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Form Approved OMB
No. 0938-0391

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	09/06/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 45583 Based on record review and interview, the facility failed to ensure residents were offered the choice to formulate an advanced directive for one (#44) of 12 sampled residents whose advance directive acknowledgements were reviewed. The Executive Director identified 43 residents resided in the facility. Findings: Resident #44 had diagnoses which included malignant neoplasm of the lungs and end stage renal disease. On 09/04/24 at 9:45 a.m., the ED was asked to locate the advanced directive acknowledgment. On 09/06/24 at 1:05 p.m., the ED was asked again to locate the advanced directive acknowledgement. They stated they were unable to locate the acknowledgement. They were asked for the policy. No policy was provided by the time of exit.

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: 375574	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER The Lodge at Brookline		STREET ADDRESS, CITY, STATE, ZIP CODE 5301 North Brookline Oklahoma City, OK 73112	

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 45583 Based on observation and interview, the facility failed to ensure: a. privacy was maintained during provision of care for two (Resident #25, and an unidentified resident) of four residents whose protected health information and privacy was reviewed during a tour of the facility, and b. protected health information was secure, for two, (Resident #21 and #40). The Executive Director identified 43 residents in the facility. Findings: A HIPAA Security Measures policy, dated 07/24/2024, read in part, It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of the residents identifiable information and/or records that are in electronic format. A Promoting/Maintaining Resident Dignity policy, dated 07/24/24, read in part, Maintain resident privacy. On 09/04/24 at 8:43 a.m., observation made of a cart on hall 500 to be unlocked and the laptop open exposing resident information of resident #21. There was no nurse near the cart. LPN #4 was also observed walking to the cart with gloves on and had a glocometer in their hand. While removing their gloves they stated they had come from doing a FSBS in the lobby on a resident. They stated the policy for infection control and privacy was they probably should not have done the FSBS in the lobby, to clean after each resident. They stated the policy did not include wearing gloves in the hallway or doing a FSBS in the lobby. LPN #4 stated they should have taken the resident to their room. They stated they did not follow the policy. On 09/04/24 at 8:47 a.m., LPN #4 was observed to return to the cart. They stated the policy for securing medical information was to lock the computer screen. They then locked the screen. On 09/06/24 at 9:39 a.m., an observation was made of a laptop on top of the hall 400 treatment cart open and showing the TAR for Resident #40. There was no staff near the cart. On 09/06/24 at 9:41 a.m., LPN #3 came out of a room down the hall and stated they were aware they left the laptop open and were not aware of the exact policy. Resident #25 had diagnoses which included muscle wasting and chronic pain. On 09/06/24 at 9:43 a.m., LPN #3 was observed; in the hall of hall 400 next to the treatment cart with 2 staff members and the ED in the hall; to have a cup with cream inside. They were observed to put on gloves and apply cream to a residents legs. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/06/24 at 9:44 a.m., LPN #1 was asked how they ensure dignity and privacy with point of care treatments. They stated they could not answer that and they did not know the policy. LPN #1 acknowledged they applied the cream in the hall and stated it was their second day at the facility. Their badge stated they were a member at a sister facility. On 09/06/24 at 9:49 a.m., the ED was made aware of the findings and stated they had already started the inservice's.

