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| 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 03/24/2025 |
| 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>48344</p> <p>Based on record review and interview, the facility failed to ensure a resident's legal representative was notified of a resident's refusal to use a c-pap for 1 (#3) of 3 sampled residents reviewed for respiratory care.</p> <p>The administrator identified 72 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #3 had diagnoses which included chronic respiratory failure with hypoxia, bipolar disorder, generalized anxiety, and major depressive disorder.</p> <p>A court ORDER APPOINTING GUARDIAN, dated 04/07/21, showed the Resident #3 had a court appointed guardian. The court appointed guardian was listed on Resident #3's electronic health record as the guardian, power of attorney, and emergency contact.</p> <p>Resident #3's quarterly resident assessment, dated 11/21/24, showed the resident's cognition was intact with a BIMS of 15.</p> <p>A care plan, initiated, 07/12/24, showed Resident #3 often will remove the c-pap once staff has left the room, staff has found it under their bed before where they had tossed/tried to hide it. Staff to encourage them to keep it in place and not remove it.</p> <p>A physician's order, dated 07/19/24, read in part, the resident was to wear c-pap due to sleep apnea. Oxygen to bleed [oxygen going through the tube] in at 3 LPM [liters per minute], c-pap setting: 6 cmH2O to 14 cmH2O. The Resident may remove at their discretion every evening and night shift related to chronic respiratory failure with hypoxia. Document when the resident refuses to wear c-pap.</p> <p>The January 2025 TAR showed refused for Resident #3's evening shift c-pap administration on the 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, 12th, 13th, 18th, 19th, and 25th.</p> <p>The January 2025 TAR showed refused for Resident #3's night shift c-pap administration on the 1st, 2nd, 3rd, 7th, 8th, 9th, 10th, 11th, 12th, 14th, 15th, 16th, 17th, 20th, 21st, 22nd, and 23rd.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A nursing note, dated 01/16/25 at 10:09 a.m., read in part, Resident's representative [name withheld], expressed concerns to me regarding Resident #3's condition reporting they were experiencing low oxygen saturation. Resident was refusing to wear their c-pap at night due to discomfort. I let [name withheld] know we were going to send a new pulmonologist referral and have the c-pap company come evaluate their c-pap and pressure setting. [name withheld] requested to be updated when we have updates. I assured them I would. No additional questions or concerns at this time.</p> <p>There was no documentation prior to 01/16/25 Resident #3's legal guardian was aware of their refusal to use the c-pap.</p> <p>On 03/19/25 at 4:14 p.m., CNA #4 stated Resident #3 was non-compliant with care and diet including the use of the c-pap machine. They stated the resident's memory was intact.</p> <p>On 03/19/25 at 4:16 p.m., CNA #4 stated Resident #3 mostly needed assistance with transfers.</p> <p>On 03/19/25 at 4:21 p.m., LPN #3 stated they were familiar with Resident #3. They stated the resident was non-complaint with oxygen and c-pap use.</p> <p>On 03/19/25 at 4:25 p.m., LPN #3 stated Resident #3's cognition was intact.</p> <p>On 03/19/25 at 4:27 p.m., LPN #3 stated nurses were responsible for administering c-pap for residents.</p> <p>On 03/19/25 at 4:28 p.m., LPN #3 stated if a resident refuses care, the first emergency contact was notified and if unable to reach, call the second emergency contact, notify the doctor and document notification.</p> <p>On 03/19/25 at 4:30 p.m., LPN #3 stated if there was a pattern of refusal to use a c-pap, they would notify the resident's representative. They stated Resident #3's family had a camera in the resident's room and were able to see everything.</p> <p>On 03/19/25 at 4:32 p.m., LPN #3 stated they did not notify Resident #3's legal guardian of the resident's refusal to use the c-pap.</p> <p>On 03/19/25 at 4:36 p.m., the DON stated staff were to notify the physician and family of refusal of treatment unless the resident is their own representative. They stated when they started working at the facility in January 2025, they identified staff were not notifying family so they did a performance improvement plan and staff in-service.</p> <p>On 03/19/25 at 4:38 p.m., the DON stated refusal to use a c-pap required family/guardian notification.</p> <p>On 03/19/25 at 4:47 p.m., the DON stated there was no documentation Resident #3's legal guardian was notified of refusals to use c-pap prior to 01/16/25.