OKLAHOMA
State Department
of Health

August 25, 2020

License Number: AL1401

Ms. Florence (Naomi) Abbey, Administrator
Brookdale Norman
1701 East Alameda
Norman, OK 73071

RE: Survey Event ID: M9NF11

Dear Ms. Abbey:

On **March 10, 2020**, agents from our office concluded a State Licensure survey along with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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;
(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.

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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

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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,

Users, Lisa D Calvin

Digitally signed by Users, Lisa D Calvin
Date: 2020.08.25 09:33:25 -05'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Norman**
Address: **1701 East Alameda**
City, State, Zip: **Norman, OK 73071**
Provider #: **AL1401**
Complaint #: **OK00055113**
Investigation Date(s): **03/04/2020, 03/05/2020 and 03/10/2020**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medication was properly administered.	S

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

An unannounced on-site investigation was initiated on 03/04/2020 at 9:15 a.m.

A sample of 8 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 and C1951 for details.

An investigation specific to medication administration was conducted.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 03/12/2020

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
	AL1401	A. BUILDING: _____ B. WING _____	C 03/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NORMAN	1701 EAST ALAMEDA NORMAN, OK 73071

(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 A re-licensure survey was conducted 03/04/2020, 03/05/2020 and 03/10/2020, in conjunction with complaint #OK 00055113. Resident census was 30. The following deficient practices were cited.	C 000		
C1505 SS=H	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		

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C1505	Continued From page 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the center failed to administer Lasix (a diuretic) medication as ordered by the physician for 1 (#3) of 1 resident who depended on the center's staff to administer their medication. This failed practice resulted in actual harm at a pattern. Findings:

On 02/17/2020 at 11:26 a.m., licensed practical nurse (LPN) #1 noted the resident had blood labwork results that noted Potassium was at a critical (life threatening) low lab value of 2.7 (reference 3.4-5.1). Hypokalemia (low potassium level) is a known side affect of the administration of diuretics. Lasix is a diuretic.

On 02/19/2020 a medication error was discovered by licensed practical nurse (LPN) #2, two days after the critical blood labwork value. Resident #3 had been administered an excessive dose of Lasix for 12 days.

Resident #3 moved from a nursing home to the assisted living center 10/28/19. The resident required and had a completed Plan of Accommodation upon admission. The resident had multiple comorbidities including unstable diabetes mellitus type II (insulin dependent) and other diagnoses to include heart failure, chronic kidney disease, edema, anemia, hypertension, neuropathy, general weakness, nausea and lack of coordination.

The care plan dated 11/26/19 documented medication interventions as follows: order medications and coordinate medications, provide

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C1505	Continued From page 2 assistance with administration of medications with outcomes/goals as the resident will receive medications as prescribed. The February 2020 electronic medication administration record (eMAR) documented resident #3 was to receive Lasix 20 mg tablet, 4 tablets, two times a day to equal "80 mg" for edema. The resident was actually administered Lasix 20 mg, 4 tablets, two times a day to equal 160 mgs, for 12 days from February 07, 2020 to February 19, 2020. This was double the dose of the physicians order. An incident report, dated 02/19/2020, documented a medication error had been made due to a transcription error into the eMAR. The resident was given Lasix 80 mg twice a day (BID) for 12 days instead of Lasix 40 mg BID. A medication error, dated 02/19/2020, documented the resident received the wrong dose of Lasix for 12 days. On 02/19/20, the resident's daughter took the resident to the ER where she was subsequently admitted for hypokalemia (low potassium). The center indicated the medication dose had been entered in to the electronic record incorrectly. On 02/20/2020 at 10:41 a.m. a physician note documented the chief complaint was nausea and cramping. The patient was described as lethargic. The patient had been administered 160 mg of Lasix (daily) instead of Lasix 80 mg (daily). Upon arrival to the emergency room, sodium was 125 (reference 136-144) , potassium 3.1 (reference 3.4-5.1), chloride 81 (reference 100-109), carbon dioxide 33 (reference 24-31), blood urea nitrogen (BUN) 64 (reference 7-20), creatinine 1.66 (reference 0.60-1.20), glucose	C1505		

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C1505	Continued From page 3 240 (reference 65-100), calcium 10.4 (reference 8.4-10.0). The patient was admitted to the hospital for intravenous (IV) fluids and aggressive potassium replacement. At 4:41 p.m. a physicians note documented the reason for the consultation was electrolyte imbalance. The resident was supposed to be getting Lasix 40 mg twice a day, but [the center] were making errors with her medication. The resident had become dehydrated and the potassium levels dropped. The resident had presented with nausea and vomiting. The residency agreement, documented the center would provide assistance with medications, staff attention while taking medications, physical assistance with taking medications and ordering and coordinating medications.	C1505		
C1951 SS=H	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 interview and record review, it was determined the center failed to transcribe physician orders correctly to the electronic medication administration record (eMAR) for 1 (#3) of 1 resident who received the wrong dose of medication. This failed practice resulted in actual harm at a pattern. Findings:	C1951		

