STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375574	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Brookline	5301 North Brookline Oklahoma City, OK 73112

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On [DATE] an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to ensure a Resident #4 received timely CPR per the physician's order when the resident was found unresponsive and without vital signs. The resident was pronounced deceased by EMS.On [DATE] at 11:26 a.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation.On [DATE] at 11:43 a.m., the administrator and DON were notified of the existence of the IJ situation and was provided the IJ template. On [DATE] at 4:28 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, [DATE] 3:58pm1.The facility failed to initiate CPR immediately when a resident with a full code status was found without signs of life.2. All residents residing in the facility who are full code status are at risk.3. Staff are in-serviced on policy and procedure of Medical Emergency Response and educated on locations of Code Status Identifiers for all residents residing in the facility. Signs are placed throughout facility for quick identification of how to respond to a resident without signs of life. DON updated code status sheets on [DATE].4. Plan will be completed [DATE] by 5:00pm.5. Staff present in building on [DATE] are in-serviced. Staff not present in building are contacted by phone call to provide verbal in-service on [DATE] with written documentation of date and time of contact for in-service. Signage posted throughout facility on [DATE].6. Changes to Code Status Document will be discussed in morning meeting to include Code Status changes, room changes, new admits or discharges. PIP will be initiated [DATE] for monitoring during 3 months for any changes needed to the system and will be added to QAPI [quality assurance and performance improvement]. New employees will be educated on Medical Emergency Response Policy and Procedure. A PIP will be initiated for the RN supervisor, [name withheld], [DATE] and monitored for the next 3 months.7. Medical Emergency Response Policy and Procedure provided with oral in-service, Signage posted throughout facility for quick identification of how to respond to a resident without signs of life with oral in-service for explanation of signage, and verbal education of locations of Code Status Identifiers for all residents residing in the facility. 8. The facility failed to initiate CPR immediately when a resident with a full code status was found without signs of lifeOn [DATE] at 9:11 a.m., after all staff members had been in-serviced, staff CPR training was verified, residents code status was verified for accuracy, and performance improvement projects were initiated with ongoing auditing, the immediacy was lifted, effective [DATE] at 5:00 p.m. The deficient practice remained at an isolated level with the potential for more than minimal harm.Based on observation, record review, and interview, the facility failed to initiate CPR to an unresponsive resident with a full code status for 1 (#4) of 1 sampled resident reviewed for emergency basic life support to include CPR.The administrator identified 47 residents resided in the facility and 31 Residents had a full code status.Findings: (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 6:38 a.m., laminated code response/instructions were observed posted on shower doors, above nurse carts, and in the dining room. A Cardiopulmonary Resuscitation (CPR) policy, with a copyright date of 2024, read in part, If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services, and: a. in accordance with the resident's advance directives, or b. in the absence of advance directives or a Do Not Resuscitate order; and c. if the resident does not show obvious signs of clinical death (e.g. [for example] rigor mortis, dependent lividity, decapitation, transection, or decomposition). CPR certified staff will be available at all times.The employee who first witnesses or is the first on the site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate, basic first aid and summon for assistance. CPR will continue unless: a. there is a DNR order in place. b. There are obvious signs of clinical death (rigor mortis, dependent lividity, decapitation, transection, or decomposition). c. initiating CPR could cause injury or peril to the rescuer.This will continue until emergency personnel arrive and resident is transported to the emergency room by the EMS. A Physician's order, dated [DATE] at 8:47 p.m., showed the resident was a full code and was admitted on [DATE]. An admission assessment, dated [DATE], showed Resident #4 had diagnoses which included bladder cancer, stage 3 kidney disease, and absence of kidney. A Nurse Progress Note, dated [DATE] at 3:27 p.m., showed LPN #1 received report from the night shift nurse at 7:00 a.m., Resident #4 had been anxious and attempting to get out of bed all night and that pain medication had been given at 6:30 a.m. The note showed at 8:00 a.m., LPN #1 completed the initial assessment, and vital signs were within normal limits. The note showed Resident #4 appeared anxious and was requesting