</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48344</p> <p>Based on record review and interview, the facility failed to ensure:</p> <p>a. the results of an abuse/mistreatment investigation were reported to the State Agency within 10 business days for 1 (#2); and</p> <p>b. an allegation of abuse/mistreatment was reported to the appropriate licensing board in a timely manner for 1 (#2) of 3 sampled residents reviewed for timely care and treatment.</p> <p>The administrator identified 72 residents resided in the facility.</p> <p>Findings:</p> <p>The Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, revised 04/2021, read in part, Findings of all investigations are documented and reported.</p> <p>Resident #2 had diagnoses which included altered mental status and quadriplegia.</p> <p>An Initial INCIDENT REPORT FORM, dated 03/03/25, showed an allegation of abuse/mistreatment. The report showed Resident #2 told LPN #1 that they were sick. The report showed Resident #2 vomited on themselves, and LPN #1 refused to clean them up and left them covered in their vomit until the aide on the next shift came in to clean them up. The report showed the appropriate licensing board had been notified.</p> <p>The final investigation report was not sent to the State Agency within 10 business days after the incident on 03/03/25. There was no documentation to show the appropriate licensing board was notified on 03/03/25.</p> <p>On 03/20/25 at 12:34 p.m., the administrator stated the process was to send a final report of an investigation to the State Agency within five days. They stated their fax machine had issues so the final report was sent in today.</p> <p>On 03/20/25 at 12:35 p.m., the administrator stated the report was not successfully sent in a timely manner to the State Agency.</p> <p>On 03/20/25 at 12:44 p.m., the administrator stated they did not notify the appropriate licensing board in a timely manner. They stated they sent the notification today.</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344</p> <p>On 03/21/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to assess, intervene, and evaluate a resident in accordance with physician's orders and professional standards of practice for Resident #2.</p> <p>On 03/21/25 at 10:21 a.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.</p> <p>On 03/21/25 at 1:45 p.m., the administrator, DON, and the director of clinical services were notified of the IJ situation and the IJ template was provided.</p> <p>On 3/24/25 at 1:55 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,</p> <p>[NAME] healthcare Center Plan of Removal Immediate Jeopardy 03/21/25.</p> <p>The facility's response to the IJ called for the facility to implement a plan of removal to ensure there is a system in place to assess, intervene and evaluate to receive appropriate care and treatment. The facility will be in compliance on 3/21/25 by 10:00 p.m.</p> <ol style="list-style-type: none"> 1. All staff are educated on reviewing and following physician orders for a change of condition on hire and annually, as well as periodically as a reminder. 2. In-service will be completed with all core nursing staff by 10:00 p.m. on 03/21/25 over the following: <ol style="list-style-type: none"> A. Acute Change of Condition Policy to include the following interventions to prevent a decline in condition and/or a lack of treatment/care: <ol style="list-style-type: none"> a. Any resident who is determined to have a change of condition during a nurse's shift will be assessed and a progress note will be placed describing the event and the interventions that were done to prevent further decline. b. Resident will be monitored every shift with documentation on residents condition until stable. c. The resident's provider will be notified in a timely manner as well as the resident's family if applicable, and any orders implemented as required. B. Following physicians orders as required. 3. The Administrator and DON have been in-serviced over events requiring investigations and reports to OSDH [Oklahoma State Department of Health] and presenting related education to the staff following the event or situation to prevent recurrence. <p>3. Agency will be provided with in-service materials as well.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>4. Any staff on vacation or unable to reach will be in-serviced before working their next shift.</p> <p>The IJ was lifted, effective 03/21/25 at 10:00 p.m., when all components of the plan of removal had been completed. Multiple staff on all shifts were interviewed on the in-service received and the acute change in condition and physician notification policies were reviewed. The deficiency remained at an isolated level with the potential for more than minimal harm.</p> <p>Based on record review and interview, the facility failed to complete a resident assessment, intervene, and evaluate the resident in accordance to physician's orders and professional standards of practice for 1 (#2) of 3 sampled residents reviewed for timely care and treatment.