because the Resident was a danger to self and others due to their behaviors. They stated they could not meet the Resident's needs at the facility. On 03/05/24 at 1:48 p.m., the Administrator stated there was no contact information in Resident #2's medical record for a DPOA to notify them about the transfer to the hospital that occurred on 12/01/23. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/24 at 3:52 p.m., the Administrator stated they did not know if Resident #2 or their DPOA were given a notice of the Resident's discharged from the hospital to the sister facility. On 03/05/24 at 3:53 p.m., the Administrator stated there was no physician documentation in Resident #2's medical record for the reasons the Resident could not return to the facility.