more pain medication. The note showed Resident #4 was repositioned and the bed was lowered to the floor for safety. The note showed at approximately 9:00 a.m., CNA #1 reported Resident #4 had refused to put on a gown. The note showed CNA #1 responded to the call light at 9:30 a.m. and Resident #4 was sitting up in bed complaining of feeling hot and still did not want a gown on. The note showed between 10:30 and 10:45 a.m., CNA #1 checked on Resident #4 again and the resident still refused a gown, but was sitting up in the bed. The note showed at 11:05 a.m., Resident #4's family member stepped into the hall and alerted CNA #1 Resident #4 was breathing weird. The note showed CNA #1 entered the room and found Resident #4 unresponsive, with one leg on the floor and one on the bed. The note showed CNA #1 called for help and LPN #1 and two other nurses, and three other CNA's responded. The note showed Resident #4 was not breathing and had no pulse. The note showed 911 was immediately called and CPR was initiated until EMS arrived and assumed CPR. The note showed EMS performed CPR for approximately 26 minutes and administered six rounds of epinephrine, when they pronounced Resident #4 dead at 12:03 p.m. The note showed the physician, administrator, and DON were notified. The note showed the resident's family member was assisted in notifying other family members, Resident #4 was put back into bed and cleaned up. The note showed the family was provided privacy and time to make arrangements. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:52 p.m., a phone interview was conducted with Resident #4's family member that was present during the incident. The family member stated Resident #4 was admitted on [DATE] at 6:20 p.m. The family member stated when they returned to the facility on [DATE] at 11:11 a.m., Resident #4 had both knees on the floor and was leaning to their right onto their lowered bed. The family member stated Resident #4's mouth and eyes were open, but they were not breathing. The family member stated they walked to the hall and told a nurse Resident #4 was not breathing. The family member stated CNA #1 walked into the room and back out and then within two minutes seven to eight staff arrived. The family member stated the staff picked Resident #4 off the floor and placed them into the bed where staff proceeded to clean Resident #4 up and make the bed. The family member stated when air came out of Resident #4, the staff then called 911, and moved Resident #4 to the floor and may have done three compressions before the fire department arrived. The family member stated it was probably seven to nine minutes before the staff called 911 after being aware the resident was not breathing. The family member stated, They did not do anything resuscitative all the way up until after they called 911. On [DATE] at 3:37 p.m., via a telephone interview, RN #1 stated LPN #1 and LPN #2 were the ones that responded. RN #1 stated, I was in the building, but was not aware of the situation. RN #1 stated they did not know anything about that resident. On [DATE] from 3:44 p.m. to 4:00 p.m., via a telephone interview, LPN #1 stated they had received report from night shift Resident #4 had been anxious. LPN #1 stated they did not have a lot of information, except the resident had been crying out in pain and was anxious during their assessment. LPN #1 stated they were in a different resident's room when CNAs were running towards Resident #4's room. LPN #1 stated CNA #1 had told them they were just in Resident #4's room [ROOM NUMBER] minutes prior to being called into the room by a family member. LPN #1 stated somebody was checking for a pulse or breathing, and when it was not found, the staff moved Resident #4 up into the bed and were cleaning the resident up. LPN #1 stated they thought it was weird Resident #4 did not have much bowel movement in their colostomy, but there was bowel movement coming from the rectum. LPN #1 stated One of the CNAs thought they heard a breath, so the supervisor (RN #1) instructed them to move Resident #4 to the floor. LPN #1 stated LPN #2 started CPR while they called 911. LPN #1 stated RN #1 was going to check for code status. LPN #1 stated they took over CPR for LPN #2, so that LPN #2 could go get the crash cart. LPN #1 stated CPR was continued until EMS arrived and took over. LPN #1 stated, I am not going to override my clinical nurse supervisor on when to start CPR, when they were asked why CPR was not initiated as soon as it was recognized there was no pulse or breathing. On [DATE] from 4:08 p.m. until 4:28 p.m., via a telephone interview, CNA #1 stated they had checked on and spoken with the resident when breakfast trays were dropped off, picked up, and at least twice while they were offering to assist Resident #4 to put on a gown. CNA #1 stated they had last observed Resident #4 sitting up in bed at approximately 10:55 a.m. CNA #1 stated they were coming out of a different resident's room when the family member told them Resident #4 was not breathing at approximately 11:05 a.m. CNA #1 stated they ran up the halls asking for a nurse. CNA #1 stated while the nurses were checking for vital signs, the CNAs put Resident #4 on the bed and put a gown, and a brief on Resident #4. CNA #1 stated, It felt like an eternity, but was probably four to five minutes before CPR was initiated. CNA #1 stated, while RN #1 was looking for the code status one of the CNAs thought they heard a breath, so when RN #1 returned, they were instructed to move the resident to the floor and initiate CPR. CNA #1 stated LPN #2 started CPR, but then LPN #1 took over compressions while LPN #2 went to get the crash cart. CNA #1 stated they did not remember when 911 was called, but it started quickly once they were told to start CPR. CNA #1 stated the electronic health record system could be logged into from their phones within 60 seconds if they have good wireless internet. