Oklahoma State Department of Health
Creating a State of Health

December 11, 2019

License Number: AL1601

Ms. Linda Climer, Administrator
The Brentwood Senior Living
6920 West Lee
Lawton, OK 73505

RE: Survey Event ID: C3IE11

Dear Ms. Climer:

On **November 13, 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 November 13, 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;

(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,

Lisa Calvin

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1601	A BUILDING _____ B WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRENTWOOD SENIOR LIVING	6920 WEST LEE LAWTON, OK 73505

(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 relicensure survey was completed on 11/12/19 to 11/13/19. Census was 50. Deficient pratice was cited as follows.	C 000		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the registered nurse failed to complete a significant change assessment for 1 (#6) of 1 sampled resident that had experienced a significant change in condition. This deficient practice had the isolated potential for more than minimal harm. Findings: Resident #6 was admitted to the center on 10/20/07, diagnoses include (congestive heart failure) CHF, (chronic kidney disease stage 3) CKD, osteoarthritis of left knee, gastroesophageal reflux disease, and rhinitis. Resident #6's annual assessment and care plan dated 12/20/18 documented the resident was independent with bathing, dressing, transferring, toileting and used a walker or scooter to ambulate long distances. On 10/03/19 resident #6 had a fall that resulted in	C 522		

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C 522	Continued From page 1 a fracture to her left wrist. A monthly wellness visit completed by the center's (director of nurses) DON on 10/10/19 documented a change/decline in resident #6's condition compared to the monthly wellness visit completed on 09/15/19. Resident #6 had a decline with her independence in personal care and grooming and required family and staff to assist with activities of daily living. Resident #6 had a change in her eating pattern," not eating well", and now needed assistance to evacuate the center. On 11/01/19 the DON completed a functional level of care evaluation (centers evaluation for level of care monthly cost) for resident #6. The DON was asked if resident #6 should have had a significant change completed at this time? She stated yes. The DON stated resident #6's family had requested more help for resident #6. The DON was asked if she thought the fractured wrist was self limiting and expected resident #6 to improve she replied no, she did not expect the resident to improve in her level of function. On 11/13/19 at 10:05 a.m., resident #6's daughter stated resident #6 was lying down in bed because she was not feeling well. Her daughter was interviewed at this time. Resident #6's daughter stated her mother had a decline in her health in the last two weeks and now had to have assistance with dressing and bathing. Resident #6's daughter stated her mom was wearing her oxygen more now due to her " breathing situation had worsened".	C 522		
C 911 SS=F	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary	C 911		

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C 911	Continued From page 2 to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review it was determined the registered nurse failed to ensure blood pressure readings were reported to the physician for 1 (#7) of 1 sampled resident with blood pressure parameters. This deficient practice had the potential for more than minimal harm at a pattern. Findings: Resident #7 was admitted to the center on 07/31/19 with diagnoses: chronic left diastolic heart failure, history of cerebral infarction (stroke), hyperlipidemia (high cholesterol), anxiety, dysphagia (difficulty swallowing), coronary artery disease (heart disease), and chronic kidney disease. November 2019 physicians orders documented the center was to obtain (blood pressure) B/P readings twice daily. Resident #6 was admitted to home health on 09/30/19 for skilled services due to continued weakness from (cerebral vascular accident) CVA (stroke), recent falls, weakness, unsteady gait, and (congestive heart failure) CHF. The skilled nurse was to notify physician of vital signs out of range. (Blood pressure) B/P parameters were listed as follows: B/P greater than 160/90 or less than 90/50.	C 911		

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C 911	Continued From page 3 On 11/13/19 at 2:00 p.m., the (director of nurses) DON was asked if she was aware of resident #7's blood pressure readings documented by the home health nurse on an outside agency report sheet used by home health. On 10/09/19, the B/P reading was 180/95 and on 10/30/19 the B/P reading was 172/90. She stated no, she was not aware and the report sheet did not document the physician was notified by the home health agency. At 4:45 p.m., the (medication administration record) MAR documented the DON recorded a B/P reading on 10/03/19 of 170/90 and on 10/13/19 of 184/96. The DON was asked if she notified the physician of the readings outside the parameters, she stated no. The October 2019 MAR documented resident #7 had 17 readings outside the B/P parameters. The November MAR documented resident #7 had nine readings outside B/P parameters. The DON was asked if the doctor was notified of any of these readings. She stated no. At 4:55 p.m., the DON stated she was not familiar with the blood pressure parameters set by the physician that were obtained by home health.	C 911		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the	C5010		

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C5010	Continued From page 4 provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to coordinate home health services to notify the physician of abnormal blood pressure readings for 1 (#7) of 1 sampled resident with blood pressure parameters. This deficient practice had the potential for more than minimal harm at a pattern. Findings: Resident #7 was admitted to the center on	C5010		

