STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375255	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Healthcare, Inc	832 Isabel Southwest 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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41873 Based on observation, record review, and interview, the facility failed to follow physician orders for wound care for one (#1) of three sampled residents who were reviewed for wound care. Resident #1 was admitted to the hospital for wound dehiscence, cellulitis, and sepsis. The facility reported seven residents in the facility required wound care. The DON reported 61 residents resided in the facility. Findings: The facility's Wound Care policy, dated 10/01/10, read in part, .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing .The following information should be recorded in the resident's medical record: All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound . Resident #1 had diagnoses which included diabetes mellitus, atherosclerotic heart disease, and hemiplegia. An admission assessment, dated 03/08/24, documented resident #1's cognition was intact, no behaviors, and was dependent on staff for most activities of daily living. A care plan, dated 04/05/24, read in part, .Surgical incision located to left [error] lower leg related to hematoma .Address c/o pain promptly .Administer medication per physician's orders .Administer wound care per physician's orders .Notify physician of changes in condition .Observe incision site for odor, drainage . A progress note, dated 04/05/24 at 3:45 p.m., documented in part, .readmitted to skilled services status post hospitalization for right lower leg hematoma evacuation .Right lower leg incision covered with a dressing and wrapped with large ace wrap as pressure dressing applied today at the hospital. It is clean, dry, and intact . A physician order, dated 04/05/24, documented, Triad wound dressing paste; apply to affected area three times a day; 8:00 a.m., 12:00 p.m., 5:00 p.m.; Diagnoses: nontraumatic hematoma of soft tissue. (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
	375255	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Healthcare, Inc	832 Isabel Southwest 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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A progress note, dated 04/06/24 at 6:21 p.m., documented Resident #3 also had a dressing to their right lower extremity from a hematoma that was evacuated at [name removed] during their recent hospitalization . A progress note, dated 04/07/24 at 3:07 a.m., documented in part, .Hydrocodone-acetaminophen 10-325 mg tablet given at 4:33 p.m. for complaints 8 of 10 right leg pain was effective .Has a dressing to her right lower extremity . A physician order, dated 04/07/24, documented to cleanse the wound on left [error] lower leg with normal saline solution and pat dry. Adaptic touch non-adhering dressing to wound bed, cover with 4x4 gauze and wrap with Kerlix. Apply ace bandage to cover. Elevate leg. Once a day 7:00 a.m. - 3:00 p.m. Diagnoses: Nontraumatic hematoma of soft tissue. A progress note, dated 04/08/24 at 2:59 a.m., documented in part, .Upon chart review, dressing to lower [error] left leg from hematoma evacuation is to be hanged daily .Area is to be cleansed with NSS, pat dry, apply adaptic touch dressing to wound bed, cover with 4x4 gauze, wrap with Kerlix and cover with ace bandage .Leg is to be elevated when possible .Dressing changed this morning .Stitches still in place .Res has small areas of fluid retention under the skin .Moderate amount of serous drainage noted .Res stated that she was having pain the area .PRN Norco given and was effective . A progress note, dated 04/08/24, documented in part, .at 10:12 a.m.I came into room to get bandage off of right lower extremity for a bath .The bandage was stuck to the wound .Applied wound cleaner to soak the bandage .Went to get the resident a pain pill as this was painful .When med aide brought her the pain pill in 2 minutes later, there was a puddle of blood coming out of the right lower extremity .Firm continuous pressure was immediately applied by another nurse .Called Dr. [NAME] and received order to sent to ER to eval and treat .Ambulance called and resident transferred to the hospital . An Administration History report, dated 03/02/24 through 05/02/24, documented the following administration history for wound care: (Cleanse wound on left [error] lower leg with normal saline solution, pat dry. Adaptic touch non-adhering dressing to wound bed, cover with 4x4 gauze and wrap with Kerlix. Apply ace bandage to cover. Elevate leg. Once a day 7:00 a.m. - 3:00 p.m. Diagnoses: Nontraumatic hematoma of soft tissue.) 