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 8:39 a.m., CNA #4 stated resident code statuses were kept in a binder. They showed the surveyor the binder in the linen closet by room [ROOM NUMBER] that showed resident names with a red column for DNR and a green column for full code. They stated every hall had a binder. They stated the DON was responsible for entering the code status. They stated the nurse would probably be the person to determine when to initiate CPR on a resident. CNA #4 stated they had not been involved in a code and would try to help in any way. On [DATE] at 8:44 a.m., CNA #5 showed the surveyor a binder in the linen closet by room [ROOM NUMBER]. They stated it identified each resident’s code status. They stated the nurses put the information in. They stated if a resident appeared to not be breathing, they would get the nurse. CNA #5 stated when a resident dropped to the floor, if staff were right there, they could not leave the resident by themselves. They stated if the resident started turning a color, they would start CPR. They stated their role in a code was to make sure everyone was out of the way. On [DATE] at 8:49 a.m., CNA #6 stated if a resident appeared to not be breathing, they would get the nurse and call for help. They stated they guessed they could initiate CPR if needed. On [DATE] at 8:52 a.m., CNA #3 stated staff would check to see if a resident was unresponsive. They stated if they did not respond they would start CPR. They stated their role could vary from chest compressions or swapping out breathing depending on what the person running the code instructed them to do. On [DATE] at 8:55 a.m., ACMA #2 stated resident code statuses were located in the MAR. They stated if a resident was unconscious or lethargic with a slow response, not moving, or not responding when their name was called, they would notify the nurse before beginning CPR. They stated their role was to assist the nurse when needed during a code. On [DATE] at 9:01 a.m., ACMA #3 stated there was a code sheet in both the linen closet on the hall and in their MAR. They stated when a resident appeared to not be breathing, they would check for a pulse, check their oxygenation, and call for a nurse. They stated they believed the nurse decided when to initiate CPR. They stated they would assist the nurse in whatever they needed. On [DATE] at 9:05 a.m., ACMA #4 stated if a resident appeared to not be breathing, they would stay with the resident, get the nurse, look at the code book to make sure they were a full code, call 911, and complete CPR until the paramedics arrived. On [DATE] at 9:08 a.m., LPN #4 stated if a resident appeared to not be breathing, they would get their stethoscope, watch for their chest to rise and fall, if it did not, they would do a sternal rub. They stated if the resident continued to not respond, they would check their code status if they were not breathing. They stated if they were a full code, depending on the bed, they would either deflate the bed or pull the resident to the ground and start chest compressions while calling for help. On [DATE] at 9:13 a.m., RN #2 stated the DON was the person responsible for putting resident code statuses in. They stated if a resident appeared to not be breathing, they would check their airway, circulatory status, and heart rate. They stated they would call for help, call 911, and initiated CPR if they did not have a pulse. RN #2 stated they would likely be the person running the code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:10 a.m., RN #1 was re-interviewed via telephone. RN #1 stated, They came to get me, [Resident #4] wasn't responding. I went down there, [their] [family member] was sitting by the bed. [Resident #4] was already gone. RN #1 stated when one of the CNAs heard spontaneous breathing they found the code status on the electronic health record and instructed staff to initiate CPR and call 911. On [DATE] at 9:25 a.m., the DON stated, CPR should be initiated when you find a resident with the absence of vital signs and you find out they are a full code. The DON stated, Staff should assume CPR is necessary unless there is a DNR on file. I put [Resident #4's] orders in, and I know [Resident #4] was a full code. The DON stated the RN #1 told them Resident #4 had an absence of vital signs and they stated yes when they asked if we were doing a full code. The DON stated, CPR should be initiated quickly within a couple minutes