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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. 49701 Based on record review and interview, the facility failed to ensure Resident Assessments were accurately coded for two (#21 and #34) of 13 residents reviewed for assessments. The Executive Director identified 43 residents resided in the facility. Findings: A Conducting an Accurate Resident Assessment policy, undated, read in part, qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical record. 1. Resident #21 had diagnoses which included gastrostomy, pressure ulcer of sacral region stage 4, stage 4 right heel, osteomyelitis, and hepatitis C. An Annual Resident Assessment, dated 08/06/24, documented that anticoagulants were taken in the last 7 days and there was an indication for their use. There were no physician orders for anticoagulant use. On 09/06/24 at 10:48 a.m., LPN #1 stated the medication administration record for August does not show that resident #21 was taking anticoagulants. LPN #1 stated the MDS was coded inaccurately. 2. Resident #34 had diagnoses which included heart disease, end stage renal disease, and COPD. A Quarterly Resident Assessment, dated 06/28/24, documented Resident #34 had received insulin injections for 7 of the past 7 days. There was no physician order for insulin. On 09/06/24 at 10:52 a.m., LPN #1 stated the medication administration record for June does not show that resident #34 received insulin. LPN #1 stated the MDS was coded inaccurately. On 09/06/24 at 10:58 a.m., the Executive Director stated the policy was for the MDS to be coded accurately.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49701 Based on record review and interview, the facility failed to ensure a baseline care plan was completed in a timely manner for one (#38) of 13 sampled residents reviewed for baseline care plans. The Administrator identified 43 residents resided in the facility. Findings: A Baseline Care Plan policy, undated, read in part, The baseline care plan will be developed within 48 hours of a residents admission. Resident # 38 admitted on [DATE] with diagnoses which included hemiplegia, malnutrition, gastrostomy, and chronic pain. There was not a baseline care plan put into place within 48 hours. The comprehensive care plan was created on 06/26/24. On 09/06/24 at 10:39 a.m., LPN #1 Stated the baseline care plan must be completed within 48 hours, they stated the baseline care plan was not completed within the 48 hours and it should have been. On 09/06/24 at 10:58 a.m., the Executive Director stated the policy was for the baseline care plan to be completed within 48 hours.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45583 Based on record review and interview, the facility failed to ensure neurological checks were conducted and monitored after an unwitnessed fall for one (Resident #29) reviewed for falls. The ED identified 43 residents resided in the facility. Findings: Resident #29 had diagnoses which included epilepsy, end stage renal disease, cirrhosis of the liver. A Nurse Note, dated, 08/27/24 at 2:47 p.m., documented, resident presented on [their] bedroom floor, upon entering resident's room resident observed resident laying on [their] right side. Noted resident's chair in front of [them]. Resident stated My chair was hurting my back and I didn't want to wait for someone to help me into bed, so I did it myself, I fell and now I can't get up. Head to toe evaluation implemented, no noted injuries, resident stated that [they] did not hit [their] head, no noted abnormalities to [their] head, no bruising, no hematomas, no skin tears, resident able to move all four extremities without any difficulty. Neurological checks initiated noted blood pressure 136/74, temperature 97.6, pulse 72, respirations 18, O2 sat 98% room air. Resident was offered medication for pain, resident refused pain medication, resident was assisted off of the floor by this Nurse and CNA and assisted into [their] bed, resident then stated I feel good now, thank you. Dr. [name withheld] was notified of fall with no injuries, noted no new orders. Director of Clinical Services notified, Administrator notified, resident's daughter noticed. No neurological checks located to review. On 09/06/24 at 12:58 p.m., the interim DON was asked where the neurological checks for the 8/27/24 fall were located. Present in the room was the Executive Director, LPN #1, and the DON. On 09/06/24 at 1:00 p.m., LPN #1 went to look for the documents. The DON stated they were done on paper because the electronic medical record form did not allow for multiple people to document on it. On 09/06/24 at 1:15 p.m., LPN #1 stated Resident #29 did not hit their head so neuro's were not initiated. They were asked why the note stated the neuro's were initiated and an un-witnessed fall. After LPN #1 reviewed the nursing note, they stated the note for 8/27/24 documented they were initiated but did not do a form. LPN #1 stated they would need to get the policy to know if the policy was followed. On 09/06/24 at 1:28 p.m., LPN #1 stated the policy did not specifically state neuro checks had to be done for an un-witnessed fall. They were asked to show where in the policy. LPN #1 read the policy and stated if there was a variance from the initial neurological assessment then not needed unless they had worsened. LPN #1 was asked how they would determine if the resident had worsened if there were no neurological assessments to monitor. LPN #1 stated they would resort back to best practice if there was not anything specific in the policy. They stated there should have been neurological assessments completed.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 45583 Based on observation and interview, the facility failed to ensure staffing information, which included the facility name, date, actual hours worked for RNs, LPNs, CMAs, and CNAs, and the resident census was updated. The ED identified 43 residents resided in the facility. Findings: On 09/04/24 at 9:08 a.m., observed the staffing sheet posted on the wall next to the nurses station window that did not have the name of the facility or the census or hours on it. On 09/06/24 at 10:54 a.m., observed the staffing sheet posted on the wall next to the nurses station window. It did not have the census, the name of the facility, nor the hours or total number of hours listed. On 09/06/24 at 11:00 a.m. the ED was asked what was required to be on the posted staffing sheet. They stated each discipline for direct care and for the shift that they were on, the date, and the census. On 09/06/24 at 11:04 a.m., the ED stated it did not have the required information.

