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	01/05/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, record review, and interview, the facility failed to ensure the physician was notified of a change in condition for 1 (#21) of 3 sampled residents reviewed for changes in skin condition. The administrator identified 72 residents resided in the facility. Findings: On 01/02/26 at 10:55 a.m., CNA #1 and CNA #2 were observed assisting Resident #21 into their bed via mechanical lift after providing shower assistance. Resident #21 was observed to have an open area and multiple scabbed areas of various sizes to their left buttocks. A physician's order for Resident #21, dated 06/17/24, showed weekly skin assessments were to be done every Monday on the day shift. A skin assessment report for Resident #21, dated 12/11/25, showed no skin problems. No other skin assessments were completed after 12/11/25. On 01/05/26 at 8:25 a.m., LPN #2 was asked if the physician had been notified of the areas on Resident #21's left buttocks and what kind of treatment was performed on the wounds. LPN #2 stated there was no documentation the physician had been notified of Resident #21's skin problems or a physician's order for wound care to the resident's left buttocks.

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure:a. a discharge assessment was encoded and transmitted for 1 (#3) of 3 sampled residents whose discharge assessments were reviewed for encoding and transmission; andb. a quarterly assessment was completed, encoded, and transmitted for 1 (#66) of 18 sampled residents whose quarterly assessments were reviewed for completion, encoding, and transmission.The administrator identified 72 residents resided in the facility. Findings: A policy titled Electronic Transmission of the MDS, dated [DATE], read in part, All MDS assessments .and discharge and reentry records are completed and electronically encoded and transmitted .in accordance with current OBRA [Omnibus Budget Reconciliation Act] regulations. A Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, read in part, For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or PPS [prospective payment system] assessment, encoding must occur within 7 days after the MDS Completion Date. 1. A Quarterly MDS, dated [DATE], showed Resident #3 was admitted to the facility on [DATE] with diagnoses to include quadriplegia and respiratory failure. A Discharge Return Anticipated MDS, dated [DATE], showed Resident #3's MDS assessment was in progress. On 12/31/25 at 11:21 a.m., the MDS coordinator was asked what their process was for completing and transmitting discharge assessments. They stated, I complete it the day the resident goes out. The MDS coordinator was asked when Resident #3's discharge assessment from 12/05/25 was to be completed and transmitted. They stated, It was supposed to already be done. 2. Resident #66's quarterly resident assessment, dated 12/04/25, showed the assessment was in progress. The assessment showed it was to be completed by 12/17/25. On 12/31/25 at 1:57 p.m., the MDS coordinator stated the required time frame to complete the assessment was about seven days. They stated it did not take them long to complete the assessments, but they were running behind on all of them.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, and interview, the facility failed to:a. ensure weekly skin assessments were completed for 1 (#21), andb. complete wound treatment as ordered for 1 (#45) of 3 sampled residents reviewed for wounds.The administrator identified 72 residents resided in the facility. Findings: 1. On 01/02/26 at 10:55 a.m., CNA #1 and CNA #2 was observed assisting Resident #21 into bed via mechanical lift after providing shower assistance. CNA #1 donned a gown and gloves and continued to assist Resident #21 with catheter care and incontinent care. Resident #21 was observed to have an open area and multiple scabbed areas of various sizes to their left buttocks. A physician's order for Resident #21, dated 06/17/24, showed weekly skin assessments were to be done every Monday on the day shift. A care plan, updated on 05/08/25, showed to monitor wound dressing to left buttocks and change as needed if soiled. December 2025 monthly physician orders showed Resident #21 had diagnoses which included cerebrovascular infarction, traumatic brain injury, hemiplegia, chronic pain, and neuromuscular dysfunction of the bladder A skin assessment report for Resident #21, dated 12/11/25, showed no skin problems. No other skin assessments were shown to be completed after 12/11/25. A quarterly assessment, dated 11/24/25, showed a BIMS score of 6, indicating moderate cognitive deficit. No skin issues were identified. On 01/05/26 at 8:25 a.m., LPN #2 was asked what kind of treatment did Resident #21 receive to the wounds on their left buttocks. LPN #2 stated there was no order for wound care to Resident #21's left buttocks. LPN #2 stated there was no other weekly skin assessment performed since 12/11/25. On 01/05/26 at 8:40 a.m., the DON stated the wound care nurse was responsible for completing weekly skin assessments. 