at the most and should be continued until someone says they are a DNR or EMS takes over. The DON stated they did an in-service and placed the code status of every resident on the insides of the closets, on the nurses' carts, crash cart book, and the electronic health record. The DON stated staff should be able to get logged into the electronic health record within 60 seconds usually, and it should not take more than three to four minutes to find a resident's code status. On [DATE] at 10:47 a.m., the administrator was present, while the DON stated the code status list was updated for any new admissions, changes in room, or code status. The DON stated the ADON and administrator had access and would be able to update the list if the DON was not available. The DON stated they had completed CPR in-service on the weekend of [DATE], and then again with the weekly staff the following Monday. The DON stated the inaccuracies of residents being listed, or incorrect room numbers being listed, were found by surveyors were because one resident had just recently passed, one was recently discharged , and two had just had their rooms changed. The DON stated they were planning on updating the code status sheet that day. On [DATE] at 7:29 a.m., CNA #2 stated they were CPR certified, but that they had not received in-service in the past two weeks. On [DATE] at 7:44 a.m., performance improvement projects in regard to CPR initiation, were provided to state surveyors. They had been initiated on [DATE]. On [DATE] at 8:35 a.m., the administrator stated all of the staff had now been in-serviced, except one of the staff members who was in the intensive care unit, but they would in-service them when and if they returned to work. The administrator also stated that CNA #2 had been in-serviced that morning at 8:32 a.m. On [DATE] at 8:49 a.m., the updated code status sheet was provided and verified to be accurate.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure interventions to promote pressure ulcer healing were implemented for 1 (#1) of 3 sampled residents reviewed for pressure ulcers.The administrator identified three residents with pressure ulcers resided in the facility.Findings:A wound care policy, revised 10/2010, read in part, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.Make the resident comfortable. Use supportive devices as instructed.An undated turning policy, read in part, To prevent pressure injuries, promote comfort, and maintain skin integrity by ensuring residents are turned and repositioned at appropriate intervals.All residents who are immobile, at risk for pressure ulcers, or require assistance will be turned and repositioned at a minimum of every two to three hours or as individually assessed and documented in the care plan. Position changes should be documented and communicated appropriately.Wound care provider visits notes, dated 02/06/25, 02/13/25, 02/20/25, 03/04/25, 03/11/25, 03/27/25, 04/01/25, 04/15/25, 04/22/25, and 04/29/25 showed interventions for wound care treatment that included turning Resident #1 every two hours using a foam wedge.Resident #1's February 2025 ADL records showed blanks for the task of turning and repositioning every two hours 63 out of 336 opportunities.Resident #1's March 2025 ADL records showed blanks for the task of turning and repositioning every two hours 93 out of 300 opportunities.A quarterly resident assessment, dated 03/22/25, showed Resident #1 had functional limitation in range of motion for bilateral upper and lower extremities. The assessment showed they required substantial/maximal assistance to roll left and right, had one stage three pressure ulcer, had four stage four pressure ulcers, and had one unstageable deep tissue injury. All wounds were present upon admission/entry or reentry. The assessment showed skin and ulcer/injury treatments which included a turning and repositioning program. The assessment showed Resident #1 had diagnoses which included pressure ulcer of sacral region stage four, pressure ulcer of right heel stage four, pressure-induced deep tissue damage of left heel, osteomyelitis, and viral hepatitis. Resident #1's April 2025 ADL records showed blanks for the task of turning and repositioning every two hours 146 out of 339 opportunities.Resident #1's care plan, revised 05/05/25, showed interventions for wounds which included the need for staff assistance with transfers and/or repositioning due to having limitations in mobility. Resident #1 no longer resided in the facility and their wounds were unable to be observed.On 07/10/25 at 11:46 a.m., CNA #3 stated staff turned residents every two hours to prevent pressure ulcer development. They stated Resident #1 at times would not allow staff to turn them due to being uncomfortable. They stated they would ask the resident how they could make them more comfortable.On 07/10/25 at 11:49 a.m., CNA #3 stated Resident #1 had wounds that were always covered.On 07/10/25 at 1:14 p.m., LPN #3 stated Resident #1 had wounds on their back side and knee. They stated the resident was contracted and paralyzed. They stated the resident could not roll or turn themselves. They stated the resident was turned every two hours to promote wound healing.On 07/10/25 at 2:24 p.m., the DON stated Resident #1 had several wounds with slow healing progression. The administrator stated the resident admitted to the facility with several wounds. On 07/10/25 at 2:27 p.m., the administrator stated Resident #1 was contracted, not mobile, and did not want to turn. The DON stated the resident was very resistive to turning. The DON stated staff repositioned the resident with pillows as much as they would allow staff to. On 07/10/25 at 2:29 p.m., the DON stated staff attempted to turn the resident at least every two hours. On 07/10/25 at 2:32 p.m., the DON stated with the blanks in the ADL documentation, they had no way to prove Resident #1 was turned every two hours.