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	09/17/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 46653 Based on record and interview, the facility failed to ensure call lights were accessible for one (#5) of seven sampled residents reviewed for call lights. The DON identified 82 residents resided in the facility. Findings: A Falling Leaves Fall Prevention Program, dated 08/25/23, read in part, 22. Call lights in reach and in good working order. Res #5 had diagnoses which included heart failure, emphysema, paraplegia and quadriplegia. A physician order, dated 05/07/24, documented falling leaves prevention program. On 09/12/24 at 1:54 p.m., Res #5's call light was not accessible while resting in bed. On 09/12/24 at 1:55 p.m., LPN #1 stated Res #5's call light was supposed to be within reach while resting in bed. On 09/17/24 at 4:12 p.m., Res #5's call light was not in accessible while resting in bed. On 09/17/24 at 4:13 p.m., RN #1 stated Res #5's call light was stuck behind their pillow in their bed.

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

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	09/17/2024

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 46653 Based on observation and interview, the facility failed to have an effective pest control for one (#9) of nine sampled residents reviewed for pest control. The DON identified 82 residents resided in the facility. On 09/17/24 at 2:50 p.m., Res #9 was observed with eight flies located on different areas of their body. On 09/17/24 at 2:52 p.m., housekeeping #1 stated there were lots of flies, but they sprayed. On 09/17/24 at 2:56 p.m., CMA #1 stated there had always been a lot of flies on hall 400.