2. On 01/05/26 at 10:48 a.m., LPN #3 was observed performing Resident #45's wound treatment. They did not treat Resident #45's wound with silver alginate as ordered by the wound care provider. A physician's order for Resident #45, dated 12/28/25, showed to cleanse right anterior ankle with normal saline, pat dry, apply Medi-honey, cover with abdominal pad, wrap with Kerlix, secure with tape, initial and date. The order showed to treat daily and as needed if soiled until wound care consult was complete. A wound care visit report for Resident #45, dated 12/30/25, showed to cleanse right anterior lower leg with wound cleanser, apply honey gel and silver alginate, cover with border island dressing Monday, Wednesday, and Friday and as needed. On 01/05/26 at 11:35 a.m., LPN #3 stated the wound care provider was responsible the resident's wound orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/05/26 at 11:38 a.m., LPN #3 stated the wound care provider changed Resident #45's wound orders on 12/30/25 and the new order was to use wound cleanser, honey gel, silver alginate, super absorbent dressing Monday, Wednesday, and Friday. On 01/05/26 at 11:39 a.m., LPN #3 stated they did not update the resident's orders. They stated the orders should have been updated when they were changed. On 01/05/26 at 11:40 a.m., LPN #3 stated they did not complete Resident #45's wound treatment as ordered.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interview, the facility failed to ensure:a. ordered pain medication was available for administration; andb. a resident received pain medication as ordered for 1 (#66) of 1 sampled resident reviewed for pain management.The administrator identified 72 residents resided in the facility.Findings: An Administering Medications policy, revised 04/2019, read in part, Medications are administered in accordance with prescriber orders, including any required time frame.A physician's order for Resident #66, dated 04/04/25, showed Percocet (an opioid medication) oral tablet 10-325 mg. Give one tablet by mouth every six hours for pain. Discontinue Percocet 7.5-325 mg upon arrival of Percocet 10-325 mg.Resident #66's quarterly resident assessment, dated 11/02/25, showed the resident had diagnosis of pain in unspecified joint. The assessment showed the resident's cognition was intact with a BIMS of 15.A physician's order, dated 11/17/25, showed Percocet oral tablet 7.5-325 mg. Give one tablet by mouth every 24 hours as needed for breakthrough pain, hold for sedation.A December 2025 MAR showed 9 for Percocet 10-325 mg on the 30th at the 6:00 a.m. administration. The MAR showed the medication was administered at 12:00 p.m. and 6:00 p.m.A CONTROLLED DRUG RECEIPT/RECORD/DISPOSITION FORM [narcotic sheet], dated 12/02/25, for Percocet 10-325 mg, showed the last dose was administered on 12/30/25 at 12:00 a.m.A CONTROLLED DRUG RECEIPT/RECORD/DISPOSITION FORM, dated 12/13/25, for Percocet 7.5-325 mg, showed the medication was administered on 12/30/25 at 12:30 p.m. and at 6:00 p.m.A CONTROLLED DRUG RECEIPT/RECORD/DISPOSITION FORM, dated 12/31/25, for Percocet 10-325 mg, showed the first dose was administered on 12/31/25 at 12:00 a.m.Percocet 10-325 mg was not available to administer on 12/30/25 at 6:00 a.m., 12:00 p.m., and 6:00 p.m. There was no documentation to show the reason the medication was not administered.On 12/30/25 at 7:28 a.m., Resident #66 stated the facility ran out of their routine Percocet medication. They stated they did not receive the medication at 6:00 a.m. Resident #7 rated their pain 7 out of 10 on the numerical scale.On 12/31/25 at 2:22 p.m., LPN #3 stated the 9 on the resident's December MAR meant other see progress notes. They stated they did not see any progress notes for the 9 documented.On 12/31/25 at 2:31 p.m., LPN #3 stated if there was a check mark on the MAR, the medication was administered. They stated they could assume the Percocet 10 mg was not administered at 6:00 a.m. on 12/30/25.On 01/02/26 at 8:31 a.m., CMA #2 stated they used the punch, initial, give method for medication administration. They stated they verified the resident's physician orders against the narcotic sheet before administering medications.On 01/02/26 at 8:34 a.m., CMA #2 stated Resident #66's order for Percocet 10-325 mg showed to administer 7.5-325 mg if the 10 mg was not available. They stated they were to document in the MAR and narcotic sheet the 7.5 mg was administered.On 01/02/26 at 8:36 a.m., CMA #2 reviewed the resident's December 2025 narcotic sheet. They stated the resident received 7.5 mg on 12/30/25 at 12:30 p.m. and at 6:00 p.m. but the 10 mg was documented in the resident's electronic MAR at 12:00 p.m. and 6:00 p.m.On 01/02/26 at 8:43 a.m., CMA #2 was asked if the resident's Percocet 7.5 mg order showed to administer routine if the 10 mg was not available. They stated, No.On 01/02/26 at 8:48 a.m., the DON stated the resident's order for Percocet 7.5 mg was to be given once every 24 hours as needed for breakthrough pain.On 01/02/26 at 8:51 a.m., the DON stated if the resident's order did not state to administer 7.5 mg in place of the 10 mg, then staff should not administer it. They stated staff were to ensure they refilled medications in a timely manner. The DON stated it was a medication error.