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure:a. urinary catheter care was completed as ordered for 1 (#7); andb. orders for urinary catheter care were transcribed and completed for 1 (#1) of 3 sampled residents reviewed for urinary catheters.The administrator identified three residents with urinary catheters resided in the facility.Findings:A catheter care policy, with a handwritten date of 02/07/25, read in part, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care.Catheter care will be performed every shift and as needed by nursing personnel.1. A significant change resident assessment, dated 12/20/25, showed Resident #1 had an indwelling catheter, and diagnoses which included benign prostatic hyperplasia and viral hepatitis. A discontinued physician order, dated 01/28/25, showed staff were to provide catheter care to Resident #1 every shift related to neuromuscular dysfunction of the bladder.The February 2025 treatment administration record showed Resident #1's catheter care every shift was discontinued on 02/28/25.The March 2025 treatment administration record did not contain catheter care every shift for Resident #1.Resident #1's hospital records, dated 03/12/25, showed they admitted with a urinary tract infection associated with indwelling urethral catheter. The records showed the urinary catheter contained lots of sediment, was dark, and was changed upon admission to the hospital.Resident #1's after visit hospital summary showed the resident was hospitalized [DATE] through 03/17/25. The summary showed discharge instructions which included urinary catheter with routine care. Resident #1's orders did not show the catheter care was continued when the resident returned to the facility from the hospital.A quarterly resident assessment, dated 03/22/25, showed Resident #1 had an indwelling catheter.The April 2025 treatment administration record did not contain catheter care every shift for Resident #1.On 07/10/25 at 11:44 a.m., CNA #3 stated their only responsibility when a resident had a urinary catheter was to empty the bag and ensure nothing was leaking. They stated if it was leaking, they would notify the nurse. They stated they believed it was the nurse's responsibility to clean the catheter and provide care while a resident had an indwelling urinary catheter. They stated Resident #1 did have a urinary catheter while they were a resident at the facility.On 07/10/25 at 12:10 p.m., ACMA #1 stated they did not provide any urinary catheter care. They stated the nurse was responsible for providing care to a urinary catheter. They stated Resident #1 did have a urinary catheter while a resident.On 07/10/25 at 1:00 p.m., LPN #3 stated a urinary catheter being placed and not cleaned could contribute to a resident developing a UTI.On 07/10/25 at 1:01 p.m., LPN #3 stated every staff member was allowed to clean a urinary catheter. They stated the aides cleaned them when they gave a resident a shower or changed their brief. They stated they were allowed to clean around the catheter. On 07/10/25 at 1:02 p.m., LPN #3 stated where the information was documented was a good question. They stated there would be a spot on the MAR or TAR that would pop up on their end from time to time. They stated they believed their charting was to just monitor the output, not anything other than that. LPN #3 stated they were not a fan of urinary catheters because they believed they promoted UTIs. LPN #3 identified the last catheter care for Resident #1 was documented in February 2025. They stated when a resident returned from the hospital the DON, ADON, or administrator was responsible for ensuring the orders from the hospital were put in. On 07/10/25 at 1:10 p.m. , LPN #3 stated they believed Resident #1 had a urinary catheter in March and April 2025. They reviewed the 03/12/25 hospital records and stated the records indicated Resident #1 was treated for a UTI. On 07/10/25 at 1:38 p.m., the administrator stated Resident #1 came back from the hospital on [DATE] and was also hospitalized [DATE] and returned to the facility on [DATE]. On 07/10/25 at 2:06 p.m., the DON stated decreased fluid intake, improper incontinent care, dietary intake, and general cleanliness were factors that could contribute to a resident developing a UTI. On 07/10/25 at 2:07 p.m., the DON stated when a resident had a urinary catheter, the nurses should provide catheter care as ordered by the physician. They stated it should be listed in the physician orders. The DON stated the floor staff who provided incontinent care should also be providing general catheter care such as cleaning the meatus around the catheter to ensure bacteria and stool did not get in there. They stated CNAs, CMAs, and nurses could all clean the catheter.On 07/10/25 at 2:09 p.m., the DON stated nurses documented catheter care in the treatment records. They stated Resident #1 did have a urinary catheter. On 07/10/25 at 2:10 p.m., the DON reviewed the after visit hospital note, dated 03/12/25 through 03/17/25, and stated, Foley catheter with routine care. The DON reviewed the hospital update, dated 03/12/25, and stated Resident #1 was treated for a UTI. On 07/10/25 at 2:18 p.m., the

