OKLAHOMA
State Department
of Health

**Delivery via email to: leah@thebrentwoodseniorliving.com**

November 3, 2023

License Number: AL1601

Ms. Leah Bell, Administrator
The Brentwood Senior Living
6920 West Lee
Lawton, OK 73505

**Survey Event ID: J84O11**

Dear Ms. Bell:

On **October 18, 2023**, 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.

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.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

# INVESTIGATIVE REPORT

**Facility:** **The Brentwood Senior Living**
**Address:** **6920 West Lee**
**City, State, Zip:** **Lawton, OK 73505**
**Provider #:** **AL1601**
**Complaint #:** **OK00061563**
**Investigation Date(s):** **10/16/23, 10/17/23, and 10/18/23**

## ALLEGATION(S)

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| The center failed to ensure adequate supervision to prevent falls, failed to ensure call lights were in working order and failed to ensure every one to two hour checks for residents without working call lights. |
| The center failed to maintain a working call light system for resident safety. |

An unannounced on-site investigation was initiated 10/16/2023 at 1:00 p.m.

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

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

**A Summary of Complaint Investigation:**

A tour of the facility was conducted upon entrance and throughout the investigation. Residents were observed in their rooms, in common areas, during meals, when receiving medications, and while participating in activities. Residents were observed to demonstrate use of the call light system in their rooms. The facility call light system was observed for working lights and sound alerts. Staff members were observed for response to activated call lights. Staff were observed for routine rounds and checking on residents every two hours or as needed.

Sampled clinical records were reviewed for physician orders, assessments, care plans, progress notes, and hospital records. Incident reports were reviewed. Facility policies and procedures were reviewed. Resident council minutes were reviewed. Individual resident invoices for a supplemental call light system were reviewed. Staff in-services were reviewed for abuse/neglect and resident safety training.

Several residents, including sampled residents, were interviewed related to call lights and adequate supervision. Residents were interviewed regarding an optional pendent/bracelet alert system offered by the facility and paid for by residents. Residents were interviewed regarding the frequency of staff rounds, as well as checks during the nighttime hours. Staff members were interviewed regarding call lights and the facility policy for checking

on residents. Administrative staff were interviewed regarding the status of the optional call light alert system and maintenance of the call light system.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/19/2023

# INVESTIGATIVE REPORT

**Facility:** **The Brentwood Senior Living**
**Address:** **6920 West Lee**
**City, State, Zip:** **Lawton, OK 73505**
**Provider #:** **AL1601**
**Complaint #:** **OK00061608**
**Investigation Date(s):** **10/16/23, 10/17/23, and 10/18/23**

## ALLEGATION(S)

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| The center failed to ensure call lights were working and failed to ensure one to two hour checks were completed during the time the call lights were not working. |
| The center failed to ensure residents and families were notified when the call lights were not working. |

An unannounced on-site investigation was initiated 10/16/2023 at 1:00 p.m.

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

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

## A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and throughout the investigation. Residents were observed in their rooms, in common areas, during meals, when receiving medications, and while participating in activities. Residents were observed to demonstrate use of the call light system in their rooms. The facility call light system was observed for working lights and sound alerts. Staff members were observed for response to activated call lights. Staff were observed for routine rounds and checking on residents every two hours or as needed.

Sampled clinical records were reviewed for physician orders, assessments, care plans, progress notes, and hospital records. Incident reports were reviewed. Facility policies and procedures were reviewed. Resident council minutes were reviewed. Individual resident invoices for a supplemental call light system were reviewed. Staff in-services were reviewed for abuse/neglect and resident safety training.

