

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/15/2024
NAME OF PROVIDER OR SUPPLIER  Brookside Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  310 Brookside Drive Madill, OK 73446	

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)
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873</b></p> <p>Based on record review and interview, the facility failed to refer residents with newly diagnosed mental illnesses to the OHCA for a level II PASARR evaluation for two (#12 and #18) of three sampled residents reviewed for PASRR's.</p> <p>The Administrator reported 56 residents resided in the facility.</p> <p>Findings:</p> <p>1. Resident #12 was admitted to the facility on [DATE].</p> <p>Resident #12 had diagnoses which included recurrent major depressive disorder, date diagnosed [DATE], and schizoaffective disorder date diagnosed [DATE].</p> <p>The Level I PASRR screen, dated 07/21/11, documented no mental illness.</p> <p>On 08/13/24 at 4:03 p.m., the MDS coordinator reported the Level I PASRR screen should have been reassessed and submitted to OHCA when resident #12 was diagnosed with a new mental illness diagnoses of recurrent major depressive disorder and the schizoaffective disorder.</p> <p>2. Resident #18 was admitted to the facility on [DATE].</p> <p>Resident #18 had diagnoses which included bi-polar disorder, date diagnosed [DATE], anxiety disorder, date diagnosed [DATE], and schizoaffective disorder, date diagnosed [DATE].</p> <p>The Level I PASRR screen, dated 10/22/19, documented no mental illness.</p> <p>On 08/13/24 at 4:03 p.m., the MDS coordinator reported resident #18's Level I PASRR screen should have documented the bi-polar disorder and schizoaffective disorder. The MDS coordinator reported the Level I PASRR was filled out correctly.</p> <p>On 08/13/24 at 4:11 p.m., RN#2 reported the facility had no PASRR policy.</p>

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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