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	375574	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Brookline	5301 North Brookline Oklahoma City, OK 73112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interview, the facility failed to ensure orders for PEG tube care were transcribed and completed for 2 (#6 and #7) of 2 sampled residents reviewed for PEG tube care.The administrator identified five residents had PEG tubes.Findings:1.On 07/09/25 at 12:33 p.m., Resident #6's peg site was observed to have no gauze around it, There was some dark residue around the PEG site entrance into the abdomen and the clamp appeared to have red droplets on it. An undated PEG Site Cleaning Policy and Procedure, read in part, To ensure the safe and effective care of residents with PEG tubes, LTC facility staff will follow standardized procedures for routine PEG site cleaning to prevent infection, skin breakdown, and complications. Purpose: To maintain cleanliness, promote healing, and prevent infections or irritation at the PEG insertion site. Scope: This policy applies to all licensed nursing staff responsible for the care of residents with a PEG tube. Frequency: Daily, after any leakage or soiling, as per physician or wound care recommendations. Supplies needed: clean gloves, mild soap or normal saline, gauze pads.There were no physician orders to clean or care for the PEG tube for Resident #6.A quarterly resident assessment, dated 06/20/25, showed Resident #6 was blind, had a BIMS of 8 (indicating moderately impaired cognition), had a PEG tube, and was dependent upon staff for all activities of daily living. On 07/09/25 at 1:31 p.m., the DON stated the PEG tube site did not look clean, there was dark matter at the site, and there was no gauze in place to keep the plastic ring from rubbing against Resident #6's skin. The DON stated PEG tube care should be done at least daily and more often if there was drainage.2. On 07/09/25 at 1:58 p.m., Resident #7's PEG tube site was observed to have a split gauze secured with tape around it with the 7-3 (indicating the shift) and 7/7/25 (indicating date) written in black marker on it. There were no physician orders to clean or care for the PEG tube for Resident #7.A quarterly resident assessment, dated 06/12/25, showed Resident #7 had a BIMS of 10 (indicating moderately impaired cognition), had a PEG tube, diagnosis which included chronic kidney disease stage 5, and was dependent on staff for all activities of daily living.On 07/09/25 at 2:03 p.m., the DON stated the PEG site had gauze around it labeled 7-3 and 7/7/25. The DON stated there was a dark residue under the gauze at the PEG site at the entrance to the abdomen of resident #7.On 07/10/25 at 8:58 a.m., LPN #4 stated the initials mean they did complete the care on that day by cleaning the site and tube with normal saline, but there was no new gauze, so LPN #4 left on the old gauze. They confirmed the initials on the treatment record did belong to them for the day shift on 07/07/25 and 07/08/25.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure PICC/central line care was provided and the site was assessed for 1 (#1) of one sampled resident reviewed for PICC lines. The administrator identified no residents with PICC lines resided in the facility at the time of the survey.Findings:A central venous catheter care and dressing change policy, revised 03/2022, read in part, The purpose of this procedure it to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings.A physician's order is not needed for this procedure. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised.Change the dressing if it becomes damp, loosened or visibly soiled and.at least every seven days.Assess central venous access devices with each infusion and at least daily.Resident #1's discharge hospital summary, dated 10/18/24, showed a tunneled PICC line was placed on 10/17/24.A hospital after visit summary, dated 10/08/24 through 10/18/24, showed Resident #1 was to start taking Unasyn (an antibiotic) three grams via intravenous piggyback route. There was no order located in Resident #1's orders for the care of the central line that was placed on 10/17/24.Resident #1's October 2024 MAR/TAR did not document central line care was provided.Resident #1's December 2024 MAR/TAR did not document central line care was provided.An interventional radiology note, dated 12/22/24, showed the removal of a tunneled single lumen powerline catheter for Resident #1.Nurse progress