STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375106	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookwood Skilled Nursing and Therapy	940 Southwest 84th Street Oklahoma City, OK 73139

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. 45583 Based on record review and interview, the facility failed to ensure a resident was free from verbal and willful physical abuse from another resident with uncontrolled abusive behavior for one (#1) of three sampled residents reviewed for abuse. The administrator identified 104 residents resided in the facility. Findings: A Resident Abuse, Neglect and Misappropriation of Property policy, dated 11/2022, read in part, The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The policy also read, Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. The policy also read, Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy also read, Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. 1. Resident #1 had diagnoses which included CHF and cerebral infarct. A MDS assessment, dated 08/10/24, documented the resident's cognition was moderately impaired with a BIMS score of 10. An initial OSDH Incident Report Form, received at OSDH on 10/14/24 at 3:01 p.m., read in part, Allegation of verbal abuse from [Resident #1's family representative] regarding [Resident #2]. The family representative was told by someone anonymously that [Resident #2] had yelled at [Resident #1]. Investigation initiated. Physician and [Resident #2] family representative notified. [Resident #2] sent to hospital for evaluation. It documented APS and law enforcement were notified. On 11/08/24 at 1:24 p.m., Resident #1 was in their room in their recliner and unable to answer interview questions. 2. Resident #2 had diagnoses which included ESRD, sepsis, DM, bilateral AKA, and PTSD. (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	A MDS assessment, dated 09/19/24, documented Resident #2 was cognitively intact with a BIMS score of 15. An incident note, dated 02/24/24 at 5:02 a.m., documented Resident #2 threw magazines at Resident #1 after Resident #1 was close to Resident #2's face. It documented Resident #2 did not think the way they reacted was inappropriate. A progress note, dated 02/24/24 at 11:18 a.m., documented Resident #2 stated they were not trying to be mean or intended to harm Resident #1. It documented they wanted Resident #1 to move away. It documented Resident #2 was educated to go the other way when they saw Resident #1 and not to engage with them or to get a staff member. A care plan focus area for Resident #2, revised 03/01/24, documented they used antidepressant medication related to depression. It documented the resident had behaviors of yelling and cursing at staff, and a history of getting upset and throwing magazines. It documented the interventions were PHQ2-9 score: 0 (initiated 09/09/24), administer Zoloft (SSRI) as prescribed (initiated 12/24/23), every shift document number of episodes/interventions/outcome and side effects (revised 06/12/24), and monitor/document/report to MD PRN ongoing s/sx of depression initiated 12/24/23). A progress note, dated 03/14/24 at 7:11 a.m., documented Resident #2 was given an order to discontinue Zoloft due to multiple refusals. A behavior note, dated 05/08/24 at 2:41 p.m., documented Resident #2 was in the hall yelling out loud for the CNA to make their bed. It documented the resident followed the CNA to the restroom yelling about their bed not being made. It documented the nurse tried to redirect Resident #2. It documented the resident stated they did not care how they were acting and wanted their bed made. It documented the resident was calmed down by a third party staff member. A progress note, dated 06/05/24 at 9:00 p.m., documented Resident #2 stated their right arm was hurting. It documented the resident refused PRN medication and demanded to go to the emergency room . It documented the resident was extremely rude to EMSA screaming and swinging their fist at them because the hospital was on diversion. It documented Resident #2 stated, That is [verbiage withheld] you will take me to [hospital name withheld]. It documented the nurse educated the resident on speaking to EMSA. An incident note, dated 06/09/24 at 12:00 p.m., documented there was a report of a resident to resident verbal altercation. It documented Resident #2 was frustrated over waiting for a long time for food. It documented Resident #2's explanation did not reveal the other resident's role in the food delay. It documented the resident received guidance on conflict resolution and indicated understanding without needing further instruction. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan focus area for Resident #2, revised on 06/10/24, documented they had impaired cognitive function/dementia or impaired thought process r/t cardiac and diabetic disease process. It documented the resident exhibited attention seeking behaviors and had verbal outbursts towards staff at times. It documented the resident was difficult to redirect and refused medications at times. It documented the resident would yell about their bed not being made, but would go back to bed and then get in and out throughout the day. It documented the resident would state they were joking with another resident and start yelling. It was documented the interventions were BIMS score 15 (revised 09/09/24), communication (revised 10/20/22), keep routine consistent (revised 10/20/22), observe/assess/document/report changes in cognitive function (revised 12/24/23), provide a homelike environment (revised 10/20/22), reminisce with resident (revised 10/20/22), and review medication and record possible causes (initiated 10/20/22). An order note, dated 06/27/24 at 1:39 p.m., documented to reorder of Zoloft 50 mg at bedtime. A progress note, dated 07/07/24 at 5:11 p.m., documented Resident #2 was in the dining room arguing with another male resident and both residents became loud across the dining room. It documented both residents were redirected and were put in separate areas. A behavior note dated, 10/23/24 at 2:30 p.m., documented Resident #2 was outside of another residents door screaming at the other resident. It documented the nurse intervened by explaining they were not allowed to go and yell at another resident no matter the circumstances. It was documented the resident stated