Several residents, including sampled residents, were interviewed related to call lights and adequate supervision. Residents were interviewed regarding an optional pendent/bracelet alert system offered by the facility and paid for by residents. Residents were interviewed regarding the frequency of staff rounds, as well as checks during the nighttime hours. Staff members were interviewed regarding call lights and the facility policy for checking

on residents. Administrative staff were interviewed regarding the status of the optional call light alert system and maintenance of the call light system.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

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Date report completed: 10/19/2023

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| THE BRENTWOOD SENIOR LIVING | 6920 WEST LEE LAWTON, OK 73505 |

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| C 000 | INITIAL COMMENTS<br><br>Complaint investigations (#OK00061563 and #OK00061608) were conducted on 10/16/23 through 10/18/23.<br><br>The following are abbreviations which will be included in this document:<br><br>ACMA - Advanced Certified Medication Aide<br>CM - Centimeters<br>CNA - Certified Nurse Aide<br>DON - Director of Nursing<br>IJ - Immediate Jeopardy<br>LPN - Licensed Practical Nurse<br>OSDH - Oklahoma State Department of Health<br>PRN - As Needed<br>RCC - Resident Care Coordinator<br>UTI - Urinary Tract Infection | C 000 | | |
| C1511 SS=E | 310:663-15-1 & 63 OS 1-1918(B)(11) RESIDENT RIGHTS - Respect/Services<br><br>Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B<br><br>63 O.S. 1-1918.(B)(11)<br>(11) Every resident shall have the right to receive courteous and respectful care and treatment and a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and a statement of related charges, including any costs for services not covered under Medicare or Medicaid, or not covered by the facility's basic per diem rate. | C1511 | | |

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| C1511 | Continued From page 1 | C1511 | | |

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to have a written statement of services provided, related to a life alert pendant, for one (#1) of three residents reviewed for resident rights.

The Administrator reported 44 residents resided in the facility.

Findings:

On 10/16/23 at 3:30 p.m., resident #1's clinical record was reviewed. The "Residence and Care Agreement" for the resident contained no documentation related to a life alert pendant service, for which the the resident was receiving and being charged for. The agreement was signed and dated on 03/01/18 and had not been amended to reflect the added service for the life alert call system.

On 10/17/23 at 11:50 a.m., the administrator reported an addendum was never added to resident #1's contract for the life alert call system services, to include the charges related to the services. The administrator stated the resident had been charged monthly for "a long time" but could not find any documentation as to when the services were initiated.

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| C1511 | Continued From page 2<br><br>Recent facility invoices for September and October 2023 documented resident #1 was charged $15.00 a month for a pendant reimbursement fee.<br><br>On 10/18/23 at 11:35 a.m., resident #1 was interviewed regarding a fall the resident had on the night of 10/09/23. The resident reported they fell trying to get into bed and could not get back up. The resident stated they had a life alert pendant but knew it was not working and stated it had not worked for a few weeks.<br><br>On 10/18/23 at 12:15 p.m., the administrator reported a technician had been to the facility that day to check the life alert system but was uncertain when the system would be properly repaired. The administrator reported residents would be informed as soon as the pendants were back in working order and residents would be reimbursed for any downtime in service. | C1511 | | |
| C1512 SS=J | 310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect<br><br>Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B<br><br>63 O.S. 1-1918.(B)(12)<br>(12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to | C1512 | | |

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| C1512 | Continued From page 3<br>treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;<br><br>Title 43A O.S. 10-103. Definitions<br>8. "Abuse" means causing or permitting:<br>a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or<br>b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult;<br><br>10. "Neglect" means:<br>a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest,<br>b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or<br>c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; | C1512 | | |

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| C1512 | Continued From page 4<br><br>This REQUIREMENT is not met as evidenced by:<br>On 10/17/23, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to follow their policy for checking on residents every two hours to ensure residents were safe and not neglected.<br><br>On 10/09/23 at 10:00 p.m., resident #1 had an unwitnessed fall in their room and laid on the floor through the night until a staff member checked on them at approximately 7:20 a.m. on 10/10/23. Staff reported they did not routinely check on independent residents every two hours. A staff member noticed the resident did not go to the dining room for breakfast, went to the resident's room to check on them, and found the resident lying on the floor. The resident reported they had been lying on the floor since the previous night. The resident was transferred to the hospital later in the day to be evaluated. The resident was admitted to the hospital with diagnoses which included Rhabdomyolysis related to the fall and laying on the floor overnight, urinary tract infection, and acute renal insufficiency. No staff in-service was conducted regarding the facility's policy to check on all residents, every two hours, on all shifts.<br><br>On 10/17/23 at 1:29 p.m., the Oklahoma State Department of Health was notified of the existence of a possible IJ situation.<br><br>On 10/17/23 at 2:50 p.m., OSDH verified the existence of the IJ situation. | C1512 | | |