</p> <p>The administrator identified 72 residents resided in the facility.</p> <p>Findings:</p> <p>The Resident Rights policy, revised 12/2016, read in part, Employees shall treat all residents with kindness, respect, and dignity.</p> <p>The Administering Medications policy, revised 04/2019, read in part, Medications are administered in a safe and timely manner, and as prescribed.</p> <p>Resident #2 had diagnoses which included altered mental status, quadriplegia, contracture of left hand, depression, schizoaffective disorder, bipolar type, and anxiety disorder.</p> <p>A physician's order, dated 05/08/24, showed Zofran (anti-nausea) 4 milligrams, give one tablet by mouth every four hours as needed for nausea and vomiting.</p> <p>Resident #2's quarterly resident assessment, dated 02/14/25, showed the resident had moderate cognitive impairment (BIMS 09) and they were dependent on staff for activities of daily living.</p> <p>An Initial INCIDENT REPORT FORM, dated 03/03/25, showed an allegation of abuse/mistreatment. It report showed Resident #2 told LPN #1 that they were sick. The report showed Resident #2 vomited on themselves, and LPN #1 refused to clean them up and left them covered in their vomit until the aide on the next shift came in to clean them up. The report showed the appropriate licensing board had been notified.</p> <p>There was no documentation in the nurses note regarding the incident or the resident was cleaned during the time of the incident as of 03/21/25.</p> <p>There was no documentation the resident received Zofran on 03/03/25 as of 03/21/25.</p> <p>On 03/20/25 at 8:35 a.m., Resident #2 stated they never threw up in the facility.</p> <p>On 03/20/25 at 9:51 a.m., Resident #2's representative stated the resident called them at around 3:00 a.m. on 03/03/25, because they threw up on themselves and wanted to be cleaned up. They stated they called the facility to inform them and the nurse in charge told them they knew and when the new shift came in, they would clean the resident. They stated they reviewed the camera in the room and the nurse had told the resident they had to wait.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 03/20/25 at 12:36 p.m., the administrator stated they reviewed the video of the 03/03/25 incident and terminated the nurse the same day. They stated there was nothing to investigate because it was clear in the video.</p> <p>On 03/20/25 at 12:37 p.m., the administrator stated the resident had told the nurse they were sick and the nurse left the room. They stated the nurse later came back and told the resident they would have to wait to be cleaned. They stated they could not tell how long the resident was left in their vomit because the video did not have a time stamp.</p> <p>On 03/20/25 at 12:40 p.m., the administrator stated they did not do an in-service related to Resident #2's incident, but they had done a staff in-service on resident rights and dignity on 02/27/25.</p> <p>On 03/20/25 at 12:41 p.m., the administrator and DON stated the nurse was terminated for leaving the resident in their own vomit, not taking care of the resident, and poor bedside manners.</p> <p>On 03/20/25 at 12:45 p.m., the director of clinical services stated Resident #2 did not receive the Zofran on 03/03/25 when they complained of being sick.</p> <p>On 03/20/25 at 12:48 p.m., the administrator and DON stated it was not acceptable for the resident to be left in their vomit.</p> <p>On 03/20/25 at 12:50 p.m., CNA #1 stated they told the nurse around 1:30 a.m. on 03/03/25, Resident #2 reported they felt sick. They stated around 2:00 a.m. on 03/03/25, Resident #2 complained of being sick again and they informed the nurse. CNA #1 stated around 6:00 a.m. on 03/03/25, they walked by the resident's room and saw the vomit on the resident and they cleaned them up. They stated they were not scheduled to work on that hall.</p> <p>On 03/21/25 at 8:36 a.m., Resident #2's representative stated the resident was upset when they called them on 03/03/25 and had used a few curse words. The resident told them it was not right that the staff did not clean them. They stated the resident's memory was not good, but complained sometimes the facility did not care about them.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344</p> <p>On 03/18/25, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to supervise a resident with a known history of suicide attempt from access to a box cutter for Resident #4.</p> <p>On 03/18/25 at 5:23 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.</p> <p>On 03/18/25 at 5:28 p.m., the administrator and the chief nursing officer were notified of the IJ situation and the IJ template was provided.</p> <p>On 3/20/25 at 9:37 a.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part,</p> <p>[NAME] healthcare Center Plan of Removal Immediate Jeopardy 03/18/25.