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	09/17/2025

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensurea. residents received pain medication in a timely manner for 1 (#122) of 2 sampled residents reviewed for pain management. The prolonged wait time despite verbalizing increased pain to multiple staff resulted in harm for Resident #122 as evidenced by not wanting to complete ADL's due to pain; and,b. residents were consistently evaluated for the effectiveness of regularly scheduled pain medication for 1 (#101) of 2 sampled residents reviewed for pain management assessment and monitoring.The regional nurse consultant identified 42 residents received pain medication.Findings:1.On 09/16/25 at 5:55 a.m., Resident #122 was observed telling CNA #3 somebody get me some pain pills, my back is killing me. Any movement about kills me and it has been that way all night. Resident #122 would not allow CNA #3 to provide incontinent care due to the severity of the pain. On 09/16/25 at 5:57 a.m., CNA #3 was observed telling LPN #1, who was charting at the computer, Resident #122 needed a pain pill because they said they couldn't move. LPN #1 stated okay. On 09/16/25 at 7:31 a.m., CMA #1 was observed providing Tylenol to Resident #122. Resident #122 was observed rubbing their back and stating ow! Resident #122 verbalized they did not think Tylenol was strong enough and would like something stronger. A policy titled Administering Pain Medications, revised 10/2022, read in part, Administer pain medications as ordered. A physician order, dated 09/09/25 at 12:35 p.m., showed Tylenol 325 mgs. Give 2 tablets by mouth every 6 hours as needed for pain. A review of the hospital discharge showed Resident #122 was admitted from the hospital on [DATE] for UTI (urinary tract infection), had a PICC line, and went to the emergency room because of chronic back pain that worsened to the point of being unable to ambulate. An undated care plan for Resident #122 showed the staff were to anticipate Resident #122's need for pain relief and respond immediately to any complaint of pain. On 09/15/25 at 9:13 a.m., a family member of Resident #122, stated the only concern they had was about pain management because they believed Resident #122 was in pain. On 09/16/25 at 6:18 a.m., CNA #3 stated Resident #122 did not use their call light, so staff had to routinely check on them. On 09/16/25 at 6:52 a.m., LPN #1 was asked if they were the nurse for Resident #122. They stated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0697 Level of Harm - Actual harm Residents Affected - Few	LPN #2 was. LPN #1 was asked if they had alerted LPN #2 Resident #122 needed pain medication. LPN #1 stated they had forgotten, but they would. LPN #1 then asked the ADON to get Resident #122 some Tylenol. On 09/16/25 at 7:03 a.m., Resident #122 told the wound nurse they were in so much pain they couldn't move. On 09/16/25 at 7:14 a.m., the ADON stated Resident #122 should have received the pain medication once LPN #2 took the medication cart keys. The ADON stated when someone was in pain they should be responded to immediately. The ADON stated Resident #122 complained of pain quite often but did not like to take anything stronger than Tylenol. They stated Resident #122 did not like to get up because of their pain. On 09/16/25 at 1:29 p.m., the DON stated, We watch for nonverbal as well as asking if they are hurting and then pain assessments are done on admission and per MDS schedule. The DON stated staff should give pain meds as soon as possible that doesn't interrupt other care. An hour and a half is not an acceptable time frame. 2. An undated Care Plan, read in part, [Resident #101] is at risk for pain due to diagnosis of chronic pain, muscle spasm, and right below the knee amputation. [They] have medication in place. Assess and record pain characteristic. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating symptoms, and resident satisfaction with results. A Physician's Order, dated 07/19/25, read in part, Oxycodone (an opioid) 5mg Give 1 every 6 hours for pain. A Physician's Order, dated 07/19/25 read in part, Baclofen (a muscle relaxant) 10mg Give 1 tablet by mouth 1 time daily. A Physician's Order, dated 07/21/25 read in part, Pregablin (an anticonvulsant prescribed for neuropathic pain) 75mg Give 150mg by mouth one time a day every Monday, Wednesday, Friday for neuropathy. A review of Resident #101's MAR for July, August, and September 2025, showed Resident #101 received these medications as prescribed. A Pain Assessment, dated 07/20/25 showed Resident #101 rated their pain seven out 10 at its worst and at the time of assessment rated it between a four and seven out of 10. The Pain Assessment showed Resident #101 reported a change in their pain as, is same and worse. The resident reported a feeling of depression caused by their pain. A Pain Assessment, dated 09/14/25 showed Resident #101 rated their pain 10 out 10 at its worst and at the time of assessment rated it at a 7 out of 10. The Pain Assessment, showed Resident #101 reported their pain as same. The resident reported a feeling of depression caused by their pain. Resident #101 reported the pain medication did not help. A review of Resident #101's medical chart and MAR did not show any consistent pain assessment or monitoring. