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	01/07/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 45462 Based on record review and interview, the facility failed to ensure the physician was notified for blood sugars outside of parameters as ordered for two (#1 and #3) of three sampled residents whose clinical records were reviewed for notification of changes. The administrator identified 111 residents resided in the facility. Findings: A Blood Glucose Monitoring Guideline, revised 08/24, read in parts, Follow physician orders based on finger stick result .notify physician of noted signs/symptoms of hypo/hyperglycemia. 1. Resident #1 had diagnoses which included type 2 diabetes mellitus. Resident #1's physician's order, dated 12/13/24, documented for the resident to receive insulin aspart (insulin) per sliding scale 10 units if blood sugar 301-999, then call provider and recheck in two hours. The December 2024 MAR documented the following blood sugars for Resident #1, a. 12/14/24 at 8 a.m. FSBS 307, b. 12/14/24 at 4 p.m. FSBS 400, c. 12/15/24 at 11 a.m. FSBS 385, d. 12/15/24 at 4 p.m. FSBS 339, e. 12/15/24 at 9 p.m. FSBS 328, f. 12/16/24 at 8 a.m. FSBS 301, g. 12/16/24 at 4 p.m. FSBS 309, h. 12/19/24 at 4 p.m. FSBS 303, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. 12/20/24 at 4 p.m. FSBS 336, j. 12/20/24 at 9 p.m. FSBS 318, k. 12/21/24 at 9 p.m. FSBS 336, l. 12/22/24 at 9 p.m. FSBS 335, and m. 12/24/24 at 4 p.m. FSBS 348. There was no documentation in Resident #1's clinical record the physician was notified of the FSBS's. 2. Resident #3 had diagnoses which included type 2 diabetes mellitus. Resident #3's physician's order, dated 11/25/24, documented to notify the physician of FSBS 0-69 or 401-999. The December 2024 MAR documented the following blood sugars for Resident #3, a. 12/12/24 at 8 a.m. FSBS 430, b. 12/16/24 at 8 a.m. FSBS 430, c. 12/18/24 at 12 p.m. FSBS 64, and d. 12/22/24 at 5 p.m. FSBS 65. There was no documentation in Resident #3's clinical record the physician was notified of the FSBS's. On 01/02/25 at 1:56 p.m., the DON reviewed the clinical records for Resident #1 and Resident #3 described above and acknowledged there was no documentation the physician had been notified of FSBS's outside of parameters as ordered.

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	375106	A. Building B. Wing	01/07/2025

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 On 01/02/25 an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure Resident #2 who had insulin dependent type 2 diabetes mellitus with hypoglycemia was assessed, monitored, and provided medication for hypoglycemia as ordered by the physician and outlined in their care plan. Resident #2 was admitted to the facility on [DATE] with orders for routine insulin administration and insulin to be administered per sliding scale. Resident #2 also had orders for blood sugar to be checked via fingerstick twice a day and as needed for signs or symptoms of hypoglycemia and to give Glucagon (oral gel or IM) (glycogenolytic agent) if blood sugar was less than 70. On 12/26/24 at 6:09 a.m., Resident #2 had a blood sugar reading of 68 and the nurse did not administer the Glucagon gel as ordered. On 12/26/24, at change of shift, the night nurse provided the oncoming dayshift nurse Resident #2's status and low blood sugar level. The oncoming nurse failed to provide any assessment, monitoring, or interventions for the low blood sugar level. On 12/26/24 at 8:12 a.m., the attending physician saw Resident #2 during rounds and provided a verbal order to send them to the emergency room . The nurse took Resident #2's blood sugar reading while awaiting the arrival of EMSA and the reading was 49. The nurse did not administer the Glucagon gel as ordered. The emergency room report, dated 12/26/24, documented Resident #2's blood sugar reading on their initial encounter with EMSA was 21. It documented Resident #2 was admitted to