STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375390	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmbrook of Hugo	1200 West Finley Hugo, OK 74743

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 33097 On 04/17/25, a past noncompliance Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure Res #35 was not verbally abused. On 04/17/25 at 1:30 p.m. the OSDH was notified and verified the existence of the past noncompliance IJ related to the facility's failure to ensure residents were not verbally abused. On 05/06/25 at 12:48 p.m. the administrator was notified of the immediate jeopardy situation. The administrator was provided the IJ template. Documentation showed the facility completed staff in-service regarding abuse on 03/03/25. Employee #1 was suspended, then terminated on 03/04/25. A quality assurance meeting was held on 03/05/25 regarding abuse. Based on observation, record review, and interview, the facility failed to ensure a resident was not verbally abused for 1 (#35) of 3 sampled residents reviewed for abuse. The DON identified six allegations of abuse were reported to the OSDH within the past year. Findings: On 04/15/25 at 2:08 p.m., Res #35 was observed walking in a common area on the memory unit. The resident was speaking loudly in a tearful voice saying could someone help they did not know how to get out. A policy titled Abuse Investigation and Reporting, revised July 2017, read in part, If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual . The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation An undated facesheet for Res #35 had diagnoses which included neurocognitive disorder with Lewy body, diabetes, and major depressive disorder. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Res #35's annual assessment, dated 02/19/25, showed the resident was severely impaired for daily decision making and had a BIMS score of 4. The assessment showed the resident received antipsychotic, antianxiety, and antidepressant medications. An OSDH incident form, dated 02/28/25, showed an allegation of abuse. The form showed per written statements by witnesses, the raised tone of voice by certified medication aide #1 caused Res #35 to become upset and cry. On 04/16/25 at 3:04 p.m., Res #35's family stated they were made aware of the verbal abuse allegation the same evening. On 04/17/25 at 2:57 p.m., the director of nursing stated upon completion of the investigation the facility decided to terminate the staff member. On 04/17/25 at 3:00 p.m., the administrator stated a video was viewed regarding the incident. The administrator stated they could not understand what was said, but by facial expressions and gestures they determined verbal abuse did occur.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 46582 Based on observation, record review, and interview, the facility failed to ensure assessments were accurate for indwelling catheters for 1 (#24) of 13 sampled residents reviewed for resident assessments. The ADON identified 52 residents resided in the facility. Findings: On 04/15/25 at 11:48 a.m., Res #24 was observed lying in bed. A bedside commode was observed sitting beside the bed. No indwelling catheter was observed. A face sheet, dated 01/05/24, showed Res #24 was admitted with diagnoses which included dementia and peripheral vascular disease. A quarterly assessment, dated 03/20/25, showed Res #24 had a BIMS score of 4 and was severely cognitively impaired. The assessment showed Res #24 had an indwelling catheter. Res #24's medical record did not document an order for an indwelling catheter during the assessment review period of 03/14/25 through 03/20/25. On 04/15/24 at 12:00 p.m., Res #24 stated they did not have a catheter. They stated they did not remember if they had ever had a catheter. On 04/16/25 at 2:37 p.m., the minimum data set coordinator stated Res #24 did not have an indwelling catheter during the assessment review period. They stated the assessment was coded in error and would be modified.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43023 Based on record review and interview, the facility failed to ensure a care plan was implemented for 1 (#33) of 1 resident sampled for smoking. The ADON reported five residents in the facility smoked. Findings: An undated medical diagnoses list for Res #33 showed the resident admitted to the facility with diagnoses which included hypertensive heart disease, chronic atrial fibrillation, and anxiety disorder. Res #33's smoking assessment, dated 01/09/25, showed the resident was safe to smoke by self. Res #33's care plan, dated 01/14/2025, showed no documentation the resident smoked. On 04/17/25 at 10:32 a.m., the ADON reported smoking should have been care planned.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43023 Based on observation, record review, and interview, the facility failed to follow the plan of care for 1 (#18) of 1 sampled residents reviewed for respiratory care . The ADON reported 52 residents resided in the facility. Findings: On 04/15/25 at 1:23 p.m., Res #18 was observed sitting on the side of their bed with oxygen at 3 liters per minute. No date was observed on the tubing or humidifier bottle. On 04/16/25 at 11:33 a.m., Res #18 was observed sitting up on the side of their bed watching television. Their oxygen tubing and humidifier bottle were observed and showed no date. An undated medical diagnoses list for Res #18 showed diagnoses which include heart failure and chronic obstructive pulmonary disease. Res #18's care plan, dated 03/17/25, read in part, Approach: Change Oxygen tubing weekly, label with correct date, ensure oxygen tubing in proper storage bag with correct date. On 04/17/25 at 10:38 a.m., the ADON reported the care plan should have been followed.