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	01/16/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 51813 Based on observation, record review, and interview, the facility failed to treat a resident with dignity and respect while providing assistance with eating for one (#33) of one resident sampled for resident rights. The administrator reported 67 residents resided in the facility. A Telephones, Employees Use of policy, dated July 2010, read in part, cellular phones may be used for personal calls and text messaging ONLY when the employee was on authorized meal and break periods. Employee cell phones will remain off and/or silent during all other work hours. Failure to comply with cellular phone policies may result in disciplinary action. Resident #33 had diagnoses which included Alzheimer's disease, depression, and seizure disorder. An MDS assessment for Resident #33, dated 11/18/24, documented the resident had severely impaired decision making. A care plan for Resident #33, dated 11/18/24, documented the resident required assistance with activities of daily living. On 01/14/25 at 1:02 p.m., during the noon meal, CNA #2 was observed to be watching a video on their personal cell phone while feeding Resident #33 a pureed meal. On 01/14/25 at 1:20 p.m., LPN #3 reported the use of cell phones while providing resident care was not allowed and stated they would address the situation with CNA #2. On 01/14/25 at 2:10 p.m., CNA #1 reported CNA #2 used their cell phone on a daily basis while feeding the residents. CNA #1 was asked if they were allowed to use their cell phone while providing care and the CNA stated it was not recommended. On 01/16/25 at 9:57 a.m., the DON reported they expected no cell phone use from staff while providing care to residents. The DON reported cell phone use had been an ongoing problem and staff were reminded frequently to put their phones away except during breaks.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34333 Based on observation, record review, and interview, the facility failed to maintain a comfortable room temperature for one (#16) of four residents sampled for the environment. The administrator reported 67 residents resided in the facility. Findings: An undated Resident Rights policy, read in parts, The facility must provide a safe, clean, comfortable, home-like environment .The facility will provide housekeeping and maintenance services .The facility will provide you with comfortable and safe temperature levels. Resident #16 had diagnoses which included atrial fibrillation, Alzheimer's dementia, muscle weakness, anxiety, coronary artery disease, iron deficiency anemia, chronic pain, and diabetes. An MDS assessment, dated 11/02/24, documented Resident #16 was moderately impaired with cognition. The assessment documented the resident used a wheelchair for mobility. On 01/14/25 at 2:40 p.m., Resident #16 was observed lying in bed covered up with blankets. The resident reported they were cold and was noted to have blankets on the windowsill underneath the blinds. The resident reported they had put the blankets on the windowsill because they were always cold. On 01/14/25 at 2:49 p.m., RN #2 reported Resident #16's room was always cold. The RN reported they had told maintenance about the room being cold the previous week. The RN reported they remembered maintenance saying there were blankets on the vent and those had been removed to get some heat flowing. The RN stated they did not think the room had gotten any warmer and maintenance had not done anything further as far as they were aware. The RN reported sometimes Resident #16's hands were so cold it was hard to get a pulse oximetry reading when doing the resident's assessment. On 01/14/25 at 3:40 p.m., a room temperature was obtained in Resident #16's room, using a digital thermometer, which read 67.6 degrees Fahrenheit. On 01/16/25 at 10:25 a.m., Resident #16 reported their room was still cold. A room temperature was obtained and the temperature was 71.4 degrees Fahrenheit. The administrator and maintenance staff obtained a similar temperature reading using their own thermometer. The resident was observed sitting in their wheelchair wearing a jacket. The surveyor asked the resident if they had been asked about possibly changing rooms. The administrator then asked the resident if they would want to change rooms and the resident stated, Yes, I would. On 01/16/25 at 10:37 a.m., the administrator reported they had just learned the previous day the resident had complained of their room being too cold and they had started a grievance report related to the resident's complaint. The administrator was informed the resident had complained to the charge nurse the previous week and the charge nurse had reported the complaint to maintenance. The administrator reported they would check into finding a different room for the resident.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873 Based on record review and interview, the facility failed to complete a MDS discharge assessment when the resident was discharged from the facility for one (#63) of one sampled resident reviewed for comprehensive assessments. The administrator reported 67 residents resided in the facility. Findings: The regional nurse consultant reported the facilty had no policy for comprehensive assessments. Resident #63 was admitted to the facility on [DATE] with a diagnosis of right femur fracture. A progress note, dated 09/07/24, documented the resident discharged from the facility. On 01/15/25 at 11:10 a.m., the MDS coordinator reported the discharge assessment was missed for Resident #63. The MDS coordinator reported the discharge assessment would be completed and submitted.