OKLAHOMA
State Department
of Health

Delivery via email to: lindac@thebrentwoodseniorliving.com

June 20, 2022

License Number: AL1601

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

Survey Event ID: YL1011

Dear Ms. Climer:

On **June 13, 2022,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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. 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 will be completed for each violation; and
(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

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **The Brentwood Senior Living**
Address: **6920 West Lee**
City, State, Zip: **Lawton, OK 73505**
Provider #: **AL1601**
Complaint #: **OK00058955**
Investigation Date(s): **06/13/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to have and/or implement an effective infection control program.	**US**
2. The facility failed to have qualified personnel performing nursing care for residents.	**S**

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

An unannounced on-site investigation was initiated 06/13/2022 at 11:45 a.m.

A sample of four residents including any identified resident, was selected for the investigation 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 having and implementing an effective infection control program was conducted.

Sampled clinical records were reviewed for physician orders, assessments, and care plans. Infection control policies and procedures were reviewed. A copy of the activities schedule was reviewed which included scheduled manicure and pedicure appointments.

A tour of the facility was conducted upon entrance and throughout the investigation. Screening of visitors was conducted at the main entrance with completion of a required questionnaire, temperature check, hand hygiene, and masks were available. The facility was observed to be clean, homelike, and without odors. Residents were observed during the noon meal, while participating in activities, and in their personal rooms. Residents were encouraged to wear a mask when outside of their room. Appropriate hand hygiene by staff was observed and residents were encouraged and reminded to perform hand hygiene. A tour of the facility Beauty Salon was conducted and found to be neat, clean, and well-maintained. Appropriate cleaning/sanitizing solutions were observed to be available for use in sanitizing tools and/or equipment in the salon.

Numerous residents were interviewed and reported no complaints or concerns related to infection control issues. Several residents reported they received manicure/pedicure services in the facility beauty salon and reported no concerns related to cleanliness or infection control practices. The resident council president was interviewed and reported no infection control concerns had been discussed in the resident council meetings. A family member was interviewed and stated she was very happy with the care her loved one received. The family member voiced no complaints related to infection control in any area of the facility. Staff members were interviewed and reported no knowledge of infection control issues in the beauty salon. The activity director was interviewed and reported a process and procedure for sanitizing tools used for manicures and pedicures.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag N-0110 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

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.

Shelia Williamson RN

Shelia Williamson, RN, Clinical Health Facility Surveyor

Date report completed: 06/14/2022

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 _____	C 06/13/2022

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
N 000	Initial Comments A complaint investigation (#OK00058955) was conducted on 06/13/22.	N 000		
N 110 SS=D	310:677-1-3 (b) Applicability An employer shall not use on a full-time, temporary, per diem, or other basis persons as nurse aides for more than 120 cumulative days unless the individual has completed a training and competency examination program approved by the Department and placed on the Nurse Aide Registry. This REQUIREMENT is not met as evidenced	N 110		

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 _____	C 06/13/2022

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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N 110	Continued From page 1 by: Based on record review, observation, and interview, the center failed to ensure an activity director was not performing personal care to residents without training, a competency evaluation, and a current nurse aide certification. The Administrator reported 59 residents resided in the facility. Findings: An activity calendar, for the week of 06/13/22 through 06/17/22, documented manicures, pedicures, and "nail clip" were scheduled for residents on Tuesday, June 14th. Four residents were documented to have scheduled times for these services. On 06/13/22 at 12:30 p.m., resident #1 reported she routinely went to the facility beauty shop every week. The resident reported she received a haircut every week by the beautician and she scheduled pedicures with the AD as needed. The resident reported the AD cut her nails for her. On 06/13/22 at 2:45 p.m., a family member of resident #4 reported the AD had provided pedicures for the resident. The family member stated manicures and/or pedicures were scheduled at the facility through the AD. On 06/13/22 at 3:10 p.m., resident #2 reported she was scheduled for a manicure and pedicure the following day. The resident stated the AD provided this service and routinely clipped her fingernails and toenails. On 06/13/22 at 3:20 p.m., the Administrator reported the AD provided nail care, manicures, and pedicures during her regular working hours.	N 110		

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 _____	C 06/13/2022

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
N 110	Continued From page 2 The Administrator stated the facility did not have a policy related to services provided in the beauty shop. The Administrator stated the AD was not responsible for resident nail care, but if the resident wanted to schedule an appointment, the AD did offer manicures and pedicures. The Administrator reported the AD did not provide any nail care to residents who were diabetics. The Administrator confirmed the AD was not a certified nurse aide, had received no nurse aide training, and had not completed a competency evaluation for providing personal care to residents. On 06/13/22 at 4:10 p.m., the activities director (AD) reported she had started offering manicures and pedicures during the Pandemic when residents could not leave the facility for these services. The AD stated the residents liked the service so well, it had continued as a weekly or biweekly activity. The AD reported she used regular clippers to cut the residents' fingernails and toenails. The AD stated she was aware of residents who were diabetics and would not cut their nails. The AD confirmed she was not a certified nurse aide, had received no nurse aide training, and had not received a competency evaluation for providing personal care to residents.	N 110		

OKLAHOMA
State Department
of Health

Delivery via email to: lindac@thebrentwoodseniorliving.com

July 12, 2022

License Number: AL1601

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

Survey Event ID: YL1011

Dear Ms. Climer:

On **June 13, 2022,** a complaint investigation was 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 17, 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: 2022.07.12 14:39:35 -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: 7/1/2022** **Facility Name:** The Brentwood Senior Living **License Number:** AL-1601 **Survey Event ID:** YL1011 **Date Survey Completed: 6/13/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N110	Based on: record review, observation, and interview, the center failed to ensure an activity director was not performing personal care to residents without training, a competency evaluation, and a current nurse aide certification.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The center will ensure that all personal care performed for residents will be done by a properly trained and licensed professional.

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 center's activity director immediately stopped performing manicures and pedicures for the residents upon receipt of the complaint.
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 of the center have potential to be affected by the deficient practice.
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 document manicures and pedicures to be performed by a properly trained and licensed professional on the center's "Manicure and Pedicure Documentation Sheet".
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 monthly review of all resident's needs pertaining to nails will be conducted by the center's staff. A monthly checklist will be compiled of who is in need of nail care and a properly trained and licensed professional will perform the service with documentation provided. Nail care will be discussed at the center's quarterly Quality Assurance meeting. The monthly checklist will be the tool used to monitor the needs and services of nail care for the residents.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/17/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Linda Climer	**Date 7/1/2022**

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 Department
of Health

Delivery via email to: lindac@thebrentwoodseniorliving.com

August 29, 2022

License Number: AL1601

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

Survey Event ID: YL1012

Dear Ms. Climer:

On **August 23, 2022,** an offsite/paper complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 13, 2022,** have now been corrected effective **August 17, 2022.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 426-8200.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.08.29 16:49:05 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1601	A. BUILDING: _____ B. WING _____	R-C 08/23/2022

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
{N 000}	Initial Comments An offsite/paper visit was conducted on 08/23/22. The facility was in substantial compliance.	{N 000}		

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