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure labs were completed in a timely manner for 1 (#3) of 3 sampled residents reviewed for lab results.The DON identified 10 residents required hemoglobin A1c monitoring. Findings: An undated Lab Policy and Procedure, read in part, All laboratory tests will be done as ordered by the physician in a timely manner and the results reported to the physician. A Physician's Order, dated 07/09/25, read in part, Laboratory: Hemoglobin a1c every 3 months (Jan [January], April [April], July [July], Oct [October]). A Lab Results Report, dated 07/16/25, showed Resident #3's hemoglobin A1c (a blood test that shows an average blood sugar) was obtained on 07/14/25. A Hospital Care Timeline, dated 10/15/25, showed Resident #3 was discharged from the hospital on [DATE] and no hemoglobin A1c lab was obtained. A Quarterly MDS, dated [DATE], showed Resident #3 was admitted to the facility on [DATE] with diagnoses to include diabetes mellitus. On 01/02/26 at 10:23 a.m., LPN #1 was asked who was responsible ensuring lab orders were completed according to physician orders. They stated, Usually me. LPN #1 was asked to show where Resident #3 had a hemoglobin a1c lab drawn in October 2025. They stated, It probably fell off because [they were] in the hospital and the practitioner didn't order it when [they] came back. On 01/02/26 at 10:36 a.m., the DON was asked who was responsible for canceling standing orders when a resident was admitted to a hospital. They stated, The nurse does if the resident is gone for 14 days and then the doctor usually resumes previous orders. The DON was asked if Resident #23's hemoglobin A1c lab order for October 2025 was canceled when they were admitted to the hospital. The DON stated it was still in their system from July and if the hospital did not draw it, the lab order was not completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure:a. linens were stored in a manner to promote infection control,b. the laundry room floor was cleaned for 1 of 1 laundry visit, andc. infection control precautions were used during activities of daily living care for 1 (#21) of 3 sampled residents reviewed for enhanced barrier precautions.The administrator identified 72 residents resided in the facility and 17 residents required enhanced barrier precautions. Findings: 1. On 01/02/26 at 10:55 a.m., CNA #1 and CNA #2 were observed assisting Resident #21 into bed via mechanical lift after providing shower assistance. No enhanced barrier precautions were observed to be practiced evidenced by both CNAs not wearing a gown. On 01/02/26 at 10:57 a.m., CNA #1 was observed to don a gown and gloves and continued to provide Resident #21 with catheter care and incontinent care. CNA #1 was observed to hold a tissue up to Resident #21's mouth so they could spit out a substance which they coughed, while wearing the same gloves used when providing catheter care and incontinent care. CNA #1 was observed to put on a clean brief and clean gown on Resident #21 while still wearing the same gloves. An EBP policy, dated 04/01/24, read in part, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. EBP refer to an infection control intervention that employs targeted gown and gloves use during high contact resident care activities. A physician's order for Resident #21, dated 05/23/24, showed enhanced barrier precautions every shift. On 01/02/26. at 11:00 a.m., CNA #1 was asked if they believed they practiced correct enhanced barrier precautions which they stated yes. 2. On 01/02/26 at 11:56 a.m., a tour of the clean linen storage room was conducted. The following observations were made: a. pillows on a shelf were stored to the ceiling, b. multiple blankets on a shelf were stored to the ceiling, and c. multiple bags, shoes, and sheets were laying around on the floor. On 01/02/26 at 12:13 p.m., a tour of the laundry room was conducted. There were moderate brown dirt stains on the floor. There were leaves and tissues on the floor. An Infection Prevention and Control Program policy, dated 05/12/23, read in part, Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection. On 01/02/26 at 12:07 p.m., the housekeeping supervisor stated the above items in the linen storage room were not stored appropriately. On 01/02/26 at 12:18 p.m., the housekeeping supervisor stated the last time the laundry room was cleaned was on 12/23/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/02/26 at 12:25 p.m., the housekeeping supervisor stated the laundry room was not clean.