STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375160	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmbrook Home	1811 9th Avenue NW Ardmore, OK 73401

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. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375160	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmbrook Home	1811 9th Avenue NW Ardmore, OK 73401

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure responsible parties were notified of a change in condition for 1 (#1) of 3 sampled residents reviewed for notifying responsible parties of a change in condition. The administrator identified 68 resided in the facility. Findings:A facility policy titled Change in a Resident's Condition or Status, dated 02/2021, read in part, Unless otherwise instructed by the resident, a nurse will notify the representative when: .it is necessary to transfer the resident to a hospital/treatment center.Except in Medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the residents' medical/mental condition or status.Resident #1's admission health record, dated 11/15/24, showed they were admitted with diagnoses which included atrial flutter, epilepsy, nutritional disorder, and chronic kidney disease. An annual assessment for Resident #1, dated 01/07/25, showed Resident #1's cognition was moderately impaired with a BIMS score of 12.A progress note for Resident #1, dated 01/31/25, showed Resident #1's physician ordered them to be sent to the emergency room. A hospital record for Resident #1, dated 01/31/25 though 02/07/25, showed Resident #1 was admitted to the hospital on [DATE] with a diagnosis of acute CVA (cerebrovascular accident). A facility form titled Corrective Action Notice, dated 02/07/25, showed LPN #3 was suspended and received a written notice for failing to notify family representatives when sending Resident #1 to the hospital.A facility document titled Performance Improvement Plan: Privileged Work Document, dated 02/19/25, showed in-service training was conducted on timely notifying family representatives of change in condition and hospital transfers. The document showed auditing events and hospital transfers to ensure timely notification of transfers and change in condition were completed daily for two weeks, weekly for four weeks, and periodically.A facility document titled Inservice Training Report, dated 02/19/25 through 02/20/25, showed 22 staff received in-service training over notification to family representatives after a change in condition. A facility document titled Daily Stand-up Rounds report, dated 02/19/25 through 03/28/25, showed the facility was monitoring for notification to family representatives in the event of a hospital transfer daily for two weeks from 02/19/25 through 03/05/25. The document showed notification of family representatives in the event of a change in condition was monitored weekly from 03/05/25 through 03/28/25.A facility document titled Monthly QA/PI Committee Meeting, dated 03/11/25, showed notification to family representatives after a change in condition was reviewed in the meeting QA/PI meeting. On 08/25/25 at 2:50 p.m., family representative #1 stated Resident #1 was sent to the hospital on [DATE]. Family representative #1 stated they were not notified that Resident #1 was being sent to the hospital on [DATE] by the facility staff. Family Representative #1 stated they were notified of Resident #1's transfer when the medical flight transport pilot contacted them. On 08/25/25 at 8:58 a.m., LPN #3 stated notification to family representatives should be documented in the progress notes. LPN #3 stated there was no documentation in Resident #1's progress notes, dated 01/31/25, the family was notified when Resident #1 was sent to the hospital. LPN #3 stated they received a written warning for not notifying Resident #1's family representative on 01/31/25. LPN #3 stated they had an in-service training on notification to family representatives after a change in condition. On 08/26/25 at 8:30 a.m., the DON stated LPN #3 did not notify the family representative of Resident #1 on 01/31/25 when the resident was sent to the hospital. The DON stated the family representative was notified by the medical flight pilot. The DON stated they did a PIP and in-service over notifying family representatives after a change in condition. The DON stated LPN #3 received a written corrective action on 02/07/25 for not notifying the family representative of Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375160	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmbrook Home	1811 9th Avenue NW Ardmore, OK 73401

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375160	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmbrook Home	1811 9th Avenue NW Ardmore, OK 73401