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| C1512 | Continued From page 5<br>On 10/18/23 at 9:12 a.m., an acceptable Plan of Removal was provided by the Administrator.<br><br>The Plan of Removal read as follows:<br><br>"Plan of Removal 10-17-2023<br><br>Each direct care staff including PRN staff will be in serviced on making rounds on each resident every two hours. This will be completed by 10-17-2023 at 1700. Any direct care staff that has not completed the in-service by 5pm on 10-17-2023 will be removed from schedule until DON can in-service them. Any agency staff will be in-serviced via phone and/or in person by DON or RCC prior to shift."<br><br>The in-service records documented all direct-care staff were in-serviced by 5:00 p.m. on 10/17/23.<br><br>On 10/18/23 at 11:20 a.m., interviews were conducted with facility staff regarding education and in-service training pertaining to the immediate jeopardy plan of removal. Staff reported they had been in-serviced and were able to verbalize understanding of the information and training provided.<br><br>The immediacy was lifted, effective 10/17/23 at 5:00 p.m., when all components of the plan of removal had been implemented. The deficient practice remained at actual harm with the potential for more than minimal harm.<br><br>Based on observation, interview and record review, the facility failed to follow their policy to check on all residents every two hours for two (#1 and #2) of three residents sampled for neglect.<br><br>The Administrator reported 44 residents resided | C1512 | | |

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| C1512 | Continued From page 6<br>at the facility.<br><br>Findings:<br><br>The "Basic Care Services" policy, not dated, read in part, " ...Each resident is monitored on a routine basis ...Check on residents every two hours, unless indicated otherwise on the resident's service plan ...Residents with confusion or a diagnosis of dementia should be checked on an ongoing basis ..."<br><br>1. Resident #1 had diagnoses which included non-Hodgkins lymphoma, hypertension, insomnia, depression, anemia, anxiety, and osteoarthritis.<br><br>An annual assessment for resident #1, dated 08/31/23, documented the resident was alert and oriented, and had limited range of motion. The assessment documented the resident was ambulatory without assistance and used a walker. The assessment documented the resident was incontinent at times and was independent with toileting.<br><br>A rounding sheet for resident #1, dated September 2023, documented the resident was not checked during the nightshift throughout the month.<br><br>A rounding sheet for resident #1, dated October 2023, documented the resident was not checked during the nightshift on 10/03/23, 10/04/23, and 10/09/23.<br><br>An OSDH incident report form, dated 10/10/23, documented resident #1 reported they had a fall attempting to get into bed and had an area of redness to the left cheek measuring 3.5 cm x 3.0 | C1512 | | |

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| C1512 | Continued From page 7 | C1512 | | |

cm. The report documented the resident was admitted to the hospital on 10/11/23 with a diagnosis of UTI and the resident remained in the hospital.

A care plan, dated 10/16/23, documented resident #1 was independent with most activities of daily living and required staff monitoring with bathing/showers.

On 10/16/23 at 2:45 p.m., CNA #3 reported she worked the evening shift (2:00 p.m. - 10:00 p.m.) and had looked in on resident #1, at approximately 9:45 p.m. the night of 10/09/23, and observed the resident sitting in their recliner. The CNA reported the resident was not known to be a high fall risk but would be at greater risk for falls if they had a UTI.

On 10/16/23 at 4:35 p.m., the administrator reviewed the October rounding log for resident #1 and confirmed the resident had not been checked during the nightshift of 10/09/23.

On 10/16/23 at 4:41 p.m., the DON reported she had received a text message regarding resident #1's fall and was told CNA #1 had found the resident on the floor. The DON stated the home health nurse told her the resident reported falling at approximately 10:00 p.m. on 10/09/23 and that the resident remained on the floor until the following morning. The DON reported a staff in-service, regarding checking on residents every two hours, was scheduled for 10/25/23. The DON stated to her knowledge, no staff had been in-serviced.

