

Delivery via email to: lindac@thebrentwoodseniorliving.com

June 8, 2022

License Number: AL1601

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

RE: Survey Event ID: FV7N11

Dear Ms. Climer:

On **April 28, 2022**, agents from our office concluded a State Licensure survey with complaint investigations 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 April 28, 2022.

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) 426-8200 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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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) 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 to the appropriate available staff members.

Sincerely,

Lisa Calvin

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

Enclosure

INVESTIGATIVE REPORT

Facility: The Brentwood Senior Living
Address: 6920 West Lee
City, State, Zip: Lawton, Ok, 73505
Provider #: AL1601
Complaint #: OK00056407
Investigation Date(s): 04/25/22 through 04/28/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate care and services, according to residents' contracts and care plans; and failed to ensure residents' property was not removed.	US
2. The center failed to ensure medications were administered safely, according to physicians' orders	US

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

An unannounced on-site investigation was initiated on Monday, April 25, 2022 at 9:00 a.m.

A sample of 10 residents including any identified residents, was selected for the investigations based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 the center providing adequate care and services, and residents' property was conducted.

Clinical records of the sampled residents were reviewed for care plans, assessments, physician orders, progress notes, medications and activities of daily living (ADL) care. One sampled resident's clinical record

documented they were on Hospice and no weights, breathing treatments or nutritional supplements had been ordered during that time. Incident reports and resident council minutes were reviewed there were no complaints related to inadequate care or missing items.

A tour of the center was conducted upon entrance and throughout the investigation. The center was observed to be clean and without odors. Residents were observed in their rooms and in the common areas. Staff were observed interacting with residents in a respectful and dignified manner.

Numerous residents were interviewed and reported staff have been attentive to their needs and provide care as needed. Numerous residents reported they have not had any missing property. Staff reported they had not received any reports or complaints from residents regarding inadequate care or missing items.

Allegation #2 Deficient practice was unsubstantiated related to this allegation.

An investigation specific to medications administered safely was conducted.

Clinical records of the sampled residents were reviewed for care plans, assessments, physician orders, progress notes and medications. Incident reports and resident council minutes were reviewed there were no complaints related to medications.

Staff members were observed passing medications to the residents. They were administered safely, one sampled resident who received breathing treatments had extra tubing in their room and the nebulizer (breathing equipment) was clean.

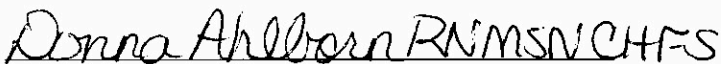
Numerous residents reported they receive their medication daily as ordered. One sampled resident reported sometimes the medications are not administered on time. Staff reported the medications have been late occasionally due to staff calling in or not showing up. Staff reported the medication is administered safely. Staff reported they are the ones responsible for keeping the breathing treatments clean.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. No further action is required.

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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

 Donna Ahlborn RN MSN CHFS

Donna Ahlborn RN MSN Clinical Health Facility Surveyor

Date report completed: 05/02/2022

INVESTIGATIVE REPORT

Facility: The Brentwood Senior Living
Address: 6920 West Lee Blvd
City, State, Zip: Lawton, OK 73505
Provider #: AL1601
Complaint #: OK00057085
Investigation Date(s): 04/25/22 through 04/28/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure resident medications were not misappropriated.	US

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

An unannounced on-site investigation was initiated on Monday, April 25, 2022 at 9:00 p.m.

A sample of 10 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 misappropriation of medications was conducted.

Clinical records of the sampled residents were reviewed for care plans, assessments, physician orders, and medications. Incident reports and resident council minutes were reviewed and documented no complaints related to medications. The last three quarterly medication pharmacy reviews documented they performed medication destruction each time.

A tour of the center was conducted upon entrance and throughout the investigation. Residents were observed to be clean and well-groomed. The facility was observed to be clean and without odors. Staff members were observed during medication administration.

