OKLAHOMA
State Department
of Health

Delivery via email to: Bhenson@Brookdale.com

October 13, 2021

License Number: AL0701

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

Survey Event ID: KXMP11

Dear Ms. Henson:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **October 1, 2021**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Durant**
Address: **1500 North 19th Street**
City, State, Zip: **Durant ok, 74701, Bryan**
Provider #: **AL0701**
Complaint #: **OK00057819**
Investigation Date(s): **09/30/21 and 10/01/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide a safe environment free of resident to resident abuse and failed to ensure residents were assesser after resident to resident abuse and failed to report resident to resident abuse with injury to OSDH as required.	**US**

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 09/30/2021 at 12:45 p.m.

A sample of five residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to resident to resident abuse allegation and reporting was conducted.

Upon entry and throughout the investigation no evidence of resident to resident abuse was observed.

Residents were observed during three meals and upon observation there was no evidence of resident to resident abuse. Residents were observed, throughout the day, in the day area, visiting in hall ways, and residents in their rooms were observed.

Resident and family interviews were conducted and questions were asked, no complaints of abuse or care were reported.

Staff were interviewed and questions specific to abuse were asked. Staff reported no concerns of resident to resident abuse.

Record review revealed no grievances had been reported. Incident reports were reviewed for abuse and the last reported incident of abuse was dated 01/24/2021. Progress notes, physicians' orders, care plans, and behavior notes were reviewed for abuse.

Determination Summary and Follow-Up Action:

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Glenda Kibart RN

Glenda Kibart, RN

Date report completed: 10/04/2021

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0701	A. BUILDING: _____ B. WING _____	C 10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE DURANT	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 09/30/21 through 10/01/21 an abbreviated survey was conducted to investigate complaint # OK00057819. Census was 37. No deficient practice was cited.	C 000		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE