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	07/24/2025

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 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. Based on record review and interview, the facility failed to complete and submit a final report of findings of an investigation after an allegation of verbal abuse for 1 (#3) of 3 sampled residents reviewed for abuse. Administrator #1 identified 80 residents resided in the facility.Findings:An Abuse Investigation and Reporting policy, revised 07/2017, read in part, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ('abuse').The administrator. or his/her designee, will provide the appropriate agencies or individuals.a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. An undated care plan for Resident #3's showed the resident had diagnoses which included hypertension and diabetes mellitus type 2.An Initial Incident Report Form, dated 03/06/25, read in part, [Resident #3] was very upset because [they] could not find [their] remote control to [their] TV [television], [CNA #5] (employee) told [Resident #3] that [they] needed to calm down and stop yelling. [CNA #5] spoke to [Resident #3] in a tone/manner that they are used to speaking but [CNA #5] did have to raise [their] volume due to [Resident #3] yelling. The resident did not seem to be offended by [CNA #5] tone/manner and [CNA #5] ordered a replacement remote for the resident. Administrator was notified, [CNA #5] was suspended immediately upon notification.There was no documentation of the results of an abuse/mistreatment investigation or documentation of final results being reported.On 07/23/25 at 3:22 p.m., the DON stated they could not find the follow up and the final 5-day investigation.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to conduct a thorough investigation after an allegation of abuse/mistreatment for 1 (#2) of 3 sampled residents reviewed for abuse.Administrator #1 identified 80 residents resided in the facility.Findings:An Abuse Investigation and Reporting policy, revised 07/2017, read in part, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ('abuse') shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident.Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it.An undated facesheet for Resident #2 showed diagnoses of dehiscence of wound of abdominal wall and acute kidney failure.A Final State Reportable Incident form, dated 07/16/25, read in part, [Family member] stated they arrived at the facility at about 2pm on Sunday 07/13/25 and noted [Resident #2] to be throwing up, and they had bowel movement on them. [Family member] said [Resident #2] had IV fluids running. [They] [were] upset that no one had called them to inform them that there had been changes or that [Resident #2] was on IV fluids or new medications. [They] stated they requested the nurse to clean [Resident #2] up and [the nurse] said [they] would get a CNA to assist. [Family member] also stated they asked for the nurse to come and check [Resident #2] and [they] did not come in a timely manner.[They] had waited for about 15 minutes total when they decided they just wanted [Resident #2] sent to the ER [emergency room]. There was no documentation of employee witness statements being conducted.On 07/23/25 at 1:48 p.m., the DON stated they had spoken with registered nurse #1, licensed practical nurse #1, and CNA #1.On 07/23/25 at 1:52 p.m., the assistant director of nursing stated they had not been told to do interviews with staff.On 07/23/25 at 1:54 p.m., the DON stated they had spoken with staff, but they had not written it down. The DON stated, I usually just talk with them.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, record review, and interview, the facility failed to place a call light within reach of a resident for 1 (#1) of 1 sampled resident who was observed for call lights.Administrator #1 identified 80 residents resided in the facility.Findings:On 07/23/25 at 2:35 p.m., Resident #1's call light was observed nearest the head of bed laying on top of a pillow. Resident #1 was observed in their Geri-chair approximately two feet away from the bed.An Answering the Call Light policy and procedure, revised 03/2021, read in part, The purpose of this procedure is to ensure timely response to the resident's request and needs.When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.A quarterly resident assessment, dated 05/17/25, showed Resident #2 was cognitively intact.An undated care plan for Resident #1 showed the resident had diagnoses which included post traumatic disorder and quadriplegia.On 07/23/25 at 2:38 p.m., Resident #1 stated they could use the call light if it was clipped to their shirt and placed under their chin so they could use their chin to activate it.On 07/23/25 at 2:50 p.m., CNA #1 stated the call light was on the bed and yes Resident #1 was able to use it. On 07/23/25 at 2:53 p.m., CNA #1 stated the policy for call lights was it was to be within reach of the resident and to make sure the call light was in working order. On 07/23/25 at 3:02 p.m., the director of clinical services stated the expectation was to have call lights within reach of the residents.