

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Southbrook Healthcare, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30875</p> <p>Based on observation, record review, and interview, the facility failed to obtain physician orders and evaluate one (#18) of one sampled resident reviewed for self-administration of medications.</p> <p>Findings:</p> <p>The DON/RN identified 63 residents resided in the facility.</p> <p>An Administering Medications policy, dated [DATE], read in part, Medications are administered in a safe and timely manner, and as prescribed. The policy also read, Residents may self-administer their own medications if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.</p> <p>A physician's order, dated [DATE], documented to apply Lantiseptic ointment to bilateral buttocks every shift.</p> <p>A quarterly assessment, dated [DATE], documented Resident #18 had moderate cognitive impairment and was independent with activities of daily living.</p> <p>A care plan, dated [DATE], documented the resident was at risk for pressure ulcers due to moisture. The plan of care did not include self-administration of medications.</p> <p>On [DATE] at 3:51 p.m., a bottle of clears eyes (expired), nasal spray, and a medication cup with Lantiseptic was observed on Resident #18's bedside table.</p> <p>On [DATE] at 2:26 p.m., a bottle of clear eyes, nasal spray, and a medication cup with Lantiseptic was observed on Resident #18's bedside table.</p> <p>On [DATE] at 8:52 a.m., RN #1 was asked about Resident #18's bedside medications. They reported they did not think the resident had medications at the bedside. They reported the family must have brought the medication into the facility. Resident #18 stated they used the nasal spray only as needed and used the eye drops every morning and every night.</p> <p>On [DATE] at 11:31 a.m., the DON/RN reported they notified the physician to keep the medications at bedside and to monitor it every Thursday.</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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