STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375483	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmond Health Care Center	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 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. 35389 Based on record review and interview, the facility failed to ensure residents were free from abuse for one (#8) of three sampled residents reviewed for abuse. The Administrator identified 82 residents resided in the facility. Findings: An Abuse and Neglect policy, undated, read in part, .no resident shall be subject to abuse and/or neglect .All incidents to include suspected resident abuse will be reported to the Administrator and Director of Nursing immediately .Any staff member involved in any incident will report it immediately to his/her supervisor, and a written statement would be obtained through interview about the incident. The Administrator will be the person to notify appropriate agencies .the employee will be suspended pending the investigation . Resident #8 had diagnoses which included quadriplegia, post-traumatic stress disorder, and schizoaffective disorder bipolar type. An Initial State Reportable Incident form, dated 06/02/24, documented an allegation of abuse/mistreatment. It documented the family of Resident #8 observed video footage of CNA #3 cursing and arguing with Resident #8. It documented the CNA was suspended pending an investigation. A Final State Reportable Incident form, faxed 06/11/24, documented the allegation of abuse was substantiated and CNA #3 was terminated. The supporting documents attached to the incident form documented CNA #3 was observed on video footage cursing and mocking Resident #8. It documented when Resident #8 asked CNA #3 to get out of their room, the CNA replied make me get out. The facility did not have documentation QAPI was involved. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/24 at 2:20 p.m., the Administrator stated the allegation of abuse with Resident #8 was substantiated. They stated it Absolutely was abuse. The stated the CNA was cursing the resident and mocking the resident. They stated it was horrible. The Administrator stated the facility completed an investigation, completed an abuse inservice, completed safe surveys, and terminated the employee. They stated, we didn't take anything to QAPI on this particular abuse investigation. They stated they would involve QAPI if they had back to back abuse or a pattern. They stated they go above and beyond the regulatory requirement for in-services on abuse and training. On 08/08/24 at 2:38 p.m., the Administrator stated the facility did go over incident reports in their QAPI meetings. They stated the meetings were a month behind. They stated they did not meet in July because they had an annual survey. They stated the QAPI had not reviewed this incident.

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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. 35389 Based on record review and interview, the facility failed to ensure the results of abuse investigations were submitted to the State within five business days for two (#7 and #8) of three sampled residents reviewed for abuse. The Administrator identified 82 residents resided in the facility. Findings: An Abuse and Neglect policy, undated, read in part, .no resident shall be subject to abuse and/or neglect .All incidents to include suspected resident abuse will be reported to the Administrator and Director of Nursing immediately .Any staff member involved in any incident will report it immediately to his/her supervisor, and a written statement would be obtained through interview about the incident. The Administrator will be the person to notify appropriate agencies .the employee will be suspended pending the investigation . 1. Resident #7 had diagnoses which included Alzheimer's disease, dysphagia, and anxiety disorder. An Initial State Reportable Incident form, faxed 07/08/24 at 2:10 p.m., documented an allegation of abuse/mistreatment. It documented a family member of Resident #7 reported CNA #4 was verbally abusive during care on the 3:00 p.m. to 11:00 p.m. shift on 07/07/24. It documented video surveillance from the resident's camera was reviewed and the physician and police were notified. It documented the resident was assessed for injuries, the staffing agency the CNA worked for was notified, and the CNA would not be working at the facility during the investigation. A Final State Reportable Incident form, faxed 07/16/24 at 10:10 a.m., documented the investigation was complete and the abuse allegation was unsubstantiated. On 08/08/24 at 12:16 p.m., the Administrator stated abuse was to be reported to the DON and the Administrator. They stated it had to be reported within two hours. They stated the timeline for reporting the final to the State Agency was five days. They stated if the investigation took longer, they would send an Addendum. On 08/08/24 at 12:22 p.m., the Administrator stated Resident #7's incident of abuse was initially reported on 07/08/24. They stated the final report was submitted on 07/16/24. They stated they could not get the accused person to come to the facility and view video footage until the afternoon of 07/15/24. The Administrator stated the final was sent in at 10:00 a.m. on the 16th. 2. Resident #8 had diagnoses which included quadriplegia, post-traumatic stress disorder, and schizoaffective disorder bipolar type. An Initial State Reportable Incident form, dated 06/02/24 at 3:20 p.m., documented an allegation of abuse/mistreatment. It documented the family of Resident #8 observed video footage of CNA #3 cursing and arguing with Resident #8. It documented the CNA was suspended pending an investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Final State Reportable Incident form, faxed 06/11/24, documented the allegation of abuse was substantiated and CNA #3 was terminated. The supporting documents attached to the incident form documented CNA #3 was observed on video footage cursing and mocking Resident #8. It documented when Resident #8 asked CNA #3 to get out of their room, the CNA replied make me get out. There were two faxed confirmations for this form with the same date but different times. One documented 11:20 a.m. and one documented 11:28 a.m. On 08/08/24 at 2:15 p.m., the Administrator stated the allegation of abuse for Resident #8 occurred on Sunday June 2nd. They stated the allegation was reported to the facility by a family member who had video surveillance of the event. They stated the original report was sent to OSDH on 06/02/24. They stated the final report was faxed on 06/11/24. They stated, It was late, but it was done.