Numerous residents, including sampled residents, were interviewed and reported no complaints related to receiving their medications. Staff reported a staff member had misappropriated some medications in November of 2020, which was investigated by the facility and by the local police department. The staff member was suspended during the investigation and was let go when the investigation was completed. The nurse aide registry was notified. Staff reported new precautions were put in place to help prevent this from happening.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

 Donna Ahlborn RN MSN CHFS

Donna Ahlborn RN MSN CHFS

Date report completed: 05/02/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/28/2022
NAME OF PROVIDER OR SUPPLIER THE BRENTWOOD SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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
N 000	Initial Comments A relicensure survey was conducted in conjunction with complaint investigations (#OK00056407 and #OK00057085) from 04/25/22 through 04/28/22. Listed below are abbreviations that will be used throughout this document. ACMA= Advanced Certified Medication Aide ADL's=Activities of Daily Living CMAs=Certified Medications Aides CNAs=Certified Nurse Aides CPR=Cardiopulmonary Resuscitation DNR= Do Not Resuscitate Eval=Evaluate LPN= Licensed Practical Nurse OSDH=Oklahoma State Department of Health POA=Power of Attorney R=Right Res= Resident RN=Registered Nurse X=Times	N 000		
N 960 SS=E	310:677-9-5 (b) Competency And Skills Examination - HHA The skills examination shall include at least the following: (1) Taking and recording temperature, pulse, and respiration. (2) Appropriate and safe techniques in personal hygiene and grooming. (3) Safe transfer techniques and ambulation. (4) Normal range of motion and positioning.	N 960		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/28/2022
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N1105	Continued From page 2 (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to obtain a current nurse aide certification for one (#17) of seven sampled CNA's employed at the center. This had the potential to affect seven CNA's employed at the center as identified by the administrator. Findings: On 04/26/22 at 1:47 p.m., fifteen direct care staff files were reviewed. The Administrator was asked to verify current CNA certifications. She was asked about CNA #17. She stated she had made an official request for the certificate but had not received a copy.	N1105		
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review.	N1442		

Oklahoma State Department of Health

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N1442	Continued From page 3 The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to: a) validate CMA skills prior to medication administration for three (#9, 10, and #12) of eight sampled CMAs who administered medications at the center, and; b) to review annual competencies for five (#4, 8, 11, 13, and #15) of eight sampled CMAs employed at the center for at least one year. This had the potential to affect 8 CMAs employed by the center as identified by the administrator. Findings: On 04/27/22 at 3:50 p.m., fifteen employee staff files were reviewed. The Administrator was asked to submit competency skills checklists for all direct-care staff members. She reported she did not have competency skills checklists for any of the direct-care staff members. The Administrator stated they had several different management companies and did not have a	N1442		

