



Oklahoma State Department of Health
Creating a State of Health

July 8, 2019

License Number: AL0701

Ms. Beth Henson, Administrator
Brookdale Durant
1500 North 19th Street
Durant, OK 74701

RE: Survey Event ID: LBMW11

Dear Ms. Henson:

On **June 20, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on June 20, 2019.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;

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- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

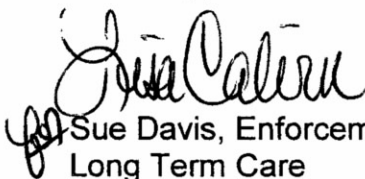
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,



Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL0701	(X2) MULTIPLE CONSTRUCTION A BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED 06/20/2019
NAME OF PROVIDER OR SUPPLIER BROOKDALE DURANT		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH 19TH STREET DURANT, OK 74701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS On 06/18/19 through 06/20/19 a re-licensure survey was conducted. Census was 26. The following deficient practice was cited.	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

If continuation sheet 2 of 5

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL0701	(X2) MULTIPLE CONSTRUCTION A BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED 06/20/2019
NAME OF PROVIDER OR SUPPLIER BROOKDALE DURANT		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH 19TH STREET DURANT, OK 74701		
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C1505	Continued From page 2 March 5, 2019, from hospice documented Colace 100 mg capsule-change to liquid 30 ml's (milliliters), PO (by mouth), 3 x (times) daily. Hospice converted the Colace 100 mg capsule to liquid related to resident #9's difficulty swallowing. Resident #9's monthly physician's orders and medication administration records (MAR's) were identical and both read to administer Colace 100 mg capsule PO TID. The monthly orders were not updated to reflect the hospice order to change the Colace to the liquid form. The pharmacy delivered the medication in a liquid form and the label located on resident #9's Colace bottle documented to administer 30 milliliters three times daily as written on the hospice order; however, the concentration of Colace was 10 mg/ml. The staff followed the directions located on the bottle of Colace which did not match with the directions printed on the MAR or the monthly physician's orders for resident #9. On the medication pass for June 18, 2019, the certified medication aide (CMA) #1 administered 30 milliliters of Colace to equal 300 mg of Colace to resident #9. Resident #9 had received 300 mg of the Colace instead of the Colace 100 mg as physician ordered. Resident #9 had received 300 mg of Colace three times a day since March 5, 2019, instead of the Colace liquid to equal 100 milligrams three times a day. The center's drug receipt ledger, for resident #9, documented Silace (Docusate Sodium) was delivered to the center in the liquid form as 10 mg/ml on 03/05/19, 04/09/19, 04/25/19, and 05/31/19.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0701	(X2) MULTIPLE CONSTRUCTION A BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED 06/20/2019
NAME OF PROVIDER OR SUPPLIER BROOKDALE DURANT		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH 19TH STREET DURANT, OK 74701		
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C1505	Continued From page 3 On 06/19/19 at 1:15 p.m., resident #9 was asked if she had diarrhea. She stated no. She was asked if her stomach hurt. She stated no. The center's regional RN (registered nurse) assessed resident #9's abdomen and verified with the physician the Colace dosage as 100 mg and to administer 10 milliliters three times a day. Policy The center's policy titled, 'Medication Administration' dated 08/2018, documented, "...The five rights of medication administration should be observed...Right dose..."	C1505		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to transcribe the correct physician's orders for Silace (Docusate Sodium/Colace) on the medication administration records for 1 (#9) of 8 sampled residents who required medication assistance from the staff. This resulted in the potential for more than minimal harm at a pattern. Findings: The physician's order for resident #9, dated	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL0701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2019
NAME OF PROVIDER OR SUPPLIER BROOKDALE DURANT		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH 19TH STREET DURANT, OK 74701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1951	Continued From page 4 March 5, 2019, from hospice documented Colace 100 mg capsule-change to liquid 30 ml's (milliliters), PO (by mouth), 3 x (times) daily. Resident #9's monthly physician's orders and medication administration records (MAR's) did not specify to administer Colace in the liquid form. The center's drug receipt ledger, for resident #9, documented Silace (Docusate Sodium) was delivered to the center in the liquid form as 10 mg/ml on 03/05/19, 04/09/19, 04/25/19, and 05/31/19. On 06/19/19 at 1:15 p.m., the center's regional registered nurse (RN) was asked about the discrepancy for resident #9's Colace. She stated they will send the bottle with the correct dosage 10 mg/ml with instructions to give 10 ml's three times daily and pharmacy will obtain clarification from the physician. Policy The center's policy titled, 'Medication Administration' dated 08/2018, documented, "...Obtain physician order for medications and medication administration..."	C1951		

STATE WORKLOAD REPORT

Provider/Supplier Number AL0701	Provider/Supplier Name BROOKDALE DURANT
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Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30875	06/18/2019	06/20/2019	1.00	0.00	17.00	0.00	7.75	4.00
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3.								
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14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours.....

0.00

Total SA Clerical/Data Entry Hours.....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

JUL 10 2019 *jm*



Oklahoma State Department of Health
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October 1, 2019

License Number: AL0701

Ms. Beth Henson, Administrator
Brookdale Durant
1500 North 19th Street
Durant, OK 74701

RE: Survey Event LBMW12

Dear Ms. Henson:

On **September 17, 2019**, a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 20, 2019**, have now been corrected effective **August 30, 2019**.

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/

Board of Health

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Terry R Gerard II, DO
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R Murali Krishna, MD
Ronald D Osterhout
Charles Skillings

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL0701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____		(X3) DATE SURVEY COMPLETED R 09/17/2019
NAME OF PROVIDER OR SUPPLIER BROOKDALE DURANT		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 NORTH 19TH STREET DURANT, OK 74701			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{C 000}	INITIAL COMMENTS On 09/17/19 a follow-up survey was conducted. All deficient practice was cleared. Census was 27.	{C 000}			

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE WORKLOAD REPORT

 Provider/Supplier Number
 AL0701

 Provider/Supplier Name
 BROOKDALE DURANT

Type of Survey (select all that apply)

☐ 2 ☒ D ☐ ☐ ☐

 A Complaint Investigation
 B Dumping Investigation
 C Federal Monitoring
 D Follow-up Visit
 M Other

 E Initial Certification
 F Inspection of Care
 G Validation
 H Life Safety Code

 I Recertification
 J Sanctions/Hearing
 K State License
 L CHOW

Extent of Survey (select all that apply)

☒ A ☐ ☐ ☐ ☐

 A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
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SURVEY TEAM AND WORKLOAD DATA

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Team Leader ID								
1. 30875	09/17/2019	09/17/2019	0.50	0.00	1.50	0.00	4.00	1.50
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12.								
13.								
14.								

Total SA Supervisory Review Hours....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

 OCT 02 2019 *jm*