04/07/24 at 12:06 p.m., 04/08/24 - missed (sent to hospital). An Administration History report, dated 04/02/24 through 05/02/24, documented the following administration history for triad wound dressing ordered three times a day: 04/06/24 at 8:00 a.m. - missed .04/06/24 at 12:00 p.m. - Late, 04/06/24 at 5:00 p.m. - missed .04/07/24 at 8:00 a.m. - Late. The report contained no documentation of wound care on 04/05/24. The report documented three missed wound care administrations if physician's orders would have been followed. A emergency department report, dated 04/08/24 at 10:30 a.m., documented in part, .presents to the ED with chief complaint of wound check .Patient was sent her for further evaluation of the right lower extremity wound .Physical exam - post surgical changes to lower extremity with dry excoriations moderate amount of cellulitis . The patient is pale .Hemoglobin down to 7.9 from the 8.4 she had at hospital discharge several days ago . Given her hypotension with a recent source of bleeding decision was made to transfer as her until 1 unit packed red blood cells .Blood pressure improved .Blood cultures obtained and antibiotics given .Hospital admission warranted, patient admitted in stable condition . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375255	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Healthcare, Inc	832 Isabel Southwest 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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An orthopedic consult, dated 04/08/24 at 1:12 p.m., documented in part, .Right lower extremity: large area of necrotic skin over the anterior leg; fluctuance over the lateral aspect of the leg; leg is TTP; grossly NV intact to the foot .Diagnoses of acute kidney injury, sepsis, and cellulitis .Recommendation if for operative treatment for debridement of the skin on the right leg with irrigation/debridement . A hospital discharge summary, dated 04/17/24, documented in part, .Patient was admitted on [DATE] with right lower extremity hematoma status post evacuation that developed wound dehiscence and infection . Patient was treated with broad spectrum antibiotics and underwent excisional debridement on 04/12/24 with orthopedics .Patient was discharged back to [name removed] skilled nursing facility .Discharge instructions: Continue wound vac for an additional 2 weeks .Referred to orthopedic surgery for follow up of cellulitis and wound vac maintenance . A progress note, dated 04/18/24 at 4:35 p.m., documented in part, .Resident readmitted to skilled services status post hospitalization on right lower extremity that developed wound dehiscence and infection and required hospitalization for diagnoses of cellulitis of right lower extremity, wound dehiscence, and bladder mass .Resident was treated with broad spectrum antibiotics and had excisional debridement .Resident has a right lower leg wound vac on at this time due to the dehisced wound . On 05/02/24 at 11:25 a.m., Resident # 1 was observed in bed. The resident reported they had not been getting up for meals or getting physical therapy due to the wound vac to their right leg and it being painful. The resident's right lower extremity was wrapped with ace bandage and had a wound vac present. On 05/03/24 at 11:20 a.m., the DON reported no skin assessments were available in resident #1's medical record from 04/05/24 through 04/08/24. The DON reported no assessment of the right lower extremity wound site was documented until 04/07/24. The DON reported the Triad wound dressing ordered on 04/05/24 for three times a day, should have been for the coccyx. The DON reported the nurse that entered the readmission orders on 04/05/24 should have called to get a clarification order for wound care for the surgical site to the right lower extremity. The DON reported the order should have been checked and the wound site assessed before 04/07/24. The DON reported the resident did not get wound care as it was documented on the physician orders, due to that type of wound would not have Triad ordered three times a day. The DON was asked why wound care was not done on 04/05/24 as scheduled at 5:00 p.m., and the DON reported resident #1 had just left the hospital and they would have done the wound care before discharge, but was unable to provide proof of the time the wound care was last done in the hospital. The DON reported they did not believe the wound dehiscence or cellulitis was caused by Triad not being administered three times a day per the documented physician order. The DON reported the resident had only missed two treatments before the new wound care order was received and started on 04/07/24.