notes from the time the resident was readmitted to the facility on [DATE] until the central line was discontinued on 12/22/24 did not document the site was assessed daily, or the dressing to the insertion site was changed. On 07/10/25 at 12:06 p.m., ACMA #1 stated it was completely the nurse's responsibility to care for a resident with a PICC/central line. On 07/10/25 at 12:48 p.m., LPN #3 stated nurses took care of any medications or dressing changes with a PICC/central line.On 07/10/25 at 12:49 p.m., LPN #3 stated they would change the dressing every two weeks, unless it was leaking, soiled, or peeling around the edges. They stated where it was documented was a good question. They stated nowadays, they knew how to put it in a progress note. They stated during this time they were not familiar with the facility's charting system. LPN #3 stated they did not know if they were documenting it anywhere at the time. They stated unless someone put in a specific order to change the dressing, it would not populate an area to chart the dressing change was completed. On 07/10/25 at 12:52 p.m., LPN #3 stated they started in November 2024. They reviewed the November 2024 MAR/TAR and stated the only documentation related to Resident #1's PICC line was the heparin flush through 12/17/24. On 07/10/25 at 12:57 p.m., LPN #3 stated they did not see anything about a dressing change for November or December 2024.On 07/10/25 at 1:48 p.m., the DON stated the care for a PICC or central line was essentially the same. They stated staff would change the dressing once a week or as needed if it became loosened or soiled. They stated the line was flushed before and after medication administration with normal saline. They stated if the line did not receive a flush with medications, then staff would flush it once per shift. The DON stated the dressing changes should be on the nurse's treatment sheet.On 07/10/25 at 1:50 p.m., the administrator stated the PICC line was placed on 10/17/24 at the hospital. On 07/10/25 at 2:03 p.m., the DON stated there was a heparin flush order started on 10/17/24 through 12/17/24. They stated that was all they were seeing on the treatment record. The administrator stated they did not find anything charted in the notes. Neither the DON or the administrator were able to locate assessments of the central line site or dressing changes while the central line was in place. On 07/10/25 at 2:05 p.m., the DON stated the site should be assessed every shift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to ensure a resident received their pain medication as ordered by the physician for 1 (#6) of 1 sampled residents reviewed for medications provided accurately. The administrator identified 47 residents resided in the facility. Findings:An Administering Medications policy, revised April 2019, read in part, Medications are administered in a safe and timely manner, and as prescribed.Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions.Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: enhancing optimal therapeutic effect of the medication.A Controlled Drug Receipt, dated 06/04/25, showed the facility received 56 tabs of oxycodone (an opioid) 10 mg tablets for Resident #6. The receipt also showed the last tablet was administered to Resident #6 on 07/01/25 at 9:30 p.m.A Controlled Drug Receipt, dated 07/04/25, showed oxycodone was not available in the facility for Resident #6 again until 07/04/25. The next dose administered was on 07/05/25 at 6:00 a.m.On 07/07/25 at 1:33 p.m., Resident #6 stated they put them on tramadol (an opioid) when they ran out of oxycodone, but the tramadol was like eating a tic tac. Resident #6 stated when the oxycodone ran out, they have had to wait three to four days before the medication was available for them again.On 07/10/25 at 11:56 a.m., LPN #4 stated staff were supposed to reorder medications when the number went into the blue area, indicating they had usually a few days of medication left. They stated they pushed a reorder button on the computer, but if they actually needed a physician signature, then they also had to fax to the physician, or tell the DON. LPN #4 stated they did fax it to the physician and told the DON, but was not sure when because they could not find a record of when that occurred. They stated they requested it a few days before the medication was completely out. They stated they remembered they had a hard time getting the hard script for the refill because the physician was out of the office at that time for the holiday.On 07/10/25 at 12:06 p.m., the DON stated the medications were supposed to be ordered when there was a four to five day supply left. They stated they sent an email on 07/01/25 to the physician's assistant because that was the first day they were made aware the medication needed to be refilled. The DON stated they did call the physician on 07/04/25 when they had still not received a response and the physician told them the assistant was out. and therefore, they had not received the request. The DON stated there should have been better communication between the facility and the physician. The DON stated it was not acceptable for Resident #6's narcotic to be unavailable to them.