Oklahoma State Department of Health

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N1442	Continued From page 4 specific policy for this.	N1442		
C 000	INITIAL COMMENTS A relicensure survey was conducted in conjunction with complaint investigations (#OK00056407 and #OK00057085) from 04/25/22 through 04/28/22. Listed below are abbreviations that will be used throughout this document. ACMA= Advanced Certified Medication Aide ADL's=Activities of Daily Living CMAs=Certified Medications Aides CNAs=Certified Nurse Aides CPR=Cardiopulmonary Resuscitation DNR= Do Not Resuscitate Eval=Evaluate LPN= Licensed Practical Nurse OSDH=Oklahoma State Department of Health POA=Power of Attorney R=Right Res= Resident RN=Registered Nurse X=Times	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.	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to complete a comprehensive assessment for four (#5, 7, 8 and #10) and failed to promptly complete a significant change assessment for one (#15) of ten sampled residents reviewed for annual assessments. This had the potential to affect 63 residents residing in the facility as identified by the administrator. Findings: 1. Res #5's "Resident Assessment Form," dated 07/16/21, read in parts, "...Admission Type Preadmission...Alert x 2, confused at times, Judgment: F [Fair]..." 2. Res #7's "Resident Assessment Form," dated 09/10/21, read in parts, "... Admission Type: Preadmission...Alert x 3...diagnoses..." 3. Res #8's "Resident Assessment Form," dated 09/10/21, read in parts, "...Admission type: Preadmission...Alert x 3..." 4. Res #10's "Resident Assessment Form," dated 10/20/21, read in parts, "...Assessment Type: Preadmission...Alert x 2/confused at times, forgetful, Judgment: F..." 5. Res #15's "Resident Assessment Form," dated 02/19/22, read in parts, "...Assessment Type Preadmission...Alert x 3, confused at times, Judgment: G [Good]...List Number of Persons Required to Assist Resident with Activities of Daily	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 6 Living to Include: Bathing (0), Eating (0), Dressing (0), Transferring (0), Toileting (0), Ambulation (0)..." On 04/26/22 at 3:40 p.m., LPN #2 was asked if Res #5 had a comprehensive assessment completed. She reported the comprehensive assessment was not done. On 04/26/22 at 3:46 p.m., LPN #2 was asked if Res #7 had a comprehensive assessment. She reported the comprehensive assessment was not done. On 04/26/22 at 3:52 p.m., LPN #2 was asked if Res #8 had a comprehensive assessment. She reported the comprehensive assessment was not done. On 04/26/22 at 4:16 p.m., LPN #2 was asked if Res #15's assessment was accurate related to her assistance required for ADL's. She stated Res #15 required one person assist for all activities of daily living except for eating. She was asked if Res #15 required a significant change assessment and she reported, yes, it should have been completed.	C 522		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to coordinate the assessment with a RN	C 542		

Oklahoma State Department of Health

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C 542	Continued From page 7 and/or physician for one (#4) of ten sampled residents reviewed for comprehensive assessments. This had the potential to affect 63 residents who reside in the facility according to the administrator. Findings: Res #4's "Resident Assessment Form," dated 03/24/22, read in parts, "...Alert x 1, confused, Judgment: P [Poor]..." 04/26/22 at 4:30 p.m., LPN #1 was asked if the RN and/or physician had signed the assessment. She reported the assessment had not been signed.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to conduct a personal interview between the resident and the person completing the form for three (#2, 3, and #6) of 10 sampled residents reviewed for comprehensive assessments.	C 543		

Oklahoma State Department of Health

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C 543	Continued From page 8 This had the potential to affect 63 residents who reside in the facility according to the administrator. Findings: 1. Res #2's "Resident Assessment Form," dated 11/24/21, read in parts, "...Alert x [times] 3..." 2. Res #3's "Resident Assessment Form," dated 04/30/21, read in parts, "...Oriented x 1, self, confused, Judgment: P [Poor]..." 3. Res #6's "Resident Assessment Form," dated 09/03/21, read in parts, "...Alert x 1, confused, Judgment: P..." On 04/26/22 at 3:35 p.m., LPN #1 was asked if Res #6 signed the assessment. She stated he was unable to sign for himself and had no POA. This information was not documented in the clinical record. On 04/26/22 at 4:30 p.m., LPN #1 was asked if Res #2 and #3's assessment should have included a personal interview with the resident. She stated, "They should all be signed."	C 543		
C 921 SS=F	310.663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist.	C 921		

Oklahoma State Department of Health

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C 921	Continued From page 9 This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to obtain evidence of RN monthly medication reviews for 63 of 63 residents who reside at the center. This had the potential to affect 63 residents who reside at the facility according to the administrator. Findings: The Administrator identified 63 residents who resided at the center. On 04/28/22 at 2:46 p.m., the Administrator was asked to submit evidence of the RN monthly medication reviews. She stated she did not have this and requested to check with LPN #1. LPN #1 was asked about RN monthly medication reviews. She reported she had not seen the RN "in a bit," and she was only aware of the pharmacy consults. The center reported a new RN consultant had been hired and would be starting soon.	C 921		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.	C 954		