On 10/17/23 at 11:07 a.m., the DON reported she did not know if they had a facility policy related to checking on residents routinely. The DON stated

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| C1512 | Continued From page 8<br>the administrator had instructed staff that all residents should be checked every two hours.<br><br>On 10/17/23 at 11:11 a.m., CNA #2 reported she had worked the night resident #1 fell. The CNA reported the resident was independent and was not one of the residents they checked on routinely throughout the night. The CNA stated she did not check on resident #1 during the night of 10/09/23, when the resident fell and remained on the floor all night.<br><br>On 10/17/23 at 12:57 p.m., CNA #1 reported she was assisting residents with breakfast the morning of 10/10/23 and noticed resident #1 was not in the dining room. The CNA stated she went to check on the resident in their room and found the resident lying on the floor between the resident's bed and dresser. The CNA reported the resident was alert and stated they were okay and not hurt. The CNA reported the resident told her they fell about 10:00 p.m. the previous night and had been on the floor all night.<br><br>On 10/18/23 at 11:35 a.m., resident #1 was observed in their room and reported they had returned to the facility from the hospital the previous evening. The resident reported on 10/09/23 about 10:00 p.m., they were trying to get into bed and fell. The resident stated they were able to get back up but then fell a second time and was unable to get up again. The resident stated they were not near a call light and remained on the floor all night until a staff member checked on them the following morning about 7:20 a.m. The resident reported they had slept in their recliner since returning to the facility, was very comfortable, and stated staff had checked on them during the previous night. The resident was observed to have a call light within | C1512 | | |

| 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 10/18/2023 |

| 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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| C1512 | Continued From page 9<br>reach of their recliner.<br><br>2. Resident #2 had diagnoses which included hypertension, neuropathy, edema, and osteoporosis.<br><br>On 10/16/23 and 1:20 p.m., resident #2 reported they had a life alert pendant call system, in addition to the facility's regular call light system. The resident reported the residents paid an additional fee each month for the pendant system but the pendants had not worked in a few weeks. The resident stated they didn't find out the life alert pendants were not working until resident #1 fell in their room and laid on the floor all night before being found the following morning. The resident reported they didn't know of any staff ever checking on them during the nightshift.<br><br>Rounding logs for resident #2, for the months of September and October 2023, documented resident #2 had not been checked during the night for the month of September. The rounding log for October documented resident #2 had not been checked on during the nights of 10/03/23, 10/04/23, 10/09/23, and 10/15/23.<br><br>On 10/17/23 at 1:15 p.m., the administrator reported the facility policy was to check on all residents every two hours, and stated this should be done on all shifts. | C1512 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to:** leah@thebrentwoodseniorliving.com

November 28, 2023

License Number: AL1601

Ms. Leah Bell, Administrator
The Brentwood Senior Living
6920 West Lee
Lawton, OK 73505

**Survey Event ID: J84O11**

Dear Ms. Bell:

On **October 18, 2023,** 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 **November 30, 2023**.