</p> <p>The facility's response to the IJ called for the facility to implement a plan of removal to ensure there is a system in place to protect residents.</p> <p>1. In-service will be completed with all staff by 10:00 p.m. on 3/18/25 over the following:</p> <p>a. Suicide Precautions Policy</p> <p>b. Supervision of residents exhibiting signs of suicidal ideations to prevent access to sharps, chemicals, and other hazardous objects or materials and if any noted staff are to remove objects of concern and notify the DON or Administrator immediately.</p> <p>c. Agency staff will be provided with in-service as well.</p> <p>d. Any staff on vacation or unable to reach will be in-serviced before working their next shift.</p> <p>2. All residents were audited for history or diagnosis of Suicidal Ideations 3/12/25 and:</p> <p>a. Psych [psychiatric] Consult and Counseling orders were received for one resident identified as having a history of suicidal ideations.</p> <p>b. Behavior Monitoring will be implemented on admission for any resident with history of suicidal ideations until resident has been cleared by psychiatric evaluation.</p> <p>c. Frequent monitoring will be immediately implemented for any resident identified as verbalizing having suicidal ideations to include 1:1 monitoring.</p> <p>d. Care Plans will be updated to include Suicidal Ideations and interventions for protection and prevention of self-harm or harm to others.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>3. Trauma Informed Care Assessment will be completed for all residents on admission and if any suicidal ideations are noted Suicide Precautions will be implemented.</p> <p>4. Physician will be notified of any resident noted with immediate concerns of suicidal ideations and they will be placed on 1:1 monitoring until resident can be transferred to a higher level of care.</p> <p>The IJ was lifted, effective 03/18/25 at 10:00 p.m., when all components of the plan of removal had been completed. Multiple staff on different shifts were interviewed regarding the in-service they received, resident audits were reviewed and the care plan and physician orders for the identified resident were reviewed. The suicide precaution policy and trauma care informed assessment completion plan was reviewed. The deficiency remained at an isolated level with the potential for more than minimal harm.</p> <p>Based on record review and interview, the facility failed to supervise a resident with a known history of suicide attempt from access to a box cutter for 1 (#4) of 3 sampled residents reviewed for accident hazards.</p> <p>The administrator identified 72 residents resided in the facility and 37 residents received mental health services.</p> <p>Findings:</p> <p>The Safety and Supervision of Residents policy, revised 07/2017, read in part, Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents .The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents .Resident supervision is a core component of the systems approach to safety.</p> <p>An undated facility SUICIDE PRECAUTION policy, read in part, To provide staff with guidelines by which to plan, intervene, to control and prevent harmful behavior .The interdisciplinary team should evaluate residents who exhibit suicidal tendencies and a plan put into place to manage their psychological needs. Definition of suicidal ideation: A history of attempted suicide.</p> <p>Resident #4 had diagnoses which included suicidal ideation, unspecified lack of coordination, and abnormalities of gait and mobility.</p> <p>A physician progress note, dated 08/27/24, read in part, Patient reported to the ER [emergency room] staff that they was attempting to kill themselves after being evicted from housing which caused them distressed.</p> <p>A physician's order, dated 09/09/24, showed community pathways to eval and treat.</p> <p>An eye institute After Visit Summary, dated 10/03/24, showed secondary optic atrophy of both eyes and ischemic optic neuropathy of both eyes.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>A care plan, initiated, 09/05/24, showed Resident #4 had impaired visual function related to secondary optic atrophy of both eyes and ischemic optic neuropathy of both eyes. The care plan showed the resident was able to see silhouettes and shades of gray and able to ambulate using a cane.</p> <p>A care plan, initiated, 11/04/24, showed Resident #4 was often manipulative, had a recent history of attempting suicide, became very angry and yelled at staff. The care plan showed to have two staff members present for all resident interactions if possible.</p> <p>Resident #4's quarterly resident assessment, dated 03/02/25, showed the resident's cognition was intact (BIMS 15).