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 09/15/25 at 8:18 a.m., Resident #101 stated, I have bad neuropathy pain. The Oxycodone and Pregablin, none of it helps. The resident denied being regularly assessed or monitored for pain. On 09/16/25 at 11:45 a.m., CNA #4 was asked what the process was when a resident's pain was identified. They stated, I tell the med [medication] aide and I tell the nurse. They were asked if they documented a resident's pain. CNA #4 stated, No, that's not part of my charting. On 09/16/25 at 1:07 p.m., RN #2 was asked what was the process for assessing and monitoring Resident #101's pain. They stated, We ask [them]. RN #2 was asked where the pain assessment and monitoring was documented. They stated, Sometimes in progress notes, but if [they're] in pain we tell the med aides to give [them] a pain pill if its time. RN #2 was asked what intervention was provided if Resident #101 was unable to have pain medication. They stated, We try distracting [them]. On 09/16/25 at 1:13 p.m., the DON was asked what the process was for assessing and monitoring pain. They stated, It pops up on the vital signs on the MAR every shift and when rounding the staff watches for physical signs and symptoms. The DON was shown Resident #101's MAR and asked if there was pain monitoring on their MAR. They stated, No, because we only monitor the pain on the MAR if it's a PRN pain medication. The DON was asked if Resident #101 had a pain assessment completed since 07/20/25 and they stated, I'm not sure. They were asked if Resident #101's pain was being assessed and monitored consistently. They stated, No. On 09/16/25 at 1:49 p.m., the corporate nurse consultant was showed a Pain Assessment, dated 09/14/25, for Resident #101. They reported that was the only other pain assessment Resident #101 had.

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were provided with an option to not sign the arbitration agreement for 6 (#24, 31, 38, 46, 53, and #96) of 6 sampled residents reviewed for arbitration agreements.The administrator identified 114 residents had entered into a binding arbitration agreement.Findings:An undated document titled An Explanation to the Resident/Family, read in part, By signing our admission contract your electronic signature will be placed on the following forms, which you will receive copies of after signing. admission Agreement/Consent to Treat/Medical Records Release Form: This agreement allows for admission into the facility, gives the facility consent to provide medical care/treatment, consent to have your medical records, and bill for your medical care. Dispute Resolution/Arbitration agreement.An admission packet, revised 11/29/22, showed DocuSign (signature) was set up in which the resident/resident's legal representative agreed to everything inside of the admission packet with just one signature. The arbitration agreement was part of the admission packet and was agreed to upon admission for everyone admitted to the facility.1. Resident #24 was admitted on [DATE] and signed the arbitration agreement on 12/31/21.2. Resident #31 was admitted on [DATE] and signed the arbitration agreement on 09/27/22.3. Resident #38 was admitted on [DATE] and signed the arbitration agreement on 02/10/24. 4. Resident #46 was admitted on [DATE] and signed the arbitration agreement on 04/08/19.5. Resident #53 was admitted on [DATE] and signed the arbitration agreement on 07/31/25. 6. Resident #96 was admitted on [DATE] and signed the arbitration agreement on 03/28/25. On 09/16/2025 at 12:38 p.m., during the Resident Council meeting, Residents #24, 31, 38, 46, 53, and #96 denied knowing what an arbitration agreement was, or that they had signed one.On 09/16/25 at 12:52 p.m., the admissions director stated an E (electronic) signature was used, and the admission process cannot continue without a signature. When asked if you can't go forward without a signature, is it really an option? The admissions director stated they had not thought about that, and they did not know the full extent of what an arbitration agreement was. The admissions director stated, I am pretty positive that the only page you can skip is the DNR/Advance Directive page.On 09/17/25 at 11:00 a.m., the regional nurse stated the residents do have to sign to move through the admission process, but the process to rescind within 30 days is explained to them.On 09/17/25 at 2:01 p.m., the administrator stated all residents had signed the arbitration agreement.