they wanted to call 911 to get help for the other resident. It was documented after Resident #2 was informed staff would assist the other resident, Resident #2 then continued to yell for the nurse to get the resident out of the room. It documented the nurse stated to Resident #2 that they were yelling just like the other resident they were upset about. It documented the resident wheeled off to their room and slammed the door. A progress note, dated 11/01/24 at 8:01 p.m., documented Zoloft was discontinued for refusals. A behavior note, dated 11/10/24 at 10:07 p.m., documented while the nurse was down another hall, Resident #2 went down the hall in their power chair yelling and cursing. It documented several attempts made to calm the resident and try to speak with them, but they continued to yell and curse and started going into other residents' rooms yelling and cursing. It documented when staff attempted to redirect Resident #2 and ask them to not go in other residents rooms, they attempted to run staff over with their power chair. It documented the resident refused to go to the hospital for an evaluation. A progress note, dated 11/11/24 at 12:30 a.m., documented Resident #2 wanted to harm themselves and requested to go to the hospital for a psych evaluation. A progress note, dated 11/11/24 at 3:58 a.m., documented Resident #2 returned with no new orders. It documented the nurse removed two pair of scissors from the resident's drawer due to statements of harming themselves. It documented they informed the resident they could have them back after speaking with the DON/administrator. It documented Resident #2 stated they would just ram the administrator's door with their chair. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 12:49 p.m., Resident #2 stated staff took over an hour to answer a call light and they got up to their chair to look for staff and heard someone yell, and saw a resident had fallen. Resident #2 stated they went to look for staff and no one wanted to help them. Resident #2 stated staff said they Threw poo, but I didn't. I don't do stuff like that. Resident #2 stated, They said I put my hands down my diaper and threw it. On 11/12/24 at 1:24 p.m., Resident #1's family representative stated they were informed by staff, that Resident #2 had been in Resident #1's room on the evening of 11/10/24. The family representative stated CNA #1 was taking care of Resident #1 to get them ready for bed. and Resident #2 went to Resident #1's door and demanded staff stop what they were doing and take care of them. The family representative stated when CNA #1 told Resident #2 they would have to wait they pushed the door closed. The family representative stated Resident #2 then hit the door open, screamed, yelled, and was cursing. The family representative stated CNA #1 was helping Resident #1 to the bathroom and went into the bathroom and shut the door. The family representative stated Resident #2 then was pounding on the bathroom door. The representative stated Resident #2 hit CNA #1 several times. The family representative stated CNA #1 made Resident #2 leave the room then CNA #1 called the police. The family representative stated Resident #2 also called the police. The family representative stated they had a camera in Resident #1's room and it did not capture the events. The family representative stated Resident #2 had threatened them, hit them and staff. The family representative stated the administrator and the police were at the facility. The family representative stated they were scared of Resident #2 hurting them, Resident #1, or someone else. The family representative stated Resident #2 was getting by with all this and Resident #1 was intimidated by them and they were trespassing in their room. On 11/12/24 at 1:39 p.m., the administrator stated the incident on 10/14/24 was discussed with the fall weekly meeting and at the end of the month. On 11/12/24 at 2:15 p.m., the administrator stated they had to come to the facility on Sunday 11/10/24 because Resident #2 was going in and out of resident rooms and Resident #1 may have been one of them. They stated they came up to the facility and Resident #2 was not dressed appropriately. Resident #2 was sent out for a psych evaluation and the police was called since Resident #2 would not calm down. They stated they did not know if Resident #2 went into Resident #1's room, but since they were on the same hall they very well could have. On 11/12/24 at 2:22 p.m., the administrator stated Resident #1's family representative told them of the events on 11/10/24 and they did not call the administrator about it or tell the nurse. The administrator stated they put Resident #2 on 1:1 until they figured out what to do. They stated they would see about discharging Resident #2. An orders note, dated 11/12/24 at 2:44 p.m., documented the provider had reviewed the resident's chart and started Zoloft 50 mg for depression again. A progress note, dated 11/12/24 at 3:14 p.m., documented the psych/counseling would be at the facility the next day to see Resident #2. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 3:28 p.m., CNA #1 stated they had two incidents with Resident #2 on 11/10/24. The first incident of the day was when Resident #2 became upset with having to wait for staff to finish with the resident they were with, and began yelling and cursing, and dug into their diaper and took it off and threw it. CNA #1 stated when they returned from their lunch break, Resident #2 was yelling saying y'all gone change me now and y'all let me sit here and is all on my bed. CNA #1 stated they checked on them before they went on break and they were fine. CNA #1 stated they went to get Resident #1 ready for bed that evening and Resident #2 busted through the door in their electric wheelchair. CNA #1 stated they put Resident #1 in their wheelchair, turned around and Resident #2 was in their face and started punching them in the stomach and arm. They stated they grabbed Resident #2's arm to stop them from hitting them. CNA #1 stated Resident #2 slapped and punched them and was cursing at them. CNA #1 stated they told Resident #2 they were going to call the police when they were done with Resident #1. CNA #1 stated when they walked out of Resident #1's room there were police in the hall. CNA #1 stated they were told Resident #2 had called the police and said