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873 Based on record review and interview, the facility failed to refer a resident with newly diagnosed mental illness diagnoses to the OHCA for a level II PASARR evaluation for one (#40) of two sampled residents reviewed for PASARR. The administrator reported 67 residents resided in the facility. Findings: Resident #40 was admitted to the facility on [DATE]. A level I PASARR, dated 02/09/21, documented no level II PASARR was required. Resident #40 had diagnoses added since admission which included mood disorder, date diagnosed [DATE], and unspecified psychosis, date diagnosed [DATE]. On 01/14/25 at 4:33 p.m., the regional nurse consultant reported the resident's PASARR had not been reevaluated after the new mental illness diagnoses. The regional nurse consultant reported the facility had no policy for PASARR.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 30875 Based on observation, record review, and interview, the facility failed to transcribe a physician order and schedule a mammography in a timely manner as requested for one (#41) of one resident reviewed for a physician ordered mammography. The administrator reported 67 residents resided in the facility. Findings: A Transportation, Diagnostic Services policy, dated December 2008, read in parts, Should it become necessary for the facility to provide transportation, the Social Service Designee will be responsible for arranging the transportation through the business office .A member of the Nursing Staff, or Social Services, will accompany the resident to the diagnostic center when the resident's family is not available. An Acute Condition Changes-Clinical Protocol policy, dated March 2018, read in parts, Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician, for example, the history of present illness and previous and recent test results for comparison .The attending physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status .The nursing staff will contact the medical director for additional guidance and consultation if they do not receive timely or appropriate response. A Resident's Council Meeting minutes, dated 08/08/24, documented an elder stated doctor appointments were taking too long to set up. Progress notes for Resident #41, dated 11/13/24, documented past surgical history, partial mastectomy left. A nurse's note for Resident #41, dated 12/26/24, read in parts, resident has a lump in breast tissue under the left arm .[physician name withheld] notified. New orders .Schedule mammogram for resident as soon as possible. The note was documented by RN #3. Resident #41's Physician Order, dated 01/16/25, read in part, diagnostic mammogram due to lump on the left side [DX: Unspecified lump in the left breast, upper outer quadrant]. LPN #1 presented the physician's order on the day of the survey. On 01/16/25 at 8:29 a.m., LPN #4 performed a skin assessment with Resident #41. A lump to the left breast area was noted and Resident #41 reported they were supposed to schedule them for a mammogram. The resident reported a history of breast cancer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/16/25 at 11:08 a.m., LPN #1 was asked when Resident #41 was scheduled for a mammography. They reported the referral was sent this morning to the hospital. They were asked when they received notification to schedule the mammography. They stated they were notified around the end of December 2024 and the physician order was received this morning. They were asked about the nurse's note stating to schedule as soon as possible. LPN #1 stated that meant, As soon as we can get it done. The nurse was asked if it had been arranged as soon as possible. They stated, No. They stated it had been 16 or 17 days and they hoped they would have an appointment scheduled this afternoon or in the morning. They were asked about Resident #41's breast cancer history. The nurse reviewed records and reported the resident had a partial mastectomy on the left side dated 05/22/24. On 01/16/25 at 11:38 a.m., the DON was asked about the facility policy related to referrals for testing. The DON reported the doctor would put in the order and they would get it scheduled in a timely manner. The DON was asked about the scheduling for the mammography for Resident #41. They stated it sounded like it had taken a couple of weeks to get it scheduled. On 01/16/25 at 12:15 p.m., RN #3 was asked if they wrote the physician order related to the nurse's note dated 12/26/24. They stated they thought they had, but did not see the order when the record was reviewed today. The RN reported they were aware of the residents' history of breast cancer. The RN reported there had been a scheduling issue in getting the resident's mammography scheduled. On 01/16/25 at 2:30 p.m., LPN #1 reported they had called the hospital to get Resident #41's mammography scheduled. The LPN reported the hospital staff stated since the resident had a lump and would need a 3-D mammography, so the process was started with receiving a physician order for a 3-D mammography.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34333 Based on observation, record review, and interview, the facility failed to follow their policy to ensure a safe environment for smokers for two (#45 and #55) of two residents sampled for accident hazards. The administrator reported 10 residents who smoked, seven of which were unsupervised smokers. Findings: A Smoking Policy - Residents policy, dated July 2017, read in parts, A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff . Residents shall have the supervision of a staff member, family member, visitor or volunteer worker at all times while smoking .Residents may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under supervision. 