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/28/2022
NAME OF PROVIDER OR SUPPLIER THE BRENTWOOD SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1505	Continued From page 11 (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. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the center failed to: a) promptly obtain signed physician orders to include medications and code status for two (#14 and #15) of two recent admissions to the center, and;	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 12 b) properly store oxygen cylinders for one (#16) of three sampled residents with oxygen. This had the potential to affect 63 residents who reside in the facility according to the administrator. Findings: 1. Resident (Res) #15 was admitted to the center in February 2022, to include diagnoses of atrial fibrillation, unspecified essential hypertension, and hyperlipidemia. The resident's electronic record, face sheet, and hard chart did not contain the information of the resident's code status. The center had no signed physician orders for medications until 04/07/22. On 04/28/22 at 09:00 a.m., ACMA #4 was asked about Res #15's code status. She reviewed the electronic record and stated, "I do not see it in there." She located the hard chart and stated the area related to DNR status was blank on the demographic sheet. She was asked if the outside of the hard chart contained a sticker with the code status. She stated, "no." She was asked about the physician orders for code status. She stated there was no code status documented on the physician order form. She located a previous history and physical in the record and stated one of the pages documented Res #15 was a DNR. She was asked if the record contained a copy of the official DNR form. She reported it did not, but there should be one. She was asked what she would do if Res #15 was found unresponsive. She stated she would have to call someone or read through the entire record. On 04/28/22 at 10:15 a.m., LPN #2 was asked about Res #15's code status. She stated the	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 13 resident's code status was DNR. She stated she knew because she had spoken to the POA and asked for a copy. She was asked if the chart was marked DNR/Full Code. She stated, "no." She was asked if the physician order included the code status. She stated, "no." She was asked what staff would do if the resident was found unresponsive. She stated, "If we don't have anything signed by the POA, we would have to start CPR." LPN #2 reported the center's policy was to obtain code status documentation when the resident was admitted to the center. LPN #2 was asked about the admission orders for Res #15. She reported Res #15 was admitted in February 2022 and the first signed physician orders were dated 04/07/22. She stated the doctor was not prompt in returning items needed for signature. On 04/28/22 at 1:55 p.m., LPN #1 was asked about signed physician orders for Res #15's admission to the center in February 2022. She submitted physician orders dated 04/07/22. She was asked about the signed physician orders for changes made in medications. She stated she used the medication list updates submitted by the physician's office. She was asked if the medication list updates were signed by the physician and she reported they were not. Some of the medication list updates in the clinical record were noted by a nurse and some of the medication list updates were not noted. 2. Resident #14 was admitted to the center in February 2022 with diagnoses which included stroke with aphasia. Res #14's clinical record did not contain signed physician orders for the resident's medications or code status until 04/07/22.	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 14 On 04/27/22 at 2:20 p.m., LPN #1 reported Res #14 was admitted to the center in February 2022. The LPN reported physician orders for the resident were not signed until 04/07/22. 3. On 04/27/22 at 1:25 p.m., Res #16 was observed in her apartment. One large portable oxygen cylinder and two small portable oxygen tanks were observed free standing in the living area of the apartment. An oxygen concentrator was observed behind the resident's recliner. At 1:25 p.m., ACMA #4 reported Res #16 was on oxygen at bedtime. She stated Res #16 had parameters to use oxygen if the oxygen saturation was below a certain number. The ACMA was asked if the portable oxygen cylinders should be free standing. She stated they were supposed to be in boxes and she would check on them to ensure they were stored safely.	C1505		
C1912 SS=E	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural	C1912		

Oklahoma State Department of Health

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C1912	Continued From page 15 causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to submit two incident reports, related to falls, to the Oklahoma State Department of Health (OSDH) for two (#11 and #12) of two sampled residents transferred to the hospital for medical treatment. This had the potential to affect 63 residents who reside in the facility according to the administrator.	C1912		