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35389 Based on observation, record review, and interview, the facility failed to utilize a safe transfer technique when transferring a resident who required two-person physical assistance for one (#10) of one sampled resident observed during a transfer. The Administrator identified 82 residents resided in the facility. Findings: A Safe Lifting and Movement of Residents policy, revised 07/17, read in part, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents .Manual lifting of residents shall be eliminated when feasible .Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices . Resident #10 had diagnoses which included nontraumatic subarachnoid hemorrhage and hemiplegia affecting left nondominant side. Resident #10's Care Plan, initiated on 09/24/23, documented the resident required one to two person assistance with all ADLs due to left sided hemiplegia from a stroke. It documented the intervention for transfers was the resident required a mechanical lift with two staff assistance for transfers. The care plan also documented a focus area for falls. It documented Resident #10 required two person assistance with all transfers with a mechanical lift. An Incident Report, dated 04/10/24, documented Resident #10 had experienced a witnessed fall without injury. It documented Resident #10 stated a CNA was trying to transfer them from the bed to the wheelchair after getting changed. It documented the bed was not low enough, and the resident was lowered to the floor by the CNA. Resident #10's Care plan was updated with interventions which included 04/10/24 actual fall noted educate staff on proper transfer technique, make sure bed is in proper position before transfers. An Incident Report, dated 05/02/24, documented Resident #10 had experienced a witnessed fall without injury. It documented the CNA had notified the nurse the resident had falled on the floor during a transfer from the wheelchair to the bed. Resident #10 reported their bad foot got caught and they ended up on the floor. Resident #10's Care Plan was updated with interventions which included 05/02/24 actual fall no injuries intervention educate staff on proper transfer technique. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Quarterly Resident Assessment, dated 05/15/24, documented Resident #10's cognition was intact, and they had an impairment on one side in the upper and lower extremity. It documented the resident required substantial/maximum assistance for toilet hygiene, shower/bath, upper body dressing, lower body dressing and putting on/taking off footwear. It documented Resident #10 was dependent for a chair/bed-to-chair transfer. An Incident Report, dated 08/02/24, documented Resident #10 had experienced a witnessed fall without injury. It documented Resident #10 stated the CNA was transferring them to the bed and the resident got weak in their good leg. It documented both the resident and the CNA went to the floor. Resident #10's Care Plan was updated with interventions which included 08/02/24 actual fall no injuries intervention staff education to use two person assistance with all transfers. On 08/07/24 at 9:41 a.m., CNA #1 and CNA #2 were observed transferring Resident #10 from their wheelchair to the bed. The CNAs placed one arm under each of the resident's arms and hoisted her onto the bed. No gait belt was utilized. On 08/08/24 at 9:50 a.m., CNA #1 stated they should have used the gait belt. On 08/07/24 at 9:53 a.m., CNA #2 stated, The policy is for safety transfers. They stated they would use a gait belt on limited assist residents and sometimes extensive. On 08/07/24 at 10:48 a.m., the Administrator stated the facility trained on use of gait belts, but staff were not required to use them during a transfer. They stated the only policy was to use a lift if it was required. They stated the care plan would document what was required for transfers. On 08/07/24 at 11:55 a.m., Resident #10 stated they were unable to stand on their own because they were paralyzed on their left side. They stated, I've been dropped five times in the last three weeks. They stated The last time was two to three days ago. They stated on the last fall, they were being transferred by one staff member from their bed to the chair. They stated their one leg got weak and they started shaking and the staff member dropped them. Resident #10 stated they did not have a gait belt on when they fell . On 08/07/24 at 12:45 p.m., CNA #1 stated they had heard Resident #10 had experienced falls. They stated the resident had informed them they experienced falls but never involving CNA #1. They stated the resident was a two person assist for transfers. On 08/07/24 at 12:50 p.m., LPN #1 stated Resident #10 was maximum assistance for transfers and toileting. They stated more than one person should assist them with transfers and it could be up to total assist with a lift. LPN #1 stated they were not aware of any falls experienced by the resident. They stated Resident #10 was very alert and oriented, knew what they can and can't do, and would ask for help. On 08/07/24 at 1:33 p.m., the Regional Nurse stated Resident #10 was a two person assist with transfers with a gait belt because the resident could bear weight. On 08/07/24 at 1:36 p.m., the Regional Nurse and DON stated the resident had experienced a fall on 08/02. The Regional nurse stated the resident had also experienced a fall in April and May of 2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/24 at 1:37 p.m., the Regional Nurse stated on 04/10/24 Resident #10 stated the CNA was trying to transfer the resident from the bed to the wheelchair after getting changed. They stated they did not know if the resident was a two person assist during this timeframe. On 08/07/24 at 1:40 p.m., the Regional Nurse stated on 05/02/24 Resident #10 fell during a transfer from the wheelchair to