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C5010	Continued From page 5 07/31/19 with diagnoses: chronic left diastolic heart failure, history of cerebral infarction (stroke), hyperlipidemia (high cholesterol), anxiety, dysphagia (difficulty swallowing), coronary artery disease (heart disease), and chronic kidney disease. November 2019 physicians orders dated 09/04/19 documented the center was to obtain B/P readings twice daily. Resident #7 was admitted to home health on 09/03/19 for skilled nursing services due to continued weakness from stroke, recent falls, unsteady gait and congestive heart failure. The skilled nurse was to notify the physician of B/P (blood pressure) results greater than 160/90 or less than 90/50. On 11/13/19 at 2:00 p.m., the DON (director of nurses) stated she was not aware of resident #7's B/P readings documented by the home health nurse on an outside agency report sheet used by home health. On 10/09/19, the B/P reading was 180/95 and on 10/30/19 the B/P reading was 172/90. The report sheet did not document the physician was notified of the B/P readings. At 4:45 p.m., the medication administration record (MAR) documented the DON recorded a B/P reading on 10/03/19 of 170/90 and on 10/13/19 of 184/96. The DON stated she did not notify the physician of the B/P readings outside the parameters. The October MAR also documented resident #7 had seventeen B/P readings outside the parameters and the November MAR documented the resident had nine readings outside the parameters. The DON stated the physician had not been notified of the B/P readings outside the parameters.	C5010		

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C5010	Continued From page 6 At 4:55 p.m., the DON stated she was not familiar with the blood pressure parameters set by the physician that were obtained by home health.	C5010		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL1601	THE BRENTWOOD SENIOR LIVING

Type of Survey (select all that apply)

[2][ ][ ][ ][ ]

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

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)
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	11/12/2019	11/13/2019	0.25	0.00	14.75	0.00	2.00	0.25
2. 41872	11/12/2019	11/13/2019	0.25	0.00	14.75	0.00	3.25	4.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

NVCS

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**

DEC 12 2019

Oklahoma State Department of Health
Creating a State of Health

December 27, 2019

License Number: AL1601

Ms. Linda Climer, Administrator
The Brentwood Senior Living
6920 West Lee
Lawton, OK 73505

RE: Survey Event C3IE11

Dear Ms. Climer:

On November 13, 2019, 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 **January 31, 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,

Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C000	INITIAL COMMENTS A relicensure survey was completed on 11/12/19 to 11/13/19. Census was 50. Deficient pratice was cited as follows.	C000		
C522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the registered nurse failed to complete a significant change assessment for 1 (#6) of 1 sampled resident that had experienced a significant change in condition. This deficient practice had the isolated potential for more than minimal harm. Findings: Resident #6 was admitted to the center on 10/20/07, diagnoses include (congestive heart failure) CHF, (chronic kidney disease stage 3) CKD, osteoarthritis of left knee, gastroesophageal reflux disease, and rhinitis. Resident #6's annual assessment and care plan dated 12/20/18 documented the resident was independent with bathing, dressing, transferring, toileting and used a walker or scooter to ambulate long distances. On 10/03/19 resident #6 had a fall that resulted in	C522	Refer to POC Template, Survey Event ID #C3IE11, ID Prefix tag C 522 Refer to POC Template, Survey Event ID #C3IE11, ID Prefix tag C 911 Refer to POC Template, Survey Event ID #C3IE11, ID Prefix tag C 5010	

Oklahoma State Department of Health

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C 522	Continued From page 1 a fracture to her left wrist. A monthly wellness visit completed by the center's (director of nurses) DON on 10/10/19 documented a change/decline in resident #6's condition compared to the monthly wellness visit completed on 09/15/19. Resident #6 had a decline with her independence in personal care and grooming and required family and staff to assist with activities of daily living. Resident #6 had a change in her eating pattern," not eating well", and now needed assistance to evacuate the center. On 11/01/19 the DON completed a functional level of care evaluation (centers evaluation for level of care monthly cost) for resident #6. The DON was asked if resident #6 should have had a significant change completed at this time? She stated yes. The DON stated resident #6's family had requested more help for resident #6. The DON was asked if she thought the fractured wrist was self limiting and expected resident #6 to improve she replied no, she did not expect the resident to improve in her level of function. On 11/13/19 at 10:05 a.m., resident #6's daughter stated resident #6 was lying down in bed because she was not feeling well. Her daughter was interviewed at this time. Resident #6's daughter stated her mother had a decline in her health in the last two weeks and now had to have assistance with dressing and bathing. Resident #6's daughter stated her mom was wearing her oxygen more now due to her " breathing situation had worsened".	C 522		
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THE BRENTWOOD SENIOR LIVING	6920 WEST LEE LAWTON, OK 73505