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

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

Enclosure

Oklahoma State Department of Health

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| THE BRENTWOOD SENIOR LIVING | 6920 WEST LEE LAWTON, OK 73505 |

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| C 000 | INITIAL COMMENTS<br><br>Complaint investigations (#OK00061563 and #OK00061608) were conducted on 10/16/23 through 10/18/23.<br><br>The following are abbreviations which will be included in this document:<br><br>ACMA - Advanced Certified Medication Aide CM - Centimeters<br>CNA - Certified Nurse Aide<br>DON - Director of Nursing<br>IJ - Immediate Jeopardy<br>LPN - Licensed Practical Nurse<br>OSDH - Oklahoma State Department of Health PRN - As Needed<br>RCC - Resident Care Coordinator<br>UTI - Urinary Tract Infection | C 000 | | |
| C1511 SS=E | 310:663-15-1 & 63 OS 1-1918(B)(11) RESIDENT RIGHTS - Respect/Services<br><br>Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B<br><br>63 O.S. 1-1918.(B)(11)<br>(11) Every resident shall have the right to receive courteous and respectful care and treatment and a written statement of the services provided by the facility, including those required to be offered on an as-needed basis, and a statement of related charges, including any costs for services not covered under Medicare or Medicaid, or not covered by the facility's basic per diem rate. | C1511 | Each employee will be in-serviced on residents rights by 11-30-2023.<br><br>Effective 11-1-2023 A Memo will be sent out to responsible parties and/or residents regarding changes, equipment problems, billing issues ect. that take place at the Brentwood by the next business day that the issue occurred from the Executive Director, Business office or corporate team. | |

Leah Bell
11/24/2023

PRINTED: 11/03/2023
FORM APPROVED

Oklahoma State Department of Health

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| C1511 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to have a written statement of services provided, related to a life alert pendant, for one (#1) of three residents reviewed for resident rights.<br><br>The Administrator reported 44 residents resided in the facility.<br><br>Findings:<br><br>On 10/16/23 at 3:30 p.m., resident #1's clinical record was reviewed. The "Residence and Care Agreement" for the resident contained no documentation related to a life alert pendant service, for which the the resident was receiving and being charged for. The agreement was signed and dated on 03/01/18 and had not been amended to reflect the added service for the life alert call system.<br><br>On 10/17/23 at 11:50 a.m., the administrator reported an addendum was never added to resident #1's contract for the life alert call system services, to include the charges related to the services. The administrator stated the resident had been charged monthly for "a long time" but could not find any documentation as to when the services were initiated. | C1511 | Effective 11-1-2023 any changes to the contract will have an addendum added and signed by the ED,and/or BOM and resident or resident representative to explain and acknowledge changes. | |





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| C1511 | Continued From page 2<br><br>Recent facility invoices for September and October 2023 documented resident #1 was charged $15.00 a month for a pendant reimbursement fee.<br><br>On 10/18/23 at 11:35 a.m., resident #1 was interviewed regarding a fall the resident had on the night of 10/09/23. The resident reported they fell trying to get into bed and could not get back up. The resident stated they had a life alert pendant but knew it was not working and stated it had not worked for a few weeks.<br><br>On 10/18/23 at 12:15 p.m., the administrator reported a technician had been to the facility that day to check the life alert system but was uncertain when the system would be properly repaired. The administrator reported residents would be informed as soon as the pendants were back in working order and residents would be reimbursed for any downtime in service. | C1511 | Effective 11-1-2023 a $15 credit will be given to all pendant users who were charged for the month of October. They will no longer be charged a pendant fee. | |
| C1512 SS=J | 310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect<br><br>Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B<br><br>63 O.S. 1-1918.(B)(12)<br>(12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment,<br>involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to | C1512 | All direct care staff will be in serviced on every 2 hour rounding policy by 11-30-2023. DON to review rounding sheets weekly to ensure compliance | |

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| THE BRENTWOOD SENIOR LIVING | 6920 WEST LEE LAWTON, OK 73505 |

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| C1512 | Continued From page 3<br>treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;<br><br>Title 43A O.S. 10-103. Definitions<br>8. "Abuse" means causing or permitting:<br>a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or<br>b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult;<br><br>10. "Neglect" means:<br>a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest,<br>b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or<br>c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct | C1512 | | |