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure:a. EBP was followed during an incontinent care observation for 1 (#122) of 6 sampled residents reviewed for incontinent care; andb. ensure nasal cannulas were bagged when not in use and oxygen tubing was labeled with the date administered in order to prevent infections for 1 (#53) of 3 sampled residents reviewed for oxygen services.The regional nurse consultant identified 11 residents had O2 orders and 32 were on EBP. Findings: 1. On 09/16/25 at 8:08 a.m., CNA #1 and CNA #2 were observed to provide incontinent care for Resident #122. CNA #1 and #2 did not have on gowns during the provision of care. Resident #122 was observed with a PICC line in their upper right arm. A facility policy titled Infection Control and Isolation Guideline, dated 07/2025, read in part, Enhanced Barrier Precautions (EBP) apply to residents with: .wounds and/or indwelling medical devices. Gloves and gown during high-contact care. Continue for the duration of the stay or until wound heals/device is removed.high-contact care activities include:.changing briefs or assisting with toileting.Indwelling Medical Devices that DO require EBP:.PICC line. A physician's order, revised 09/10/25, showed EBP related to PICC line were to be utilized. On 09/16/25 at 12:21 p.m., CNA #1 stated EBP, including gown, mask, and gloves, were to be used when taking care of someone that was on isolation. CNA #1 stated they did not have any residents that required precautions, but if they did, they would put a sign on the door. CNA #1 stated there was no sign on Resident 122's door to indicate the need for any type of precautions. On 09/16/25 at 1:27 p.m., the DON stated EBP was one of the newer things that had been put into place, and the purpose was to protect the patients that had a greater risk of getting an infection. The DON stated a tile magnet was to be placed outside of the door to indicate what type of precautions were to be utilized. The DON stated admissions, the IP, and RN #1 helped put up the signage, so staff were aware of the need for EBP. The DON stated they were not sure when the last infection prevention in-service was provided. 2. On 09/15/25 at 9:06 a.m., Resident #53 was observed in bed wearing a nasal cannula attached to an oxygen concentrator. There was no date observed on the oxygen tubing or nasal cannula. On 09/17/25 at 8:34 a.m., Resident #53's nasal cannula was hanging on the bed rail attached to an oxygen concentrator not in use. The nasal cannula was not in a bag. There was no date on the oxygen tubing indicating when it was administered. Resident #53's annual assessment, dated 07/31/25, showed Resident #53's cognition was intact with a BIMS score of 15. Resident #53's electronic health admission records, dated 07/31/25, showed Resident #53 had diagnoses which included acute pulmonary edema and chronic obstructive pulmonary disease. Resident #53's physician orders dated 09/11/25, read in part, O2 @ 2 L NC to maintain stats > 92 % PRN every shift for SHOB [shortness of breath] or distress. On 09/17/25 at 8:34 a.m., Resident #53 stated they used oxygen as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/17/25 at 8:41 a.m., CNA #4 stated Resident #53 wore oxygen, and the nasal cannula should be bagged when not in use. On 09/17/25 at 8:42 a.m., LPN #3 was asked about Resident #53's respiratory needs. LPN #3 stated Resident #53 had physician orders for PRN oxygen. LPN #3 was asked what the nursing standard for oxygen tubing and nasal cannulas being administered. LPN #3 stated oxygen tubing and nasal cannulas should be changed and labeled with the date they were administered. LPN #3 was asked what they observed in Resident #53's room. LPN #3 stated the nasal cannula, and tubing was hanging on bed side not bagged and not labeled with the date administered. LPN #3 stated the regulations were not followed because the nasal cannula was not bagged when not in use. LPN #3 stated not bagging the nasal cannula when not in use and not dating the oxygen tubing could cause can cause contamination. On 09/17/25 at 9:09 a.m., the IP was asked how oxygen tubing and nasal cannulas should be handled. The IP stated they should be bagged when not in use and labeled with the date to prevent infections. On 09/17/25 at 9:20 a.m., the DON stated all nasal cannulas and oxygen tubing should be labeled with the date they were administered. The DON stated the nasal cannula should be bagged when not in use. The DON stated they label, date and bag the nasal cannulas when not in use to prevent infections.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to implement a comprehensive care plan intervention regarding pain monitoring for 1 (#101) of 18 sampled residents reviewed for care plan implementation.Findings:An undated Care Plan, read in part, [Resident #101] is at risk for pain due to diagnosis of chronic pain, muscle spasm, and right below the knee amputation. [They] have medication in place. Assess and record pain characteristic. Evaluate the effectiveness of pain interventions. Review for compliance, alleviating symptoms, and resident satisfaction with results.A Physician's Order, dated 07/19/25, read in part, Oxycodone (an opioid) 5mg Give 1 every 6 hours for pain.A Physician's Order, dated 07/19/25, read in part, Baclofen (a muscle relaxant) 10mg Give 1 tablet by mouth 1 time daily.A Physician's Order, dated 07/21/25, read in part, Pregablin (an anticonvulsant prescribed for neuropathic pain) 75mg Give 150mg by mouth one time a day every Monday, Wednesday, Friday for neuropathy.A review of Resident #101's MAR for July, August, and September 2025, showed