the hospital on 12/26/24. On 01/02/25 at 4:52 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 01/03/25 at 1:57 p.m., the administrator was notified of the IJ situation and the IJ template was provided. On 01/06/25 at 8:10 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal, read in parts, a. How facility will ensure harm will not occur or recur .In-service all staff on signs and symptoms of hypoglycemia and treatment .Review of all residents with hypoglycemia or diabetes .Monitoring orders will be added for appropriate residents for signs and symptoms of hypoglycemia. b. Date of implementation - planned implementation (actions do not need fully resolved prior to the survey team exiting the organization); 1/3/2025 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Identify those residents who have suffered or are likely to suffer, a serious adverse outcome as a result of the noncompliance .Residents with history of hypoglycemia or diabetes. d. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete .In-service all staff on signs and symptoms of hypoglycemia and treatment .Review of all residents with hypoglycemia or diabetes .Monitoring orders will be added for appropriate residents for signs and symptoms of hypoglycemia .The likelihood for serious harm to any resident no longer exists effective 1/3/2025. e. How facility will monitor physicians orders being followed .Physician's orders, MAR's, Tar's and FSBS records will be monitored daily in Q2. f. How are you addressing assessment, intervention, documentation, and evaluation .In-service with all licensed nursing staff. On 01/07/25 it was determined the immediacy was lifted, effective 01/02/2025 at 8:00 p.m., when all components of the plan of removal had been completed. The deficient practice remained as isolated with potential for harm to the resident. Based on interview and record review, the facility failed to ensure a resident with insulin dependent type 2 diabetes mellitus with hypoglycemia was assessed, monitored, and provided medication for hypoglycemia as ordered by the physician and outlined in the resident's care plan for one (#2) of three sampled residents whose blood sugars were reviewed. The MDS Resident Matrix, submitted 12/31/24, documented there were 22 insulin dependent diabetic residents residing in the facility. Findings Resident #2 had diagnoses that included type 2 diabetes with hypoglycemia. Resident #2's physician's order, dated 12/10/24, documented for their blood sugar to be checked via fingerstick twice a day and as needed for signs or symptoms of hypoglycemia and to give Glucagon (oral gel or IM) if blood sugar was less than 70. A Progress Note, dated 12/26/24 at 6:09 a.m., documented Resident #2's FSBS was 68. There was no documentation in Resident's clinical record glucagon gel was administered as ordered at that time. There was no documentation in the clinical record Resident #2 was assessed, monitored, nor provided interventions as ordered for FSBS of 68 reported by the night nurse to the oncoming dayshift nurse on 12/26/24. A Progress Note, dated 12/26/24 at 8:12 a.m., documented the attending physician saw Resident #2 during rounds and provided a verbal order to send them to the emergency room . The nurse took Resident #2's blood sugar reading while awaiting the arrival of EMSA and the reading was 49. Theere was no documentation the Glucagon gel was administered as ordered at that time. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The emergency room report, dated 12/26/24, documented Resident #2's blood sugar reading on their initial encounter with EMSA was 21. It documented Resident #2 was admitted to the hospital on 12/26/24. On 01/02/25 at 4:30 p.m., the DON was asked to review the records for Resident #2 outlined above. After reviewing the documents, the DON acknowledged Resident #2 was not assessed, monitored, or administered Glucagon as ordered during an episode of hypoglycemic crisis.