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| | services; | | | |



Oklahoma State Department of Health

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| C1512 | Continued From page 4<br><br>This REQUIREMENT is not met as evidenced by:<br>On 10/17/23, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to follow their policy for checking on residents every two hours to ensure residents were safe and not neglected.<br><br>On 10/09/23 at 10:00 p.m., resident #1 had an unwitnessed fall in their room and laid on the floor through the night until a staff member checked on them at approximately 7:20 a.m. on 10/10/23. Staff reported they did not routinely check on independent residents every two hours. A staff member noticed the resident did not go to the dining room for breakfast, went to the resident's room to check on them, and found the resident lying on the floor. The resident reported they had been lying on the floor since the previous night. The resident was transferred to the hospital later in the day to be evaluated. The resident was admitted to the hospital with diagnoses which included Rhabdomyolysis related to the fall and laying on the floor overnight, urinary tract infection, and acute renal insufficiency. No staff in-service was conducted regarding the facility's policy to check on all residents, every two hours, on all shifts.<br><br>On 10/17/23 at 1:29 p.m., the Oklahoma State Department of Health was notified of the<br>existence of a possible IJ situation.<br><br>On 10/17/23 at 2:50 p.m., OSDH verified the existence of the IJ situation. | C1512 | | |





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| C1512 | Continued From page 5<br><br>On 10/18/23 at 9:12 a.m., an acceptable Plan of Removal was provided by the Administrator.<br><br>The Plan of Removal read as follows:<br><br>"Plan of Removal 10-17-2023<br><br>Each direct care staff including PRN staff will be in serviced on making rounds on each resident every two hours. This will be completed by 10-17-2023 at 1700. Any direct care staff that has not completed the in-service by 5pm on<br>10-17-2023 will be removed from schedule until DON can in-service them. Any agency staff will be in-serviced via phone and/or in person by DON or RCC prior to shift."<br><br>The in-service records documented all direct-care staff were in-serviced by 5:00 p.m. on 10/17/23.<br><br>On 10/18/23 at 11:20 a.m., interviews were conducted with facility staff regarding education and in-service training pertaining to the<br>immediate jeopardy plan of removal. Staff reported they had been in-serviced and were able to verbalize understanding of the information and training provided.<br><br>The immediacy was lifted, effective 10/17/23 at 5:00 p.m., when all components of the plan of removal had been implemented. The deficient practice remained at actual harm with the<br>potential for more than minimal harm.<br><br>Based on observation, interview and record review, the facility failed to follow their policy to check on all residents every two hours for two (#1 and #2) of three residents sampled for neglect.<br><br>The Administrator reported 44 residents resided | C1512 | | |

PRINTED: 11/03/2023
FORM APPROVED

Oklahoma State Department of Health

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| C1512 | Continued From page 6<br>at the facility.<br><br>Findings:<br><br>The "Basic Care Services" policy, not dated, read in part, " ...Each resident is monitored on a routine basis ...Check on residents every two hours, unless indicated otherwise on the resident's service plan ...Residents with confusion or a diagnosis of dementia should be checked on an ongoing basis ..."<br><br>1. Resident #1 had diagnoses which included non-Hodgkins lymphoma, hypertension,<br>insomnia, depression, anemia, anxiety, and osteoarthritis.<br><br>An annual assessment for resident #1, dated 08/31/23, documented the resident was alert and oriented, and had limited range of motion. The assessment documented the resident was<br>ambulatory without assistance and used a walker. The assessment documented the resident was incontinent at times and was independent with toileting.<br><br>A rounding sheet for resident #1, dated September 2023, documented the resident was not checked during the nightshift throughout the month.<br><br>A rounding sheet for resident #1, dated October 2023, documented the resident was not checked during the nightshift on 10/03/23, 10/04/23, and 10/09/23.<br><br>An OSDH incident report form, dated | C1512 | | |

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| | 10/10/23, documented resident #1 reported they had a fall attempting to get into bed and had an area of redness to the left cheek measuring 3.5 cm x 3.0 | | | |