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure medications were administered according to physicians' orders for 1 (#2) of 6 residents sampled for medications administered according to physician orders. The administrator identified 68 resident received medication from the facility. Findings:On 08/25/25 at 2:10 p.m., the medication room was observed. The room was locked and secured with a camera for monitoring. The room was clean, and all medications were labeled. RN #1 showed the e-kit (emergency medication kit) and the process for accessing the emergency medications. The e-kit was locked with a control log process when accessing medications. There was an inventory sheet attached which showed all the medications in the e-kit. The e-kit was labeled with medications set to expire on 10/2025. Macrobid antibiotic in capsules were observed in the e-kit. A facility policy titled Pharmacy Services Overview, dated 04/2019, read in part, The facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the service of a licensed pharmacist.Residents have sufficient supply of their personal medications and receive medications (routine, emergency or as needed) in a timely manner.Resident #2's admission record, dated 04/30/21, showed they were admitted with diagnoses which included malignant neoplasm of the right kidney, Alzheimer disease, dementia, malignant neoplasm of the left lung, and stage 3 chronic kidney disease.Resident #2's quarterly assessment, dated 04/02/25, showed their cognition was moderately impaired with a BIMS score of 13. Resident #2's physician order, dated 05/20/25, showed to send Resident #2's urine out for culture and cytology. Resident #2's lab results, dated 05/23/25, showed Resident #2's urine was positive for Escherichia coli greater than 100,000 cells/ml. Resident #2's nursing note, dated 05/23/25, read in part, 1400-2200 [2:00 p.m. - 10:00 p.m.] N/O [new order] per [name of physician withheld] Macrobid 100 mg x 14 days for E. coli. Resident #2's physician orders, dated 05/24/25, read in part, Macrobid (antibiotic) (nitrofurantoin monohyd/m-cryst) capsule; 100 mg; amt (amount) 1 tab; oral twice a day.A facility document titled Grievance/Complaint Report, dated 05/24/25, showed Resident #2's family representative was concerned Resident #2 did not receive their antibiotic on 05/24/25. The document showed the medications were in the building and nursing staff were in-serviced on use of the e-kit. Resident #2's MAR (medication administration record), dated 05/23/25 through 05/25/25, did not document Resident #2 received the antibiotic Macrobid 100 mg two times a day. Resident #2's nursing note, dated 05/25/25, showed Resident #2s family was present and Resident #2 was confused. The note showed Resident #2's physician was notified and ordered Resident #2 to be sent to the hospital for IV fluids. The note showed Resident #2 left the facility by ambulance to be transported to the hospital.Resident #2's hospital record, dated 05/25/25, showed Resident #2 was admitted to the hospital for a complicated UTI and was not septic. A facility document titled Performance Improvement Plan: Privileged Work Document, dated 05/25/25, showed LPNs, RNs, and CMAs were in-serviced on 05/25/25 regarding the use of the e-kit for medications and utilizing the emergency pharmacy phone number. The document showed the facility was going to conduct medication audits weekly for two weeks, then weekly thereafter. A facility document with no title, dated 05/25/25 through 06/07/25, showed daily monitoring was in place to ensure residents received their medications as ordered. The document showed weekly monitoring was conducted from 06/09/25 through 08/13/25. The daily/weekly monitoring document included the following key points:a. MAR matches current provider,b. medications given in 1-hour window, c. PRNs include indication, effectiveness documentation, and d. Any omitted or missed doses.The document showed medications were available in the facility and proper medication protocols were being followed.A facility handwritten statement from CMA #1, dated 05/26/25, read in part, Saturday 05/24/25, I was med (medication) aide on 2 p.m. to 10 p.m., I was supposed to give Macrobid around [3:00 p.m.] but it wasn't there, and I let [LPN #5] know it wasn't there and that I put it down as not given. [They] said OK and went to working on getting it from the pharmacy.A facility document titled Corrective Action Notice, dated 05/26/25, read in part, [LPN #5] displayed unprofessionalism toward family members. [LPN#5] did not ensure medications were in the building in a timely manner and did not follow the facility protocols on ensuring meds were given, and the emergency kit was utilized. The note showed LPN #5 was suspended for 4 days. The note was signed by the DON on 05/27/25.A facility document titled Resident Concern Form, dated 05/26/25, showed Resident #2 did not receive their scheduled antibiotics on 05/24/25 and 05/25/25. The note showed actions taken included internal investigation, corrective action, implement a