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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. 45583 Based on record review and interview, the facility failed to ensure medication was administered according to physician orders for one (#16) of five residents reviewed for medications. The Executive Director identified 43 residents resided in the facility. Findings: Resident #16 had diagnoses which included systemic lupus erythematosus, hypertension and diabetes mellitus. A Medication Administration, policy, dated 2/2023, read in parts, Medication are administered .as ordered by the physician . The policy also read, Review MAR to identify medication to be administered .Sign MAR after administration . A physicians order dated 8/31/24 documented to start Aquaphor to body two times a day one time only for 10 days. The September TAR had no documentation for the Aquaphor administration for 9/1/24 through 9/10/24. There were x for 9/11/24 through 9/30/24. On 09/06/24 at 2:34 p.m., Resident #16's left foot was observed to be red and inflamed with dry scaling on the leg. Resident #16 stated the foot hurt all over and stated there was cream for it. On 09/06/24 at 2:09 p.m., LPN #2 stated the blanks on the TAR usually indicate they did not do it or forgot. They stated there were blanks on the TAR for the Aquaphor. They stated the x on the TAR meant the treatment had stopped. On 09/06/24 at 2:11 p.m., LPN #2 stated they could not tell if the resident received the Aquaphor. They stated there were no initials so they would say the treatment was not done. They were not aware of any foot issues for the resident. On 09/06/24 at 2:15 p.m., LPN #2 observed Resident #16's left foot and stated there was dryness and slight redness to the top that indicated there was a problem.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45583 Based on observation and interview, the facility failed to ensure medication carts were secured when not in use for three observations at random times throughout the survey on hall 400. The Executive Director identified 43 residents resided in the facility. Findings: A Medication Storage policy, dated 7/2024, read in part, All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. On 09/03/24 at 12:42 p.m., an observation of the nurse cart on hall 400 was unlocked and unattended. There were medications, insulin, needles, etc located inside. On 09/03/24 at 12:44 p.m., LPN #1 was observed exiting a resident room. They stated the cart was not locked and the policy was to lock it when step away. On 09/04/24 at 7:59 a.m., LPN #1 was observed to walk away from the medication cart on hall 400 with medication cups in both hands. The cart was unlocked. On 09/04/24 at 8:01 a.m., LPN #1 returned to the cart and stated they did it again and it was not locked. On 09/06/24 at 9:39 a.m., an observation was made of a cart on hall 400 unattended and unlocked. The cart contained medication, insulin, needles, etc. On 09/06/24 at 9:41 a.m., LPN #3 returned to the cart and stated they were aware the cart was unlocked and they did not know the exact policy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45583 Based on observation and interview, the facility failed to ensure the appropriate dishwasher temperature and sanitization concentration levels were reached on a high temperature dishwasher. The ED identified 43 residents resided in the facility. Findings: A Dishwashing Machine Use policy, dated, 5/2024, read in parts, Dishwashing machines that use hot water to sanitize must maintain the following wash solution temperatures: c. 165 F for stationary rack, single temperature machines .Dishwashing machine hot water sanitation rinse temperatures may not be more than 194 F, or less than: a. 165 F for stationary rack, single temperature machines. b. 180 F for all other machines. The policy also read, A supervisor will ensure the dishwashing machine is checked for proper concentrations of sanitizer solution (measured as parts-per-million[PPM] or ml/L) .The supervisor will check the calibration of the gauge weekly . On 09/04/24 at 10:38 a.m. during the follow up tour of the kitchen, the high temperature dishwasher was observed. Dietary Aide #1 was asked to run the dishwasher and to check the sanitizer. They were observed to have used the machine already and were to run it again. The wash temp was 162 degrees. On 09/04/24 at 10:46 a.m., the CDM stated with high temperature dishwasher not use sanitizer if the temperature reached 180 degrees. The machine was run again and read 167 degrees at the wash and 159 degrees at the rinse. There was no reaction on the sanitizer strip when tested . The CDM stated they were going to call maintenance to switch out the container but that it was not empty. On 09/04/24 at 10:49 a.m., the CDM ran the machine again. Wash temperature was 157 degrees and the rinse was 157 degrees. Ran again at wash and rinse at 156 degrees. On 09/04/24 at 10:40 a.m., maintenance had arrived and stated they did not hear the pump switch on and stated to call the company as they were not able to touch those. The CDM was to call. On 09/04/24 at 10:54 a.m., the CDM stated they called the appropriate companies to repair and will use the three compartment sink until repaired. On 09/04/24 at 12:26 p.m., observation made of the three compartment sink and appropriate temperature and sanitization.