Oklahoma State Department of Health

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| C1512 | Continued From page 7<br><br>cm. The report documented the resident was admitted to the hospital on 10/11/23 with a diagnosis of UTI and the resident remained in the hospital.<br><br>A care plan, dated 10/16/23, documented resident #1 was independent with most activities of daily living and required staff monitoring with bathing/showers.<br><br>On 10/16/23 at 2:45 p.m., CNA #3 reported she worked the evening shift (2:00 p.m. - 10:00 p.m.) and had looked in on resident #1, at approximately 9:45 p.m. the night of 10/09/23, and observed the resident sitting in their recliner. The CNA reported the resident was not known to be a high fall risk but would be at greater risk for falls if they had a UTI.<br><br>On 10/16/23 at 4:35 p.m., the administrator reviewed the October rounding log for resident #1 and confirmed the resident had not been checked during the nightshift of 10/09/23.<br><br>On 10/16/23 at 4:41 p.m., the DON reported she had received a text message regarding resident #1's fall and was told CNA #1 had found the resident on the floor. The DON stated the home health nurse told her the resident reported falling at approximately 10:00 p.m. on 10/09/23 and that the resident remained on the floor until the following morning. The DON reported a staff in-service, regarding checking on residents every two hours, was scheduled for 10/25/23. The DON stated to her knowledge, no staff had been in-serviced.<br><br>On 10/17/23 at 11:07 a.m., the DON reported she did not know if they had a facility policy related to checking on residents routinely. The DON stated | C1512 | | |





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| C1512 | Continued From page 8<br>the administrator had instructed staff that all residents should be checked every two hours.<br><br>On 10/17/23 at 11:11 a.m., CNA #2 reported she had worked the night resident #1 fell. The CNA reported the resident was independent and was not one of the residents they checked on routinely throughout the night. The CNA stated she did not check on resident #1 during the night of 10/09/23, when the resident fell and remained on the floor all night.<br><br>On 10/17/23 at 12:57 p.m., CNA #1 reported she was assisting residents with breakfast the morning of 10/10/23 and noticed resident #1 was not in the dining room. The CNA stated she went to check on the resident in their room and found the resident lying on the floor between the resident's bed and dresser. The CNA reported the resident was alert and stated they were okay and not hurt. The CNA reported the resident told her they fell about 10:00 p.m. the previous night and had been on the floor all night.<br><br>On 10/18/23 at 11:35 a.m., resident #1 was observed in their room and reported they had returned to the facility from the hospital the previous evening. The resident reported on 10/09/23 about 10:00 p.m., they were trying to get into bed and fell. The resident stated they were able to get back up but then fell a second time and was unable to get up again. The resident stated they were not near a call light and remained on the floor all night until a staff member checked on them the following morning about 7:20 a.m. The resident reported they had slept in their recliner since returning to the facility, was very comfortable, and stated staff had checked on them during the previous night. The resident was observed to have a call light within | C1512 | | |

PRINTED: 11/03/2023
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Oklahoma State Department of Health

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| C1512 | Continued From page 9<br>reach of their recliner.<br><br>2. Resident #2 had diagnoses which included hypertension, neuropathy, edema, and osteoporosis.<br><br>On 10/16/23 and 1:20 p.m., resident #2 reported they had a life alert pendant call system, in addition to the facility's regular call light system. The resident reported the residents paid an additional fee each month for the pendant system but the pendants had not worked in a few weeks. The resident stated they didn't find out the life alert pendants were not working until resident #1 fell in their room and laid on the floor all night before being found the following morning. The resident reported they didn't know of any staff ever checking on them during the nightshift.<br><br>Rounding logs for resident #2, for the months of September and October 2023, documented resident #2 had not been checked during the night for the month of September. The rounding log for October documented resident #2 had not been checked on during the nights of 10/03/23, 10/04/23, 10/09/23, and 10/15/23.<br><br>On 10/17/23 at 1:15 p.m., the administrator reported the facility policy was to check on all residents every two hours, and stated this should be done on all shifts. | C1512 | | |

OKLAHOMA
State Department
of Health

**FINAL DETERMINATION**
***USPS Tracking #7021 2720 0002 0354 1679***

January 3, 2024

License Number: AL1601

Ms. Leah Bell, Administrator
The Brentwood Senior Living
6920 West Lee
Lawton, OK 73505

**Survey Event ID: J84O12**

Dear Ms. Bell:

A revisit conducted **December 27, 2023**, revealed that your facility corrected deficiencies effective **November 30, 2023**.

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

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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 12/27/2023 |

| 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<br><br>A revisit was conducted on 10/27/23. All deficiencies from the 10/18/23 survey were cleared. | {C 000} | | |

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