Oklahoma State Department of Health

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C1912	Continued From page 16 Findings: A "Policy and Procedure for reporting incidents to the Oklahoma State Department of Health, not dated, read in parts, "...Internal incident reports will be reviewed Monday through Friday by the Director of Nursing, Assistant Director of Nursing, or Administrator. Internal reports involving a state reportable incident will be identified according to OSDH regulation 310:663-19-1(b)..." 1. Res #11's "Incident/Occurrence Report," dated 01/16/22, read in parts, "...Resident fell backing up to bed. Bleeding from back of head. Left hand bleeding...Transferred for treatment: Yes..." Res #11's "Hospital Discharge Instructions," dated 01/17/22, read in parts, "... You have been treated for a laceration of your scalp. A laceration is a cut through the skin. This will require stitches or staples, if it is deep..." 2. Res #12's "Incident/Occurrence Report," dated 05/16/21, read in parts, "...Resident was laying in floor in bathroom, sent to...complaint R hip pain..." fell backing up to ...Transferred Yes..." Res 12's "Referral," dated 06/29/21, read in parts, "...Please eval and treat right hip, she can start range of motion, strengthening with weight bearing as tolerated, 2 to 3 times a week for 6 to 8 times a week...Periprosthetic [a broken bone that occurs around the implants of a total hip replacement] fracture around internal prosthetic right hip joint, initial encounter..." On 04/27/22 at 10:28 a.m., the Administrator was asked if Res #11's incident was reported to OSDH. She reported she had no documentation	C1912		

Oklahoma State Department of Health

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C1912	Continued From page 17 on that. She was asked about Res #12's incident. She stated the resident had a fracture and it was not reported to OSDH.	C1912		
C1922 SS=E	310:663-19-2(a)(2) MEDICATION ADMINISTRATION (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour prior to administration. This Rule is not met as evidenced by: Based on record review, observation, and interview the center failed to: a) administer medications within the one hour window for one (#19) of 11 sampled residents who required medication assistance. b) observe the swallowing of medications for one (#10) of 11 sampled residents who required medication assistance. This had the potential to affect 63 residents who reside in the facility according to the administrator. Findings: A "Medication Administration" policy, not dated, read in parts, "...Medication safety is up (sic) the utmost importance...It is imperative that the following guidelines be followed: Right time...All medication administered must be followed by the proper documentation and signed by the proper staff member with date and time administered..."	C1922		

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C1922	Continued From page 18 A policy "The Brentwood Senior Living Medication Pass times", "...There is a one hour window before and after each med pass to complete the pass..." 1. On 04/26/22 at 11:30 a.m., LPN #2 prepared Res #19's scheduled medications for 9:00 a.m. She was asked which medications she had prepared. She stated the medications were for Res #19. She was asked what was the medication time for the medications she had prepared. She stated, "morning and like afternoon." She was asked if she had 9:00 a.m. medications in the cup and she stated, "yes." Res #19 was not aware of the exact medication time the medications were to be delivered. Res #19 had seven medications scheduled for 09:00 a.m., and two medications scheduled for 12:00 p.m. On 04/28/22 at 10:17 a.m., LPN #2 was asked if she administered Res #19's medications after the one hour window. She stated, "yes." She stated it was her first day on the medication cart and it was because the center called her in to help administer medications. 2. On 04/26/22 at 11:30 a.m., a cup full of medications was observed in Res #10's apartment on the table next to the recliner. On 04/27/22 at 10:28 a.m., the Administrator was asked if the medication aides were allowed to leave medications in the resident apartments. She reported they were not supposed to leave medications in the resident apartments. At 12:10 p.m., LPN #2 was asked about medications left at the bedside. She stated, "we	C1922		

Oklahoma State Department of Health

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C1922	Continued From page 19 definitely do not leave medications in the resident's room. Staff will need to be in-serviced."	C1922			
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 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.	C5010			

Oklahoma State Department of Health

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C5010	Continued From page 20 This Rule is not met as evidenced by: Based on record review, observation, and interview the center failed to coordinate services with a third-party provider related to bathing assistance for one (#15) of eight residents reviewed with home health services. This had the potential to affect 8 residents who reside in the facility who are on home health according to the administrator. Findings: The center's "shower list" documented three residents required assistance by the center's night shift staff, and one resident required assistance by the center's day shift staff for bathing. The other residents were independent and/or received home health/hospice services with bathing. On 04/27/22 at 2:00 p.m., Res #15 was unable to interview per pen and paper and Res #15's family member stated, "Res #15 had not had a shower since admission to the center." On 04/27/22 at 2:20 p.m., LPN #1 was asked who provided Res #15's bathing. She reported home health provided the resident's baths. The LPN reported she would need to check the home health book to see when the last bath was documented for Res #15. The third-party outside agency visit sheets, dated February 2022 through April 2022 for Res #15, were reviewed. LPN #1 reported none of the outside agency sheets documented information about bathing assistance for Res #15.	C5010		