1. Resident #45 had diagnoses which included Alzheimer's dementia, diabetes, asthma, chronic kidney disease, visual loss, muscle spasm, anxiety, depression, psychosis, and a history of falls. A smoking assessment for Resident #45, dated 12/19/24, documented the resident was a safe smoker with a smoking risk of 0. The assessment documented the resident could smoke independently. An MDS assessment, dated 12/20/24, documented the resident was cognitively intact and independent with activities of daily living. A care plan for Resident #45, dated 12/24/24, documented the resident was at risk for injury related to being a smoker. The care plan documented the resident would smoke in designated areas. The care plan documented the resident required oxygen as needed. On 01/15/25 at 10:47 a.m., Resident #45 reported they smoked independently. The resident was asked if staff kept their cigarettes and they stated, No. They stated that was only for residents who got caught smoking in their room. The resident was noted to have oxygen in place per nasal cannula. The resident reported they used oxygen most of the time. On 01/15/25 at 10:58 a.m., CNA #2 reported Resident #45 was fairly independent and was allowed to keep their cigarettes in their room. On 01/15/25 at 11:03 a.m., LPN #3 reported they only kept cigarettes for one resident on the hall. The LPN reported Resident #45 and all other unsupervised smokers kept their own cigarettes in their rooms. On 01/15/25 at 4:51 p.m., RN #2 confirmed Resident #45 kept their cigarettes and lighter in their room. The RN reported the resident smoked independently. The RN reported the resident normally only went out to smoke two or three times a day because the resident usually did not feel like going out. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #55 had diagnoses which included Alzheimer's disease, pain, depression, anxiety, essential tremor, and a history of falls. A progress note, dated 11/24/24 at 6:47 p.m., documented Resident #55 was outside smoking with family members. The note documented the family reported the resident got up to walk over and get a cigarette when they tripped and fell . The note documented the resident was assessed for injury. A smoking assessment for Resident #55, dated 01/07/25, documented the resident smoked every few hours. The assessment documented a smoking risk of 0. The assessment documented the resident was a safe smoker and could smoke independently. An MDS assessment, dated 01/07/25, documented the resident was severely impaired with cognition. A care plan for Resident #55, dated 01/09/25, documented the resident was at risk for injury related to smoking. The care plan documented the resident would smoke in designated areas. The care plan documented the resident had cognitive impairment related to Alzheimer's disease. On 01/14/25 at 11:17 a.m., the social services director reported Resident #55 frequently walked the halls often looking for someone to take them outside to smoke. On 01/14/25 at 11:25 a.m., Resident #55 was observed to walk to the outside door near the designated smoking area. An unidentified staff member was observed to open the door for the resident and the resident was observed to smoke with three staff members. On 01/15/25 at 11:05 a.m., LPN #3 reported they kept Resident #55's cigarettes at the nurse's station. The nurse reported the resident did not typically request to go smoke, but staff would take the resident out a couple of times a day. The nurse reported the resident was always supervised with a staff member. On 01/15/25 at 4:06 p.m., CNA #3 reported Resident #55 did not actually get staff to take them out, but would often go to the door to see if anyone else was smoking. The CNA reported staff usually took the resident out a couple of times a day and the resident was always supervised. On 01/16/25 at 9:45 a.m., the DON reported Resident #55's smoking assessment was correct. The DON reported they would normally keep cigarettes for a resident with dementia, so the nurses kept the resident's cigarettes at the nurse's station. The DON reported Resident #55 could smoke safely with no concern related to how they held a cigarette and no concern with lighting a cigarette. On 01/16/25 at 9:50 a.m., the DON reported the MDS nurse usually completed the resident smoking assessments. The DON reported if residents were considered unsupervised, they could go outside and smoke independently without supervision. The DON reported they had some residents who kept their cigarettes and lighter in their room, and were free to go out and smoke whenever they wanted without notifying staff. The DON reported a resident with dementia usually required staff to keep their cigarettes and required supervision while smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/16/25 at 9:58 a.m., the DON was asked about the facility's policy for all smokers to be supervised at all times and that residents would not keep any smoking articles except under supervision. The DON reported often residents wanted to keep their own cigarettes, so it was a nursing judgement as to who would be allowed to keep their cigarettes and lighter with them. The DON stated the facility policy probably needed to be re-worded to reflect their process more accurately.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 30875 Based on observation, record review, and interview, the facility failed to ensure proper disposal of blood contaminated glucometer strips for one (#52) of two sampled residents reviewed for finger stick blood sugar levels. The DON reported 25 residents received finger stick blood sugar levels. Findings: A policy for Blood Sampling, dated 09/14/14, read in parts, The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees .Equipment and supplies, sharps container .Discard lancet and platform into the sharps container. Resident #52's Physician Order, dated 04/28/24, documented FSBS BID notify provider if over 300 and below 60. Resident #52's Care Plan, dated 05/13/24, documented nutritional status, resident has a diagnosis of diabetes mellitus. On 01/14/25 at 5:10 p.m., RN #2 was observed to gather supplies for a FSBS, which included a glucometer, gauze, lancet, and glucometer strip. The RN obtained a blood sample from Resident #52 and the glucometer had timed out. The RN removed the bloody strip and disposed of it in the resident's trashcan in their room. The RN was then observed to repeat the procedure and again disposed of the bloody test strip in the resident's trashcan. The RN reported they were nervous and normally would have disposed of the contaminated strip in the sharps container. On 01/16/25 at 2:25 p.m., the DON reported their policy was to dispose of contaminated supplies in the sharps container.