</p> <p>A 30-Day Involuntary Transfer/Discharge Notice, dated 02/10/25, showed the resident had failed after reasonable notice, to pay for their stay at the facility. The discharge date was set for 03/11/25 to a shelter.</p> <p>A social service note, dated 03/05/25, read in part, Resident discharging to [shelter name withheld] on Tuesday. [name withheld] will transport. No DME [durable medical equipment] or home health needed for resident. Medication will be called in to [pharmacy name withheld] on Monday.</p> <p>A nursing note, dated 03/11/25 at 12:30 p.m., read in part, Staff alerted me that resident was in their bathroom and had cut both wrists and left side of their neck, upon arrival observed resident with boxcutter in their right hand and blood running down both wrist and right side of their neck, resident was waving the boxcutter in anger manner telling staff to move away or they will cut them, that they want to die because they don't want to go back to homeless shelter and dying was their best outlet, continue to talk to resident to get them to calm down and to remove the boxcutter out of their hand, they at this time allowed me to remove boxcutter and apply pressure to bilateral wrist and right side of neck area, resident started yelling and crying saying they just wanted to die, continue with pressure applied to the areas of concern until EMS [emergency medical services] arrive to take over and transport resident to [hospital name withheld].</p> <p>A nursing note, dated 03/11/25 at 12:55 p.m., read in part, While resident was being transported asked resident where they get the boxcutter from they stated they purchased it while they went out on self initiated trip to [name withheld] and placed in their pocket and kept it there until today when attempted to cut bilateral wrists and right side of neck, stated they kept it there to keep away from staff.</p> <p>An Initial INCIDENT REPORT FORM, dated 03/11/25, showed physical harm. The report showed the resident had cut both wrists and left side of their neck. The report showed the resident was observed with a boxcutter in their right hand. The report showed the resident had a planned discharge for today.</p> <p>There was no documentation Resident #4 was on behavior monitoring as of 03/17/25.</p> <p>On 03/17/25 at 2:30 p.m., CNA #2 stated Resident #4 had their moments of behavior. They stated they never witnessed it, but was informed the resident did yell and got upset sometimes.</p> <p>On 03/17/25 at 2:32 p.m., CNA #2 stated Resident #4 used a cane for ambulation. They were told the resident was legally blind, but they believed the resident could see.</p> <p>(continued on next page)</p> | | |

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| 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 03/24/2025 |
| 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. | | | |
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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 03/17/25 at 2:34 p.m., CNA #2 stated they were not familiar with the facility neighborhood, but the shopping center was not within walking distance of the facility. They stated the facility had shopping center trips. CNA #2 stated they were not sure when those trips were held.</p> <p>On 03/17/25 at 2:36 p.m., CNA #2 stated they were not aware Resident #4 had a box cutter.</p> <p>On 03/17/25 at 2:46 p.m., CNA #3 stated Resident #4 liked attention and proving a point. They stated the resident had manipulative behaviors.</p> <p>On 03/17/25 at 2:47 p.m., CNA #3 stated they were not aware Resident #4 had a box cutter.</p> <p>On 03/17/25 at 2:55 p.m., LPN #2 stated Resident #4 complained a lot, but did not have behaviors.</p> <p>On 03/17/25 at 2:56 p.m., LPN #2 stated Resident #4 used a cane for ambulation. They stated there was no shopping center within walking distance of the facility.</p> <p>On 03/17/25 at 2:57 p.m., LPN #2 stated they were the nurse for Resident #4 on 03/11/25. They stated they were informed to call 911 upon returning from a 15 minute break. They stated they went into the resident's room and found the assistant director of nursing and DON assisting the resident to stop the bleeding prior to emergency services arrival.</p> <p>On 03/17/25 at 3:00 p.m., LPN #2 stated they were not aware the resident received medication for behaviors.</p> <p>On 03/17/25 at 3:02 p.m., LPN #2 stated Resident #4 was not on behavior monitoring.</p> <p>On 03/17/25 at 3:03 p.m., LPN #2 stated they were not aware Resident #4 had a box cutter.</p> <p>On 03/17/25 at 3:12 p.m., the social services director stated they first initiated talks about discharge on 01/14/25. They stated they gave Resident #4's 30 day involuntary discharge notice on 02/10/25.