| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375160 | A. Building<br>B. Wing | 02/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Elmbrook Home | 1811 9th Avenue NW<br>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) |
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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>Based on record review and interview, the facility failed to ensure the proper repositioning of a dependent resident was performed for 1 (#3) of 3 sampled residents reviewed for safe transfers.The regional nurse consultant identified 65 residents resided in the facility. Findings:On 02/11/26 at 12:00 p.m., Res #3 was observed sitting in their recliner with their feet elevated. A bandage and dark purple bruising were observed on their right forearm.On 02/11/26 at 1:24 p.m., Res #3 was observed sitting in their recliner and watching television. A bandage and dark purple bruising were observed to their right forearm.An undated face sheet for Res #3 showed the resident was admitted to the facility with diagnosis which included unspecified pain.A quarterly assessment for Res #3, dated 12/03/25, showed the resident's cognition level was moderately impaired with a BIMS score of 11. The assessment showed the resident was dependent with activities of daily living and required the assistance of two staff.On 02/11/26 at 1:24 p.m., Res #3 was asked about the bruising and the bandage on their right forearm. Res #3 stated CNA #1 and LPN #1 tried to pull them up in bed. When CNA #1 leaned over them and pushed down on their arm while trying to move them up in bed. Res #3 stated they hollered and told CNA #1 and LPN #1 their arm was hurting, but they continued to move them up in bed.On 02/12/26 at 5:25 a.m., LPN #1 stated Res #3 had just returned from the emergency room, and they assisted the resident to bed. LPN #1 stated CNA #1 reached over Res #3 and grabbed the draw sheet that was under the resident while LPN #1 put their arm under the resident's knees to help move the resident up in bed. LPN #1 stated the resident stated, Ow my arm. LPN #1 stated they stopped and readjusted the resident then finished moving the resident up in bed.On 02/12/26 at 10:01 a.m., CNA #1 stated them and LPN #1 assisted Res #3 to bed after they returned from the emergency room. CNA #1 stated the resident needed to be moved up in the bed, so they reached across the resident and grabbed the draw sheet that was under the resident on both sides and LPN #1 grabbed under the resident's knees and they moved Res #3 up in bed. CNA #1 stated they never heard the resident complain of pain. CNA #1 was asked if that was the correct way to move a resident up in the bed. They stated, No, that one person should have been on each side of the bed and pulled the resident up in bed using the draw sheet.On 02/12/26 at 10:12 a.m., the DON stated on 02/06/26 at 4:30 p.m., Res #3's family member had called and informed them of the bruising to the resident's right forearm with a hematoma in the middle of it. The DON stated CNA #1 stated they did not hear Res #3 say Ow, my arm and LPN #1 stated they heard it and just assumed the resident referred to their chronic arm pain. The DON stated both employees were written up and re-educated on the proper way to move a resident up in bed.In-service training documentation, dated 02/06/26, was reviewed. The documentation showed all staff were re-educated on proper transfers, repositioning techniques, and pain management/assessments.A quality assurance meeting, dated 02/09/26, showed a performance improvement plan was established for improper lifts/transfers and pain assessment/re-assessment compliance documentation.On 02/13/26 at 9:56 a.m., CNA #2 stated to assist a resident up in the bed they had to have one person on each side and use the draw sheet to<br><br>(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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | move the resident up.On 02/13/26 at 10:00 a.m., LPN #2 stated if a resident complained of pain, you repositioned first. LPN #2 stated pain medication was administered if the resident was still having pain and charted in the medication administration record and nurses' notes. LPN #2 stated if it was not an everyday pain then they documented in the nurse' notes, monitored, and notified the physician.On 02/13/26 at 10:10 a.m., CNA #3 stated you lowered the head of the bed, one person was on each side of the bed, and they used the pad or draw sheet to move the resident up.On 02/13/26 at 10:20 a.m., CNA #3 stated to move a resident up in bed you had to have one person on each side of the bed. CNA #3 stated they used the draw sheet to move the resident up in bed.On 02/13/26 at 10:35 a.m., restorative aide #1 stated you had to have one person on each side of the bed and used the draw sheet or pad to move the resident up in bed.On 02/13 26 at 10:45 a.m. LPN #3 stated if the resident complained of pain they assessed, checked physician orders, notified the physician if it was not chronic pain, completed a report sheet, and charted in the nurses' notes. |