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C1951	Continued From page 4 On 02/06/2020 licensed practical nurse (LPN) #1 transcribed a physician order of Furosemide (Lasix) 40 milligrams (mg) twice a day (BID) into the center's electronic medication administration record (eMAR) as Furosemide (Lasix) tablet 20 mg, give 4 tablets, by mouth two times a day for edema [give 4 tablets to equal 80 mg two times a day]. The resident was administered the wrong dose of 160 mg of Lasix each day for 12 days when the ordered amount was 80 mg each day. This amount of medication was double the dose of the original physician order. The eMAR, dated February 2020, documented the resident was administered the wrong dose of 80 mg of Lasix twenty-four (24) times by a certified medication aide or a medication administration technician who were delegated by the nurse in assisted living centers to administer medications. On 03/10/2020 at 2:12 p.m. LPN #1 stated she had transcribed the physician order incorrectly. Policy The centers policy, dated 08/2000, titled, 'Transcription of Orders', documented, "The nurse is responsible for the accurate transcription of all physicians/healthcare providers' orders within the documentation system." "The nurse will review the transcription for accuracy..."	C1951		

OKLAHOMA
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of Health

Delivery Via Email: Nabbey@Brookdale.com

September 8, 2020

License Number: AL1401

Ms. Florence (Naomi) Abbey, Administrator
Brookdale Norman
1701 East Alameda
Norman, OK 73071

RE: Survey Event M9NF11

Dear Ms. Abbey:

On **March 10, 2020**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 10, 2020**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State Department of Health, ou=Long Term Care, email=katies@health.ok.gov, c=US
Date: 2020.09.08 11:43:25 -05'00'

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/31/2020** **Facility Name:** Brookdale Norman **License Number:** AL1401 **Survey Event ID:** M9NF11 **Date Survey Completed: 3/10/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Based on interview and record review, it wasdetermined the center failed to administer Lasix(a diuretic) medication as ordered by thephysician for 1 (#3) of 1 resident who dependedon the center's staff to administer theirmedication. This failed practice resulted in actualharm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Norman regarding the Statement of Deficiencies dated 03/10/2020. This POC is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery or quality health care services and will continue to make changes and improvement to satisfy that objective.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	On February 19, 2020 the Health and Wellness Director, HWD, was inputting a new Lasix order and discovered the error. HWD contacted family and physician, family requested resident be taken to the hospital, resident did not return to Brookdale Norman after hospitalization. HWD sent a state reportable in on the incident.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	HWC and HWD have been re-trained on existing policy regarding Transcription of Orders in the eMAR on February 24, 2020 following self report of the incident. HWC was assigned additional PCC training. HWD or RN Case Manager will complete random monthly MAR audits to review for accuracy.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The HWD/or Designee will conduct random monthly audits for compliance. RN Case Manager will do random audits monthly. Random monthly audits will be conducted for three months. Monitoring results will be discussed during QA meetings. Monitoring will be documented and signed by ED/or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/10/2020

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature CC OAC 310:663-25-4(F)		**Date** Enter a date of signature.	9/4/2020
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/31/2020** **Facility Name:** Brookdale Norman **License Number:** AL1401 **Survey Event ID:** M9NF11 **Date Survey Completed: 3/10/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1951	Based on: Based on interview and record review, it wasdetermined the center failed to transcribephysician orders correctly to the electronicmedication administration record (eMAR) for 1(#3) of 1 resident who received the wrong dose ofmedication. This failed practice resulted in actualharm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Norman regarding the Statement of Deficiencies dated 03/10/2020. This POC is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery or quality health care services and will continue to make changes and improvement to satisfy that objective.

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2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
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5. On what date will corrective action be completed?	6/10/2020

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.		**Date** Enter a date of signature. 9/4/20	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
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BROOKDALE NORMAN	1701 EAST ALAMEDA NORMAN, OK 73071

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C1505	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to administer Lasix (a diuretic) medication as ordered by the physician for 1 (#3) of 1 resident who depended on the center's staff to administer their medication. This failed practice resulted in actual harm at a pattern. Findings: On 02/17/2020 at 11:26 a.m., licensed practical nurse (LPN) #1 noted the resident had blood labwork results that noted Potassium was at a critical (life threatening) low lab value of 2.7 (reference 3.4-5.1). Hypokalemia (low potassium level) is a known side affect of the administration of diuretics. Lasix is a diuretic. On 02/19/2020 a medication error was discovered by licensed practical nurse (LPN) #2, two days after the critical blood labwork value. Resident #3 had been administered an excessive dose of Lasix for 12 days. Resident #3 moved from a nursing home to the assisted living center 10/28/19. The resident required and had a completed Plan of Accommodation upon admission. The resident had multiple comorbidities including unstable diabetes mellitus type II (insulin dependent) and other diagnoses to include heart failure, chronic kidney disease, edema, anemia, hypertension, neuropathy, general weakness, nausea and lack of coordination. The care plan dated 11/26/19 documented medication interventions as follows: order medications and coordinate medications, provide	C1505		

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	AL1401	A. BUILDING: _____ B. WING _____	03/10/2020

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C1505	Continued From page 2	C1505		

assistance with administration of medications with outcomes/goals as the resident will receive medications as prescribed.