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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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 On [DATE] an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to promptly notify the physician of Resident #2's laboratory results which fell outside of clinical reference ranges and showed a deterioration in their condition. Resident #2 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection (ESBL) and pneumonia and was receiving antibiotic therapy. Resident #2's admission lab results, dated [DATE], documented WBC 11.3 (Ref range 3XXX,d+[DATE].04) and Neutrophil # 7.7 (Ref range 1XXX,d+[DATE].13). The report was signed by the physician. Resident #2's follow-up lab results, dated [DATE], documented WBC 26.2 (Ref range 3XXX,d+[DATE].04) and Neutrophil # 19.7 (Ref range 1XXX,d+[DATE].13). There was no documentation the results were reported to the physician. On [DATE], Resident #2 was transferred to the emergency room . They were admitted to the hospital on [DATE] with admitting diagnoses of severe sepsis with septic shock, pyelonephritis, and C-difficile colitis. Resident #2 expired in the hospital on [DATE]. On [DATE] at 12:15 p.m., the DON reviewed Resident #2's clinical records and reported no documentation could be found to confirm the follow-up lab results were reported to the physician. On [DATE] at 2:27 p.m., Resident #2's physician reported no abnormal lab results were reported for the resident regarding labs completed on [DATE]. They stated the resident would have been started on IV antibiotics or immediately sent out to the hospital. On [DATE] at 4:52 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On [DATE] at 1:54 p.m., the administrator was notified of the IJ situation and the IJ template was provided. On [DATE] at 8:10 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal, read in parts, a. How facility will ensure harm will not occur or recur .In-service regarding immediate physician notification of change in condition/abnormal laboratory results .All current laboratory results reviewed to ensure physician notification has been made. b. Date of implementation - planned implementation (actions do not need fully resolved prior to the survey team exiting the organization); [DATE] c. Identify those residents who have suffered or are likely to suffer, a serious adverse outcome as a result of the noncompliance .Residents with orders for laboratory tests. (continued on next page)

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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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete .In-service with all licensed nursing staff regarding immediate physician notification of change in condition/abnormal laboratory results . All current laboratory results reviewed to ensure physician notification has been made .The likelihood for serious harm to any resident no longer exists effective [DATE]. e. How is facility addressing assessment, intervention, documentation and evaluation .In-service with all licenses nursing staff. On [DATE] it was determined the immediacy was lifted, effective [DATE] at 8:00 p.m., when all components of the plan of removal had been completed. The deficient practice remained as isolated with potential for harm to the resident. Based on observation and interview, the facility failed to promptly notify the physician of a resident's laboratory results which fell outside of clinical reference ranges and showed a deterioration in the resident's condition for one (#2) of three sampled residents whose clinical records were reviewed for physician notification of lab results. The administrator identified 111 residents resided in the facility. Findings Resident #2 was admitted to the facility on [DATE] with diagnoses of urinary tract infection (ESBL) and pneumonia and was receiving antibiotic therapy. Resident #2's admission lab results, dated [DATE], documented WBC 11.3 [Ref range 3XXX,d+[DATE].04] and Neutrophil # 7.7 [Ref range 1XXX,d+[DATE].13]. Report was signed by physician. Resident #2's follow-up lab results, dated [DATE], documented WBC 26.2 [Ref range 3XXX,d+[DATE].04] and Neutrophil # 19.7 [Ref range 1XXX,d+[DATE].13]. There was no documentation that results were reported to the physician. A hospital report, dated [DATE] through [DATE], documented Resident #2 was transferred to the emergency room . It documented they were admitted to the hospital on [DATE] with admitting diagnoses of severe sepsis with septic shock, pyelonephritis, and C-difficile colitis. It was documented Resident #2 expired in the hospital on [DATE]. On [DATE] at 12:15 p.m., the DON reviewed Resident #2's clinical record and reported no documentation could be found to confirm that follow-up lab results had been reported to the physician. On [DATE] at 2:27 p.m., Resident #2's physician reported no abnormal lab results were reported for the resident regarding labs done [DATE]. They stated, if the results had been reported, the resident would have been started on IV antibiotics or immediately sent out to the hospital. On [DATE] at 4:20 p.m., LPN #3 was asked if they had reviewed the results of Resident #2's labs received during their shift on [DATE] and reported the abnormal results to the physician. They stated they had not seen the results because only critical results would be faxed over or called into the facility during the evening shift. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:00 a.m., the DON was asked the process for ensuring lab results were reviewed and reported to the physician. They stated lab results were printed from the lab company's electronic system each morning and reviewed in the morning meeting. The DON stated there was no way to confirm if the abnormal lab results received for Resident #2 on [DATE] had been reviewed in the morning meeting on [DATE], or if their abnormal results had been reported to the physician. The DON was asked if the facility had a system of communication or documentation in place to ensure staff knew when abnormal lab results were reviewed and reported to the physician. They stated, Sometimes the nurse may document it in the notes or on the lab itself, but not always.