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C 911	Continued From page 3 On 11/13/19 at 2:00 p.m., the (director of nurses) DON was asked if she was aware of resident #7's blood pressure readings documented by the home health nurse on an outside agency report sheet used by home health. On 10/09/19, the B/P reading was 180/95 and on 10/30/19 the B/P reading was 172/90. She stated no, she was not aware and the report sheet did not document the physician was notified by the home health agency. At 4:45 p.m., the (medication administration record) MAR documented the DON recorded a B/P reading on 10/03/19 of 170/90 and on 10/13/19 of 184/96. The DON was asked if she notified the physician of the readings outside the parameters, she stated no. The October 2019 MAR documented resident #7 had 17 readings outside the B/P parameters. The November MAR documented resident #7 had nine readings outside B/P parameters. The DON was asked if the doctor was notified of any of these readings. She stated no. At 4:55 p.m., the DON stated she was not familiar with the blood pressure parameters set by the physician that were obtained by home health.	C 911		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the	C5010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1601	A. BUILDING: _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRENTWOOD SENIOR LIVING	6920 WEST LEE LAWTON, OK 73505

(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
C5010	Continued From page 4 provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to coordinate home health services to notify the physician of abnormal blood pressure readings for 1 (#7) of 1 sampled resident with blood pressure parameters. This deficient practice had the potential for more than minimal harm at a pattern. Findings: Resident #7 was admitted to the center on	C5010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1601	A. BUILDING: _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRENTWOOD SENIOR LIVING	6920 WEST LEE LAWTON, OK 73505

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C5010	Continued From page 5 07/31/19 with diagnoses: chronic left diastolic heart failure, history of cerebral infarction (stroke), hyperlipidemia (high cholesterol), anxiety, dysphagia (difficulty swallowing), coronary artery disease (heart disease), and chronic kidney disease. November 2019 physicians orders dated 09/04/19 documented the center was to obtain B/P readings twice daily. Resident #7 was admitted to home health on 09/03/19 for skilled nursing services due to continued weakness from stroke, recent falls, unsteady gait and congestive heart failure. The skilled nurse was to notify the physician of B/P (blood pressure) results greater than 160/90 or less than 90/50. On 11/13/19 at 2:00 p.m., the DON (director of nurses) stated she was not aware of resident #7's B/P readings documented by the home health nurse on an outside agency report sheet used by home health. On 10/09/19, the B/P reading was 180/95 and on 10/30/19 the B/P reading was 172/90. The report sheet did not document the physician was notified of the B/P readings. At 4:45 p.m., the medication administration record (MAR) documented the DON recorded a B/P reading on 10/03/19 of 170/90 and on 10/13/19 of 184/96. The DON stated she did not notify the physician of the B/P readings outside the parameters. The October MAR also documented resident #7 had seventeen B/P readings outside the parameters and the November MAR documented the resident had nine readings outside the parameters. The DON stated the physician had not been notified of the B/P readings outside the parameters.	C5010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1601	A. BUILDING: _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRENTWOOD SENIOR LIVING	6920 WEST LEE LAWTON, OK 73505

(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
C5010	Continued From page 6 At 4:55 p.m., the DON stated she was not familiar with the blood pressure parameters set by the physician that were obtained by home health.	C5010		

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/26/2019** **Facility Name:** The Brentwood Senior Living **License Number:** AL 1601 **Survey Event ID:** C3IE11 **Date Survey Completed: 11/13/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: interview and record review it was determined the registered nurse failed to complete a significant change assessment for 1 (#6) of 1 sampled resident that had experienced a significant change in condition.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The center will compare monthly wellness visits by the DON (LPN) and incident reports will be reviewed immediately to assure that significant changes in condition are recognized.

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?	A significant change assessment was performed on resident #6 on Nov. 13, 2019 and signed by the appropriate family member.
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 in the center have the potential to be affected by this identified concern. All residents living at the center will have their comprehensive assessment completed annualy or promptly after a significant change. Signs of significant change in condition will be monitored by center's DON (LPN), direct care staff, and Administrator.
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?	The center will monitor monthly wellness visits by the DON (LPN) to compare for significant changes. This task will be completed by the DON (LPN) and the Administrator by the 20th of each month. Incident reports will be reviewed for signs of significant change upon completion by the center's RN Consultant by the center's DON (LPN) and Administrator. The center's DON (LPN) will conduct an inservice training with all direct care staff to train as to the proper methods of identifying and reporting significant changes to a resident's condition.
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.	a) All change in condition assessments and coordinating care plans will be monitored monthly by the DON (LPN) and the Administrator. The center's comprehensive assessment calender will be updated accordingly. b) The center's comprehensive assessment calendar will be reviewed and discussed at the center's Quarterly Assurance meeting.