the bed. They stated by reading the report, it was unclear how many staff members were present during the transfer. The Regional Nurse stated the report documented it was CNA #5 who no longer worked for the facility. On 08/07/24 at 1:43 p.m., the Regional Nurse stated on 08/02/24 Resident #10 was transferred by a CNA to bed, got weak, and both the resident and CNA went to the floor. They stated it was a transfer with only one CNA. On 08/07/24 at 1:45 p.m., the Regional Nurse Reviewed Resident #10's care plan and stated it had been updated today by the Regional Nurse. They stated they were informed the resident was a two person assist. They stated before today, the care plan documented the resident required a two person assist with use of mechanical lift for transfers. They stated they did not know the reason the care plan documented mechanical lift. They stated the resident was care planned for a two person assist for transfers since 09/24/23.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 35389 Based on record review and interview, the facility failed to monitor nutritional intake for two (#1 and #2) of three sampled residents reviewed for nutrition. The Administrator identified 82 residents resided in the facility. Findings: A Snacks policy, revised 09/10, read in part, .The purpose of this procedure is to provide the resident with adequate nutrition .Supplements to be offered if meal consumption is less than 50 [percent] .To document supplement - Y - for yes supplement given N .supplement not given .record the following information in the resident's medical record .date and time the snack was served .The amount of snack eaten by resident . 1. Resident #1 had diagnoses which included senile degeneration of the brain, dementia, and Parkinson's disease. Resident #1's Care Plan, revised 03/29/24, documented provide regular diet, document how much is eaten after each meal. A Physician Order, dated 05/20/24, documented Resident #10 had a regular diet regular texture, regular thin consistency. A Quarterly Resident Assessment, dated 06/09/24, documented Resident #1's cognition was moderately impaired and required setup or clean up assistance for the task of eating. Resident #1's July 2024 Nutrition Amount Eaten record documented 59 blanks out of 93 opportunities. Resident #1's July 2024 snack pass record documented 57 blanks out of 86 opportunities. Resident #1's July 2024 supplement offer mighty shake if eats less than 50 percent documented 57 blanks out of 86 opportunities. 2. Resident #2 had diagnoses which included hypoxemia and personal history of traumatic brain injury. Resident #2's Care Plan, revised 06/06/24, documented regular no added salt diet, regular texture, regular/thin consistency liquids. It documented serve diet as order and monitor intake and record every meal. Resident #2's Quarterly Resident Assessment, date 07/17/24, documented the resident's cognition was intact and they required setup or clean up assistance for the task of eating. Resident #2's July 2024 Nutrition Amount Eaten record documented 28 blanks out of 93 opportunities. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's July 2024 snack pass record documented 31 blanks out of 86 opportunities. Resident #2's July 2024 supplement offer might shake if eats less than 50 percent documented 30 blanks out of 86 opportunities. On 08/08/24 at 11:15 a.m., CNA #6 stated if they assisted a resident on the hall with eating, they would document what they ate. They stated if the resident ate in the dining room, then the staff in there would write down what they ate. They stated it was documented in the computer. They stated if there were blanks, it meant Someone didn't do them. On 08/08/24 at 11:20 a.m., CNA #7 stated staff would feed residents and mark the amount consumed on the meal percentages. They stated if the area was blank, They didn't chart it. On 08/08/24 at 11:30 a.m., the DON stated either the nurse or the CNA would document residents' meal intake after they were finished eating. They stated blanks meant It wasn't charted. On 08/08/24 at 11:37 a.m., the DON stated they did not have an explanation for the blanks, and staff wouldn't know whether or not to give a mighty shake if there was nothing documented.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35389 Based on observation, record review, and interview, the facility failed to ensure medication was swallowed by the resident for one (#1) of one sampled resident observed with a medication on their shirt. The Administrator identified 82 residents resided in the facility. Findings: An Administering Medications policy, revised 04/19, read in part, .Medications are administered in a safe and timely manner, and as prescribed .The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones . Resident #1 had diagnoses which included senile degeneration of the brain, dementia, constipation, and Parkinson's disease. A Physician Order, dated 05/21/24, documented Colace 100mg give one capsule by mouth one time a day related to constipation. A Quarterly Resident Assessment, dated 06/09/24, documented Resident #1's cognition was moderately impaired. On 08/07/24 at 12:10 p.m., Resident #1 was observed to have a red circular pill on the top of their blue shirt. On 08/07/24 at 12:15 p.m., LPN #1 stated It looks like a pill. They stated maybe it had dropped when the staff gave the resident their pills. On 08/07/24 at 12:16 p.m., CMA #1 stated it was the resident's Colace. They stated the resident spit it out on me. CMA #1 stated they had administered the resident's medication that morning. They stated they were to stand there and make sure [the Resident] swallowed. They stated they did not leave medications in resident rooms. They stated Resident #1 cheeked them. They stated that was the first time the resident had done that. The CMA stated they administered the medication around 10:00 a.m. that morning. On 08/07/24 at 2:00 p.m., the Regional Nurse stated the facility used the punch initial give method for medication administration. They stated staff would verify it was the right medication, right resident, right dose, right time, and right route before administering the medication. They stated staff would sign off on the electronic medical record once the medication was administered.