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C5010	Continued From page 21 On 04/28/22 at 10:55 a.m., LPN #1 was asked about Res 15's bathing. She stated home health did not have Res #15 down for bathing and the center did not have Res #15 down for bathing either. She stated Res #15 had a bath, but it was not documented.	C5010		

Delivery via email to: lindac@thebrentwoodseniorliving.com

June 24, 2022

License Number: AL1601

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

Survey Event ID: FV7N11

Dear Ms. Climer:

On **April 28, 2022**, a Relicensure survey and a complaint investigation were conducted at your Assisted Living Center. 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 **August 6, 2022**.

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) 426-8200.

Respectfully,

Tempal Killman

Digitally signed by Tempal
Killman

Date: 2022.06.24 09:16:50 -05'00'

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 6/22/2022	
	Facility Name: The Brentwood Senior Living	
	License Number: AL-1601	
	Survey Event ID: FV7N11	
Date Survey Completed: 4/28/2022		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: N960	Based on: Record review and interview, the center failed to conduct competency skills evaluations for 15 direct care staff of 15 (#4-#6, #8-#13, #15, and #17-#21) of 15 sampled direct care staff members.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: The center will ensure that all direct care staff undergo competency skills evaluations upon hire and annually thereafter.		
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?		Competency skills examinations for all direct care staff will be complete by June 30, 2022.
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 right to receive proper and competent care. The competency skills examinations will ensure that all residents will receive this kind of care.
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?		A Competency skills examination binder will be created and the examinations will be placed in that binder. The binder will be compared monthly by the center's Human Resources Officer to the current employee list to ensure that all current employees have a current examination in the binder.
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: The effectiveness of this correction will be measured by the presence of a current examination for all direct care staff in the Competency Skills Examination binder. Competency skills examinations status will be discussed at the center's quarterly Quality Assurance meeting. There will be a checklist placed in the Competency Skills Examination binder monthly after review by the center's Human Resources Officer.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		8/6/2022
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature <i>Linda Climer</i> OAC 310:663-25-4(F)		Date 6/22/2022
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 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 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: 6/22/2022

Facility Name: The Brentwood Senior Living

License Number: AL-1601

Survey Event ID: FV7N11

Date Survey Completed: 4/28/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1105

Based on: Record review and interview, the center failed to obtain a current nurse aide certification for one (#17) of seven sampled CNA's employed at the center.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The Center shall ensure that all nurse aide certifications are current and not expired.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Linda Climer

Date 6/22/2022

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 date](#)

	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 6/22/2022		
	Facility Name: The Brentwood Senior Living		
	License Number: AL-1601		
	Survey Event ID: FV7N11		
Protective Health Services Long Term Care Service	Date Survey Completed: 4/28/2022		
	SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: N1442	Based on: record review and interview, the center failed to a.) validate CMA skills prior to medication administration for three (#9,10, and 12) of eight sampled CMAs who administered medications at the center, and; b.) to review annual competencies for five (#4,8,11,13, and 15) of eight sampled CMAs employed at the center for at least one year.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: The center will ensure that all CMAs will have skills validated and documented.			
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?		CMA skill validation will be performed immediately for all staff members lacking proper validation or documentation by the center's DON(RN), and/or ADON(LPN).	
OSDH Response: Element accepted Yes ☐ No ☐		A review of all employee files will identify employees who are lacking proper validation or documentation.	
2. How will other residents having the potential to be affected by the same deficient practice be identified?			
OSDH Response: Element accepted Yes ☐ No ☐		The center will ensure that CMA skill validation will be performed on all new hires before they administer medications and annually thereafter. A Skill Validation checklist will be included in the Employee Credential binder to monitor the dates validations are due.	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?			
OSDH Response: Element accepted Yes ☐ No ☐		Enter methods to ensure corrections are sustained: Effectiveness of this correction will be the presence in the Employee Credential binder of a skill validation for all CMAs. CMA skill validation will be an agenda item of the center's quarterly Quality Assurance meeting. The Skill Validation checklist will serve as the monitoring tool to ensure the effectiveness of this correction.	
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.			
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		8/6/2022	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Linda Climer</i> OAC 310:663-25-4(F)			Date 6/22/2022
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
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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/22/2022