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583 49701 Based on observation, record review, and interview, the facility failed to ensure: a. enhanced barrier precautions were utilized for two of two (#2 and #21) residents observed with indwelling devices and open wounds, b. infection control practices were adhered to after providing resident care. The Executive Director identified 43 residents resided in the facility. The Resident Matrix, dated 09/03/24, documented five residents that resided in the facility had gastric tubes, three of which had urinary catheters, and two also had pressure ulcers. Findings: A Standard Precautions policy, dated 9/2017, read in part, Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments. Place used disposable syringes and needles .and other sharp items in appropriate puncture-resistant containers located as close as practicable to the area in which the items were used . An Infection Prevention and Control Program policy, dated 1/2024, read in part, Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room . An Enhanced Barrier Precautions policy, dated 08/0724, read in part, enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). The policy also read, a. all staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. b. all staff receive training on high-risk activities and common organisms that require enhanced barrier precautions. c. clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. 1. Resident #2 had diagnoses that included gastrostomy, MRSA, Kidney Transplant Status, HIV, and quadriplegia. The quarterly MDS, dated [DATE], documented resident #2 was dependent on staff for all ADL's. They had a gastric tube, indwelling catheter, and one stage 3 pressure ulcer, two stage 4 pressure ulcers, and two unstageable pressure ulcers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/03/24, upon the initial tour, it was observed that only one room had a sign indicating EBP were required. There were no PPE carts identified. On 09/04/24 at 2:15 p.m., RN #1 stated resident #2 had a gastric tube, indwelling catheter, and multiple open wounds. RN #1 Stated they were supposed to wear a gown, gloves, and a mask when administering medications or accessing indwelling devices. They stated the supplies usually stay on the carts or in the rooms. They stated there was no EBP sign on the door and no PPE available right now. 2. Resident #21 had diagnoses that included gastrostomy, pressure ulcer of sacral region stage 4, stage 4 right heel, osteomyelitis, and hepatitis C. The annual MDS, dated [DATE], documented resident #21 was dependent on staff for all ADL's. They had a gastric tube, indwelling catheter, and two stage 4 pressure ulcers. On 09/04/24 at 2:34 p.m., LPN #2 stated resident #21 is unable to get out of bed and requires a mechanical lift to transfer. They stated resident #21 has open wounds, an indwelling catheter, and a gastric tube. They stated they use universal precautions like hand washing. They stated they had not heard of enhanced barrier precautions. They stated gowns were kept on hall 300 and resident #21 was on hall 400. There was no EBP signage on the door. On 09/04/24 at 2:56 p.m., the Executive Director stated they were not surprised that some of the staff did not know what enhanced barrier protection meant because it was a newer policy. On 09/05/24 at 1:08 p.m., LPN #1 Was observed providing wound care to a resident without a gown on. On 09/05/24 at 1:23 p.m., LPN #1 Stated there was no EBP signage on the door. They stated they got a gown out but left it on the treatment cart outside the resident's door. On 09/04/24 at 8:43 a.m., LPN #4 was observed on hall 200 wearing gloves and with a glucometer in their hand, they walked past their cart to throw something in the trash outside of the kitchen, then walked back to their cart while removing the gloves. They stated they were coming from doing a finger stick blood sugar in the lobby on a resident. LPN #4 was asked what the infection control policy was. They stated they probably were not suppose to do the blood sugar in the lobby and should have taken them to their room. LPN #4 stated the concern with the gloves on in the hall was they could cross contaminate and they did not follow the policy. On 09/06/24 at 10:08 a.m., LPN #3 was observed walking from hall 400 to hall 300 with gloves on and linen in their right hand that was not in a bag. LPN #3 was asked if the linen was suppose to be in a bag. They stated they did not know the policy, then stated, Yes, it should be in a bag and not touching the floor and taken directly to the soiled utility room. They were observed to walk back to hall 400 and take the linen inside the soiled utility room.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 49701 Based on observation, record review, and interview, the facility failed to ensure emergency call cords were within reach for one dependent resident (#21) while lying in bed of 13 sampled residents reviewed for access to call light. The Executive Director identified 43 residents resided in the facility. Findings: A Call Lights: Accessibility and Timely Response policy, dated 11/28/23, read in part, Staff will ensure the call light is within reach of resident and secured, as needed. On 09/03/24 at 1:15 p.m., the call light was observed hanging between the head of the bed and the wall, out of reach of resident #21 who was lying in bed and was dependent on staff for all ADL's. They were moaning in pain and stated they just have to scream to get staff attention. On 09/03/24 at 1:25 p.m., CNA #1 stated the call button was out of the reach of the resident, they stated resident #21 just had wound care and they must have moved it. The call light is supposed to be on resident #21's chest. On 09/04/24 at 2:56 p.m., the Executive Director agreed that call lights are supposed to be within the resident's reach.