they were abusing them. CNA #1 stated they spoke to the administrator and told them they only touched the resident to get them to stop hitting them. CNA #1 stated they did not feel comfortable working with Resident #2. CNA #1 stated Resident #2 taunts and made faces. CNA #1 stated the administrator stated they were going to talk to the corporate office to see about discharging the resident. CNA #1 stated the administrator told Resident #2 they had to go and Resident #2 became upset and started cursing and yelling. On 11/13/24 at 9:16 a.m., the administrator was asked what had been done to address Resident #2's behaviors of yelling and cursing prior to the recent events. The administrator stated they made multiple medication changes, but the resident was not compliant. The administrator stated Resident #2 previously had counseling. On 11/13/24 at 9:30 a.m., the administrator stated they were trying to figure out where to move Resident #2 as they had thought about it before. The administrator stated there was no where to move that Resident #2 wanted to move to. The administrator stated they may try to discharge Resident #2, but it could be difficult. The administrator stated they were to re-start with psych this evening. On 11/13/24 at 12:51 p.m., the corporate nurse consultant stated they do not conduct behavior monitoring unless the resident was on psych meds. The corporate nurse consultant stated they just added an order and added yelling to it. The corporate nurse consultant stated normally if a resident had behaviors it was documented in progress notes. On 11/13/24 at 12:55 p.m., the DON stated the interventions for Resident #2's behavior were to talk and deescalate, and if that did not work, the administrator was good at talking and settling the resident down. There were no new interventions on the care plan to address the resident's increasing behavior. The last update to the care plan related to behaviors/cognition/use of an antidepressant was the BIMS score and PHQ2-9 score on 09/09/24.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583 Based on record review and interview, the facility failed to report an allegation of resident to resident abuse to OSDH for two (#1 and #2) of three sampled residents reviewed for abuse. The administrator identified 104 residents resided in the facility. Findings: A Resident Abuse, Neglect and Misappropriation of Property policy, dated 11/2022, read in part, The resident has the right to be free fro verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The policy also read, Protection All employees of a nursing facility are mandated reporters of resident abuse, to appropriate personnel, neglect or misappropriation and must report any and all incidents. All employees shall report any reasonable suspicion of a crime against any individual who is a resident of the facility without fear of retaliation. The policy also read, Procedure for Investigating Facility Incidents All allegations and incidents of abuse, neglect or misappropriation of resident's property be reported to QAPI committee, appropriate Federal and State Agencies including OSDH and investigated to establish a reasonable conclusion about the validity of the allegation. 1. Resident #1 had diagnoses which included acute on chronic CHF, atrial fib, and cerebral infarct. A Resident to Resident event document, regarding Resident #1, dated 02/24/24, read in part, This nurse observed [Resident #1] being verbally abusive to what [Resident #1] thought was [their person] having an affair. [Resident #1] was also getting very close to [Resident #2] pointing and talking loudly in [their] face. When [Resident #2]attempted to re direct conversation or move away [Resident #1] would follow and get closer. This nurse after attempting to let residents resolve issue (which they often do) observed [Resident #2] become highly agitated and angry. This nurse immediately separated the two however prior to fully separate the two [Resident #2] was able to throw magazines at [Resident #1's] face. It also read, Immediate Action Taken Once completely separated by this nurse's body, [Resident #2] was able to leave and return to their room. This nurse was able to assess [Resident #1's] face and nothing was visible or assessed at this time. [Resident #1] denied pain or discomfort. This nurse accompanied [Resident #1] to [their] room as [they] were up most the night. A MDS assessment, dated 09/10/24, documented Resident #1 had moderately impaired cognition with a BIMS of 10. On 11/08/24 at 1:24 p.m., Resident #1 was in their room in their recliner and unable to answer interview questions. 2. Resident #2 had diagnoses which included ESRD, DM, and bilateral aka. A MDS assessment, dated 09/19/24, documented Resident #2 was cognitively intact with a BIMS of 15. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/8/24 at 1:41 p.m., Resident #2 stated they had a lot of interaction with Resident #1 up until they had a stroke. They stated Resident #1 was mean towards them and their family was mean towards them. They stated Resident #1 was [AGE] years old and would chase them and wanted to date them. They stated the administrator was aware. There was no report to OSDH located. On 11/12/24 at 11:54 a.m., the DON stated they did not report the event on 02/24/24 to OSDH because the residents were friends and had a weird relationship where they got along, then were frustrated, then were fine again. They stated the residents had not been around each other recently. The corporate nurse consultant stated the event should not have been reported to OSDH because of the nature of their relationship. On 11/12/24 at 1:39 p.m., the DON and administrator were asked if a resident hitting another resident with a magazine was a reportable incident due to the act of physical violence. They stated, yes, and that they concluded it did not happen and that the magazines were pushed off the table. They stated they had trouble figuring out if made contact. On 11/13/24 at 9:16 a.m., the administrator was asked to review the incident report that documented The other resident became highly agitated and angry, and was asked if the actions of throwing an object by someone who stated those words, fall under abuse. They stated, normally but once the investigated was an accident when pushed off the table and because that was normal behavior for them.