Facility Name: The Brentwood Senior Living

License Number: AL-1601

Survey Event ID: FV7N11

Date Survey Completed: 4/28/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522

Based on: Record review and interview,, the center failed to complete a comprehensive assessment for four (#5, #7, #8, and #10) and failed to promptly complete a significant change assessment for one (#15) of ten sampled residents reviewed for annual assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The Center will ensure that all comprehensive assessments are completed in a timely manner as required by regulation.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Residents #5,7,8, and 10 have had comprehensive assessments completed and signed as required for compliance. Resident #15 had moved out before the receipt of this document and a significant change assessment was not done before her discharge.

All residents residing at the Center have the potential to be affected by this identified concern All residents residing at the Center will have their comprehensive assessment completed annually or promptly after a significant change. Signs of significant change in condition will be monitored by the Center's DON(RN), ADON(LPN), direct care staff, and/or Administrator.

The Center has completed an initial chart audit for the presence of completed comprehensive assessments for all residents residing at the Center. In addition, a chart audit form will be completed on all new admissions to ensure the presence of a completed comprehensive assessment. A calender of assessment due dates has been created and will be monitored monthly by the Center's DON(RN),ADON(LPN), and/or Administrator. The center will monitor monthly wellness visits by the DON(RN) or ADON(LPN) to compare for significant change. Monthly wellness visits and comparisons will be done by the 20th of each month. Incident reports will be reviewed for signs of significant change upon completion by the Center's DON(RN), ADON(LPN), and/or Administrator. The Center's DON(RN) will conduct an inservice training with all direct care staff to train as to the proper menthods of identifying and reporting significant changes to a resident's condition.

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. The correction will be consistently effective by a presence of a completed relevant comprehensive assessment in each resident chart. Resident assessment will be an agenda item at each Quality Assurance meeting to ensure that new admission, annual, and change of condition assessments have been completed. The Center's comprehensive assessment criterion will be reviewed and discussed at the Center's Quarterly Assurance meeting.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	8/6/2022		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Linda Climer</i> OAC 310:663-25-4(F)	Date 6/22/2022		
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.			



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Department of Health
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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/22/2022

Facility Name: The Brentwood Senior Living

License Number: AL-1601

Survey Event ID: FV7N11

Date Survey Completed: 4/28/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C542

Based on: Record review and interview, the center failed to coordinate the assessment with a RN and /or physician for one (#4) of ten sampled residents reviewed for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The Center will ensure that all resident assessments are coordinated with RN/ and or physician.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained?

Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Linda Climer

Date 6/22/2022

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.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident #4's assessment has been coordinated with the Center's DON/RN and or physician to ensure compliance.

All resident assessments will be reviewed by the Center's DON(RN) and or Administrator for coordination with RN/and or physician to determine if they are in compliance.

The Center's DON(RN), ADON(LPN), or Administrator will monitor all assessments (new admissions, annual, and significant change) to ensure that they are complete with all signatures required.

Enter methods to ensure corrections are sustained:

- The effectiveness of this correction will be evaluated by discussing the assessment status of residents at monthly meetings between DON, ADON, and/or Administrator.
- Resident assessment status will be an agenda item at all Quarterly Assurance meetings.
- A calendar of assessment due dates will be created and monitored monthly by the DON(RN), ADON(LPN), and/or Administrator.