Resident #101 was receiving these medications as prescribed.A Pain Assessment, dated 07/20/25 showed Resident #101 rated their pain a seven out of 10 at its worst and at the time of assessment rated it between a four and seven out of 10. The Pain Assessment showed Resident #101 reported a change in their pain as, is same and worse. The resident reported a feeling of depression caused by their pain.A Pain Assessment, dated 09/14/25 showed Resident #101 rated their pain 10 out 10 at its worst and at the time of assessment rated it at a 7 out of 10. The Pain Assessment, showed Resident #101 reported their pain as same. The resident reported a feeling of depression caused by their pain. Resident #101 reported the pain medication dis not help.A review of Resident #101's medical chart and MAR did not show consistent pain assessment or monitoring.On 09/16/25 at 1:07 p.m., RN #2 was asked what was the process for assessing and monitoring Resident #101's pain. They stated, We ask [them]. RN #2 was asked where the pain assessment and monitoring was documented. They stated, Sometimes in progress notes, but if [they're] in pain we tell the med aides to give [them] a pain pill if its time. RN #2 was asked what intervention was provided if Resident #101 was unable to have pain medication. They stated, We try distracting [them].On 09/16/25 at 1:13 p.m., the DON was asked what the process was for assessing and monitoring pain. They stated, It pops up on the vital signs on the MAR every shift and when rounding the staff watches for physical signs and symptoms. The DON was shown Resident #101's MAR and asked if there was pain monitoring on their MAR. They stated, No, because we only monitor the pain on the MAR if it's a PRN pain medication. The DON was asked if Resident #101 had a pain assessment completed since 07/20/25. They stated, I'm not sure. The DON was asked if Resident #101's pain was being assessed and monitored consistently. They stated, No. The DON was asked if based on no consistent assessment and monitoring of pain, was Resident #101's care plan followed. They stated, No.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview, the facility failed to ensure;a. oxygen tubing was dated with the administration date, andb. a nasal cannula was bagged when not in use for 1 (#53) of 3 sampled residents reviewed for oxygen services.The corporate nurse identified 11 residents had physician orders for oxygen therapy.Findings:On 09/15/25 at 9:06 a.m., Resident #53 was observed in bed wearing a nasal cannula attached to an oxygen concentrator. There was no date observed on the oxygen tubing or nasal cannula. On 09/17/25 at 8:34 a.m., Resident #53's nasal cannula was observed hanging on the bed rail attached to an oxygen concentrator. The oxygen tubing and nasal cannula were not labeled with the date it was administered. The nasal cannula was not in a bag. The facility's' policy titled Respiratory Therapy Policies and Procedures, revised 11/23/99, read in part, It will be the policy of this department to select disposable items that allow us to utilize our resources responsibly and still offer the highest quality care and treatment to our residents.When this equipment is changed out the equipment needs to be dated. Resident #53's annual assessment, dated 07/31/25, showed Resident #53's cognition was intact with a BIMS score of 15. Resident #53's electronic health admission records, dated 07/31/25, showed Resident #53 had diagnoses which included acute pulmonary edema and chronic obstructive pulmonary disease. Resident #53's physician orders, dated 09/11/25, read in part, O2 @ 2 L NC to maintain stats > 92 % PRN every shift for SHOB or distress. On 09/17/25 at 8:34 a.m., Resident #53 stated they used oxygen as needed. On 09/17/25 at 8:38 a.m., CMA #2 stated Resident #53 used oxygen. On 09/17/25 at 8:42 a.m., LPN #3 was asked about Resident #53's respiratory needs. LPN #3 stated Resident #53 had physician orders for PRN oxygen. LPN #3 was asked what the nursing standard for oxygen tubing and nasal cannulas being administered. LPN #3 stated oxygen tubing and nasal cannulas should be changed and labeled with the date they were administered. LPN #3 was asked what they observed in Resident #53's room. LPN #3 stated the nasal cannula, and tubing was hanging on bed side not bagged and not labeled with the date administered. LPN #3 stated the regulations were not followed because the nasal cannula was not bagged when not in use. LPN #3 stated not bagging the nasal cannula when not in use and not dating the oxygen tubing could cause contamination. On 09/17/25 at 9:09 a.m., the IP was asked how oxygen tubing and nasal cannulas should be handled. The infection preventionist stated oxygen tubing and nasal cannulas should be bagged when not in use and labeled with the date to prevent infections. The infection preventionist stated they were unaware Resident #53 had physician orders for oxygen. On 09/17/25 at 9:20 a.m., the DON stated the oxygen tubing attached to the oxygen concentrator should be labeled with the date it was administered, and the nasal cannula should be bagged when not in use to prevent infections.