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|---|---|
| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>Based on observation, record review, and interview, the facility failed to ensure a resident was assessed for pain while being repositioned in bed for 1 (#3) of 4 sampled residents reviewed for pain.The regional nurse consultant identified 65 residents resided in the facility. Findings:On 02/11/26 at 12:00 p.m., Res #3 was observed sitting in their recliner with their feet elevated. A bandage and dark purple bruising were observed on their right forearm.On 02/11/26 at 1:24 p.m., Res #3 was observed sitting in their recliner and was watching television. A bandage and dark purple bruising were observed to their right forearm.A Pain-Clinical Protocol policy, dated 10/2022, read in part, the staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. Staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognition level.An undated face sheet for Res #3 showed the resident was admitted to the facility with diagnosis which included unspecified pain.A physician order for Res #3, dated 08/28/23, showed Tylenol Arthritis Pain (pain reliever) 650 milligrams every six hours as needed.A quarterly assessment for Res #3, dated 12/03/25, showed the resident had a cognition level that was moderately impaired with a BIMS score of 11. A nurse's note for Res #3, dated 02/05/26 at 2:44 a.m., showed the resident received Tylenol as requested.A care plan for Res #3, revised 02/08/26, showed to monitor any skin changes, notify physician of blood blister and changes as necessary until area resolved, and to monitor for pain and/or discomfort.On 02/11/26 at 1:24 p.m., Res #3 stated when they returned from the emergency room, CNA #1 and LPN #1 tried to pull them up in bed. Res #3 stated CNA #1 leaned over them and pushed down on their arm while trying to move them up in bed. Res #3 stated they hollered and told CNA #1 and LPN #1 their arm was hurting. Res #3 stated they continued to move them up in bed.On 02/12/26 at 5:25 a.m., LPN #1 stated Res #3 had just returned from the emergency room, and they assisted the resident to bed. LPN #1 stated CNA #1 reached over Res #3 and grabbed the draw sheet that was under the resident while they put their arm under the resident's knees to help move the resident up in bed. LPN #1 stated the resident stated, Ow my arm. LPN #1 stated they stopped and readjusted the resident then finished moving the resident up in bed. LPN #1 stated they did not assess the resident for new pain, just assumed it was the chronic shoulder pain they complained about. LPN #1 stated they should have assessed the resident to see where the pain was, reported they just administered the resident's pain medication, and made sure it was effective.On 02/12/26 at 10:01 a.m., CNA #1 stated them and LPN #1 assisted Res #3 to bed after they returned from the emergency room. CNA #1 stated the resident needed to be moved up in the bed, so they reached across the resident and grabbed the draw sheet that was under the resident on both sides and LPN #1 grabbed under the resident's knees and they moved Res #3 up in bed. CNA #1 stated they never heard the resident complain of pain. CNA #1 was asked if that was the correct way to move a resident up in the bed. They stated, No, that one person should have been on each side of the bed and pulled the resident up in bed using the draw sheet.On 02/12/26 at 10:12 a.m., the DON stated on 02/06/26 at 4:30 p.m. Res #3's family member had called and informed them of the bruising to the resident's right forearm. The DON stated CNA #1 reported they did not hear the Res #3 say Ow, my arm and LPN #1 stated they heard it and just assumed the resident referred to their chronic arm pain. The DON stated both employees were written up and re-educated on the proper way to move a resident up in bed. The DON stated LPN #1 was reprimanded for their failure to assess the complaint of pain from Res #3 during transfer. |