</p> <p>On 03/17/25 at 3:23 p.m., the social services director stated they had spoken to Resident #4 on 03/11/25 about making payments and the resident refused to pay. They stated they had informed the resident their ride was about 10 minutes away. The social services director stated housekeeping had helped the resident pack their belongings and took them to the front. The social services director stated the resident asked to use the bathroom due to having diarrhea, so they took the rest of the resident's belongings to the front. They stated they returned to the room to wait for the resident. They stated a CNA had stopped by to say [NAME] to the resident. They stated the resident remained in the bathroom so they asked the CNA to open the door and check on the resident. They stated the CNA observed blood on the floor, the resident had cut both wrists and side of their neck. The social services director stated they notified the DON.</p> <p>On 03/17/25 at 3:28 p.m., the social services director stated they were not aware the resident had a history of attempting suicide with eviction.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 3/17/25 at 3:34 p.m., the activity director stated Resident #4 required supervised shopping due to their selective blindness. They stated the transport personnel assisted the resident during their shopping center outing. The activity director stated they could not confirm nor deny the resident bought a box cutter from the shopping center trip.</p> <p>On 03/17/25 at 3:40 p.m., the activity director stated Resident #4 last went to the shopping center on 02/11/25 at 9:30 a.m.</p> <p>On 03/18/25 at 10:56 a.m., the DON stated they were notified the resident was in the bathroom with blood. They stated the resident had cut both wrists and side of their neck. They stated they were not sure how deep the cuts were, but there was a lot of blood on the floor. They stated the resident remained conscious. The DON stated they called the police and emergency services should the resident refuse to go out for treatment. They stated they applied pressure to stop the bleeding. They stated the resident initially refused to give them the box cutter, but they eventually did. They stated once the resident was calmed, they told the DON they had gone to the shopping center and purchased the box cutter and hid it. The DON stated the resident stated they attempted suicide because they did not want to go to the homeless shelter.</p> <p>On 03/18/25 at 11:02 a.m., the DON stated Resident #4 had counseling services. They stated the resident was not totally blind and they were independent for all activities of daily living except bathing. They stated the resident would not let staff touch their clothing. The DON stated the resident was allowed to check out and go out.</p> <p>On 03/18/25 at 11:11 a.m., the DON stated they started employment at the facility in January 2025. They stated they were not aware the resident had a history of attempting suicide with eviction.</p> <p>On 03/18/25 at 11:32 a.m., the activity director stated they would assist with checkout for residents who required supervision and the residents who were independent would checkout on their own. They stated they did not keep receipts to verify purchases.</p> <p>On 3/18/25 at 12:58 p.m., the administrator was asked what the facility did after the incident. They stated they did a sweep of the facility and resident rooms to identify any safety concerns. They stated they obtained statements from everyone involved and cleaned Resident #4's bathroom. They stated they sent a report to the State Agency.</p> <p>On 3/18/25 at 1:00 p.m., the administrator stated the transport personnel was in the facility on 03/11/25. They stated the transport personnel stated they could not remember the resident purchasing a box cutter. The administrator stated Resident #4 did online shopping center deliveries and food deliveries. They stated online deliveries were new and they could not impede resident rights. They stated they did not have a process in place for online deliveries.</p> <p>On 3/18/25 at 4:53 p.m., the transport personnel stated they did not normally assist residents with shopping. They stated they assisted Resident #4 because the activity director requested assistance. They stated they helped the resident retrieve a pair a pants and they accompanied the resident back to CNA #4. They stated the resident had some cookies, beauty products, and a pair of pants. The transport personnel stated they did not remember what the beauty products were.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>On 3/18/25 at 4:59 p.m., the transport personnel stated, I misremember. They stated they assisted Resident #4 with checkout prior to handing the Resident to CNA #4.</p> <p>On 3/18/25 at 5:00 p.m., the transport personnel stated they did not see Resident #4 purchase a box cutter.</p> <p>On 3/18/25 at 5:03 p.m., the transport personnel stated they no longer worked for the company as of yesterday.</p> | | |