	c) The correction will be monitored by the presence of comprehensive assessments being completed and entered into each resident's medical chart.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	**1/31/2020**		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. Linda Climer OAC 310:663-25-4(F)		**Date 12/26/2019**	
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: 12/26/2019** **Facility Name:** The Brentwood Senior Living **License Number:** AL 1601 **Survey Event ID:** C3IE11 **Date Survey Completed: 11/13/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C911	Based on: interview and record review it was determined the registered nurse failed to ensure blood pressure readings were reported to the physician for 1 (#7) of 1 sampled resident with blood pressure parameters.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: On November 30, 2019, Resident #7 terminated residency at the center. The deficiency will be addressed as it would relate to other residents at risk of the deficient practice.

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?	Resident's home health agency provided the center with a copy of physician's orders on Nov. 14, 2019 dated Sept. 27, 2019 that included the vital sign parameters.
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 in the center have the potential to be affected by this identified concern. Upon physician's order of specific notification requests, the center's DON (LPN) will ensure the order is correctly entered into the MAR. The center's RN Consultant will review monthly to ensure MAR is correct, and that physician notification has and is taking place.
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?	Physician orders that require physician reporting will be monitored by the center's DON (LPN), ADON (LPN), and RN Consultant monthly for compliance.
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.	Enter methods to ensure corrections are sustained: a) All residents with specific physician notification orders will be identified and their care plan will include specific ways for physician notification to take place. This will include verbal notification and follow-up fax, documentation to be placed in the resident's medical chart. b) At the center's Quarterly Assurance meeting, the cited deficiency and corrective action will be monitored by the center's RN Consultant, center's DON (LPN), center's ADON (LPN), and center's Administrator. c) The correction will be monitored by the presence of notes and substantiating documents in the resident's medical chart by the center's DON (LPN) or ADON (LPN).
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		1/31/2020	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Linda Climer		**Date 12/26/2019**
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: 12/26/2019** **Facility Name:** The Brentwood Senior Living **License Number:** AL 1601 **Survey Event ID:** C3IE11 **Date Survey Completed: 11/13/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C5010	Based on: interview and record review it was determined the center failed to coordinate home health services to notify the physician of abnormal blood pressure readings for 1 (#7) of 1 sampled resident with blood pressure parameters.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: On November 30, 2019, Resident #7 terminated residency at the center. The deficiency will be addressed as it would relate to other residents at risk of the deficient practice.

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?	The home health agency for resident #7 was contacted on Nov. 14, 2019 to obtain their plan of care and documentation that they had notified the physician when blood pressures were out of stated parameters. The agency was notified that their Outside Agency Reports of visits with this resident at the center were not documented correctly.
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 in the center who have care through a home healty agency have the potential to be affected by this concern. These residents will be identified by creating and maintaining a Resident Services Roster. This roster will be maintained by the DON (LPN) and ADON (LPN), and will include: Resident's name, Agency name, and date of care plan coordination.
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?	The center's DON (LPN) will conduct care plan coordination with each home health agency that serves residents in the center upon admission to home health, monthly, and upon change of care plan by the center or agency. These meetings will be documented on the Resident Services Roster. The center's DON (LPN) and ADON (LPN) will monitor Outside Agency Reports completed by home health agency staff to ensure that correct notifications have taken place and documentation is noted correctly on the report.
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	a) All Outside Agency reports will be reviewed and monitored for correctness and completeness by center's DON (LPN) or ADON (LPN). b) At the center's Quarterly Assurance meeting, the Resident Services Roster will be reviewed to make sure services and care plans are coordinated with the center.

Oklahoma State Department of Health
Creating a State of Health

February 12, 2020

License Number: AL1601

Ms.. Linda Climer, Administrator
The Brentwood Senior Living
6920 West Lee
Lawton, OK 73505

RE: Survey Event C3IE12

Dear Ms.. Climer:

On **February 6, 2020,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 13,2019,** have now been corrected effective **January 31, 2020.**

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

Sincerely,

Katie Stagner

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

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
	AL1601	A. BUILDING: _____ B. WING _____	R 02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRENTWOOD SENIOR LIVING	6920 WEST LEE LAWTON, OK 73505

(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 02/06/2020 a follow-up survey was conducted. All deficient practice was cleared. Census was 55.	{C 000}		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL1601	THE BRENTWOOD SENIOR LIVING

Type of Survey (select all that apply)

2	D			

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

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)
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	02/06/2020	02/06/2020	1.00	0.00	1.50	0.00	1.00	1.50
2.								
3.								
4.								
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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**