The February 2020 electronic medication administration record (eMAR) documented resident #3 was to receive Lasix 20 mg tablet, 4 tablets, two times a day to equal "80 mg" for edema. The resident was actually administered Lasix 20 mg, 4 tablets, two times a day to equal 160 mgs, for 12 days from February 07, 2020 to February 19, 2020. This was double the dose of the physicians order.

An incident report, dated 02/19/2020, documented a medication error had been made due to a transcription error into the eMAR. The resident was given Lasix 80 mg twice a day (BID) for 12 days instead of Lasix 40 mg BID.

A medication error, dated 02/19/2020, documented the resident received the wrong dose of Lasix for 12 days. On 02/19/20, the resident's daughter took the resident to the ER where she was subsequently admitted for hypokalemia (low potassium). The center indicated the medication dose had been entered in to the electronic record incorrectly.

On 02/20/2020 at 10:41 a.m. a physician note documented the chief complaint was nausea and cramping. The patient was described as lethargic. The patient had been administered 160 mg of Lasix (daily) instead of Lasix 80 mg (daily). Upon arrival to the emergency room, sodium was 125 (reference 136-144) , potassium 3.1 (reference 3.4-5.1), chloride 81 (reference 100-109), carbon dioxide 33 (reference 24-31), blood urea nitrogen (BUN) 64 (reference 7-20), creatinine 1.66 (reference 0.60-1.20), glucose

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C1505	Continued From page 3 240 (reference 65-100), calcium 10.4 (reference 8.4-10.0). The patient was admitted to the hospital for intravenous (IV) fluids and aggressive potassium replacement. At 4:41 p.m. a physicians note documented the reason for the consultation was electrolyte imbalance. The resident was supposed to be getting Lasix 40 mg twice a day, but [the center] were making errors with her medication. The resident had become dehydrated and the potassium levels dropped. The resident had presented with nausea and vomiting. The residency agreement, documented the center would provide assistance with medications, staff attention while taking medications, physical assistance with taking medications and ordering and coordinating medications.	C1505		
C1951 SS=H	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 interview and record review, it was determined the center failed to transcribe physician orders correctly to the electronic medication administration record (eMAR) for 1 (#3) of 1 resident who received the wrong dose of medication. This failed practice resulted in actual harm at a pattern. Findings:	C1951		

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	AL1401	A. BUILDING: _____ B. WING _____	03/10/2020

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C1951	Continued From page 4 On 02/06/2020 licensed practical nurse (LPN) #1 transcribed a physician order of Furosemide (Lasix) 40 milligrams (mg) twice a day (BID) into the center's electronic medication administration record (eMAR) as Furosemide (Lasix) tablet 20 mg, give 4 tablets, by mouth two times a day for edema [give 4 tablets to equal 80 mg two times a day]. The resident was administered the wrong dose of 160 mg of Lasix each day for 12 days when the ordered amount was 80 mg each day. This amount of medication was double the dose of the original physician order. The eMAR, dated February 2020, documented the resident was administered the wrong dose of 80 mg of Lasix twenty-four (24) times by a certified medication aide or a medication administration technician who were delegated by the nurse in assisted living centers to administer medications. On 03/10/2020 at 2:12 p.m. LPN #1 stated she had transcribed the physician order incorrectly. Policy The centers policy, dated 08/2000, titled, 'Transcription of Orders', documented, "The nurse is responsible for the accurate transcription of all physicians/healthcare providers' orders within the documentation system." "The nurse will review the transcription for accuracy..."	C1951		

OKLAHOMA
State Department
of Health

Delivery via email to: Nabbey@Brookdale.com

January 13, 2021

License Number: AL1401

Ms. Florence (Naomi) Abbey, Administrator
Brookdale Norman
1701 East Alameda
Norman, OK 73071

Survey Event ID: M9NF12

Dear Ms. Abbey:

An offsite/paper revisit conducted **January 8, 2021**, revealed that your facility corrected deficiencies effective **June 10, 2020**

We will notify you of any enforcement actions being taken. If you have any questions, please contact me at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. 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

Sincerely,

Users, Lisa D Calvin
Digitally signed by Users, Lisa D Calvin
Date: 2021.01.13 15:49:00 -06'00'

Lisa Calvin, Enforcment Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure:

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
	AL1401	A. BUILDING: _____ B. WING _____	R-C 01/08/2021

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was completed on 01/08/2021. Credible evidence of correction was submitted for all deficiencies from 03/10/2020.	{C 000}		

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