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure resident records were accurate for 3 (#1, 6, and #7) of 3 sampled residents reviewed for accurate records.The administrator identified 47 residents resided in the facility.Findings:A charting and documentation policy, revised 07/2017, read in part, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.1.Resident #1's hospital records showed the resident was hospitalized [DATE] through 03/17/25. The March 2025 MAR showed Resident #1 was administered the following medications at the facility during the dates the resident was hospitalized :a. aricept 10 mg (a medication used to treat dementia) on the 13th, 15th and 16th;b. ferrous sulfate 325 mg (a supplement for low iron) on the 15th and 16th;c. megestrol acetate suspension 5 milliliters (appetite stimulant) on the 15th and 16th;d. protonix 40 mg (used to treat reflux) on the 15th and 16th;e. prozac 20 mg (used to treat depression) on the 15th and 16th;f. vitamin B12 1000 (a supplement) micrograms on the 15th and 16th;g. zinc sulfate 220 mg (a supplement) on the 15th and 16th;h. arginaid oral packet (a supplement) on the 13th, 15th, and 16th;i. oxycontin extended release 10 mg (a pain medication) on the 13th for a pain level of four, on the 15th for a pain level of 2, and the 16th for a pain level of 2 (the narcotic count records for this medication were reviewed and did not document any dispensing of this medication on these dates);j. gabapentin 300 mg (a pain medication) on the 13th, 15th and 16th;k. lithium 150 mg (a mood stabilizer) on the 13th, 15th, and 16th;l. midodrine 5 mg (a medication to treat low blood pressure) on the 15th and 16th with blood pressures documented; andm. Ativan 1 mg (an antianxiety medication) on the 15th and 16th.On 07/10/25 at 12:02 p.m., ACMA #1 stated they would ask their nurse if they had any questions and would double check information to ensure accurate documentation. On 07/10/25 at 12:04 p.m., ACMA #1 stated they had from 7:00 p.m. to 11:00 p.m. to administer medications on their shift. They stated once they administered the medications, they would select yes on the electronic record to document it was given.On 07/10/25 at 12:06 p.m., ACMA #1 stated there was an option to document hospitalized when a resident was hospitalized . They stated they did recall Resident #1 was hospitalized at times, but could not recall what month. (This staff member was not in the facility to review the above documented administration when the resident was hospitalized , but was one of the staff members who documented medications were administered).On 07/10/25 at 12:37 p.m., LPN #3 stated there really was no way of ensuring staff documented accurately. They stated when staff administered medications, they were to initial them as administered. They stated when staff administered breathing treatments or wound care, they would click yes as they completed it. They stated ultimately at the end of the day, they hoped everyone was honest.On 07/10/25 at 12:38 p.m., LPN #3 stated when a resident was hospitalized , staff can click hospitalized as the option. On 07/10/25 at 12:40 p.m., LPN #3 stated Resident #1 was hospitalized from [DATE] to 03/17/25. LPN #3 reviewed the medications initialed as given during this time and stated, I don't know. They stated the medication aides were who gave the resident their medications. They stated they were not sure why a staff member would document medications were given when the resident was in the hospital. On 07/10/25 at 1:34 p.m., the DON stated staff should be accurately documenting at the time they complete a task.On 07/10/25 at 1:36 p.m., the DON stated staff should pull up a medication, and initial it as administered in the electronic charting system at the time it was given. They stated their initials should print for who administered the medications.On 07/10/25 at 1:37 p.m., the DON stated there was a number six option on the legend to document when a resident was hospitalized on the MAR. They stated some staff chose a nine that meant see nurse's note and documented there the resident was hospitalized . On 07/10/25 at 1:38 p.m. the administrator stated Resident #1 went to the hospital on [DATE] and returned to the facility on [DATE]. The administrator and the DON were asked to review all of the above medications initialed as administered during Resident #1's hospitalization. The DON stated they did not have an explanation for staff documenting the medications were administered or the reason vital signs were recorded when the resident was not in the building. On 07/10/25 at 1:48 p.m., the administrator and DON reviewed the narcotic count record for Resident #1's oxycontin ER 10 mg and stated there were no pills signed out during this time. They stated they believed it was a documentation error. 2. On 07/09/25 at 12:33 p.m., Resident #6's peg site was observed to have no gauze around it, There was some dark residue around the PEG site entrance into the abdomen and the clamp appeared to have red droplets on it. An undated PEG Site Cleaning Policy and Procedure, read in part, To ensure the safe and effective care of residents with PEG tubes, LTC facility staff