OKLAHOMA
State Department
of Health

Delivery via email to: leahbell@thebrentwoodseniorliving.com

September 23, 2024

License Number: AL1601

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

Survey Event ID: 9OIY11

Dear Ms. Bell:

On **September 12, 2024,** 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 Services**, then **click on Long Term Care**. 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face to face, or a virtual 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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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 #: **OK00064960**
Investigation Date(s): **09/06/24, 09/10/24, 09/11/24 and 09/12/24**

ALLEGATION(S)

The center failed to ensure services were billed according to the contract and/or resident service agreement upon discharge/transfer.

An unannounced on-site investigation was initiated 09/06/2024 at 5:15 p.m.

A sample of five 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 Summary of Complaint Investigation:

A tour of the center was conducted upon entrance and throughout the survey. There were on odors detected in the center's hallways. Residents were observed in the dining area and the common areas of the center. Staff were observed assisting residents with activities of daily living. Staff were observed in the dining area supervising dinner.

Admission and discharge policy and procedures were reviewed. Resident assessments, functional level assessments, and care plans were reviewed. Resident contracts including sampled resident contracts were also reviewed. Billing invoices were reviewed. Closed records were reviewed.

Resident and family members were interviewed related to contracted services.

The attached CMS 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: 09/13/2024

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 #: **OK00066984**
Investigation Date(s): **09/06/24, 09/10/24, 09/11/24, and 09/12/24**

ALLEGATION(S)

The center failed to assess, monitor and intervene in a timely manner for a change in condition.

An unannounced on-site investigation was initiated 09/06/2024 at 5:15 p.m.

A sample of five 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 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 Summary of Complaint Investigation:

A tour of the center was conducted upon entrance and throughout the survey. Residents were observed in the dining area and the common areas of the center. Staff were observed assisting residents with activities of daily living. Staff were observed in the dining area supervising dinner.

Sampled residents, including closed records were reviewed. The change of condition, medical emergencies, and incident report policy and procedure were reviewed. Assessments, functional level assessments, and resident contracts were reviewed. Ambulance run report, progress notes, and physician progress notes were reviewed. Staffing schedules were reviewed.

Resident and family members were interviewed related to care and emergency services.

The attached CMS 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: 09/13/2024

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 09/12/2024

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 Complaint investigations (#OK00064960 and #OK00066984) were conducted on 09/06/24, 09/10/24, 09/11/24, and 09/12/24. Census: 30 Listed below are abbreviations that will be used throughout this document. ACMA - advanced certified medication aide Appx - approximately ASA - Aspirin CNA - certified nurse aide DNR - do not resuscitate c/o - complain of EMS - emergency medical service ER - emergency room FSBS - fingerstick blood sugar GCS - glascow coma scale G - gauge IV- intravenous mg - milligrams min - minute RCC - resident care coordinator pt - patient via - by	C 000		
C1304 SS=D	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract.	C1304		

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 09/12/2024

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
C1304	Continued From page 1	C1304		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the center failed to ensure accurate billing for services outlined in the center's service agreement for one (#2) of one sampled resident reviewed for billing services.

Findings:

A "Move Out" policy, not dated, read in part, "Residents may move out of the community for a variety of reasons, such as increased need for healthcare services, a change in condition, or family/personal reasons A move-out of the community (discharge) is conducted in a dignified manner to limit transfer trauma and to ensure that resident needs are met. Procedure: The Administrator coordinates the timing of the move-out with the responsible party and receiving community or new residence. The policy also read; a resident move-out summary is completed in the resident's record."

Resident #2's "Functional Level of Care Evaluation", dated 12/04/23, level 4, bathing, requires full assistance with washing/pat dry ...level 4, dressing, total assistance with dress/undress ...level 3, continence ...incontinent/requires mod assist with products ...level 3, bowel continence, requires assistance

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 09/12/2024

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
C1304	Continued From page 2 cleaning/using products ...Total score 33 ...Level 4, 25-33, $2,000.00 ..." Resident #2's agreement, dated 12/06/23, documented, "IX Termination, subsection B. 2, Immediate Transfer and Termination. Under certain circumstances, we may initiate your immediate transfer from here and may terminate this Agreement immediately. The transfer shall be initiated within five (5) working days and progress shall be noted in the Resident's record with the following included: The agreement also read, ...iv) Your physician, you or your representative determines your needs for privacy or dignity can no longer be met by The Brentwood ..." Resident #2's assessment, documented, admission date: 12/08/2023, list number of persons required to assist resident with activities of daily living to include: Bathing (1), Eating (0), Dressing (1), Transferring (2), Toileting (2), Ambulation (2). Resident #2's plan of care, dated April 2024, documented, grooming/baths: full assist, toileting: peri care/briefs, 2 (hour) incontinent checks. Resident 2's written notice, dated 04/12/24, documented, intent to terminate this agreement on April 18, 2024, Pursuant to Section IX Termination, Subsection B. 2, Immediate Transfer and Termination. These reasons are listed below. 1. Pursuant to Section IX Termination, Subsection B. 2, Immediate Transfer and Termination. a. While good faith measures were taken in accordance to Section XII, Miscellaneous, Subsection XII, Miscellaneous, Subsection M, Disputes and Grievance, to address numerous issues, [Resident #2], and his legal representative [Resident #2's representative] agree [Resident	C1304		

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 09/12/2024

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
C1304	Continued From page 3 #2's] dignity was not met in accordance with Section IX, Subsection B. 2 (i) These issues were communicated to [Administrator]. 2. Pursuant to Section III Personal Assistance and Services ...incontinence care management ...3. Pursuant to Section III, Personal Assistance and Services ... frequency of bathing was inconsistent at best ...4. Pursuant to Section III, Personal Assistance and Services & Section XII Miscellaneous ...transfer assistance ... The sustained nature of these issues over the last several months have left [Resident #2] to feel unsafe and uncared for in this environment, with a general anxiety for his physical and mental needs being met by The Brentwood Senior Living staff; therefore, we wish to part ways and find care elsewhere ...Your Monthly Rent Fee $3,000.00, Fee for Level of Care Services ... (if applicable) $2,000.00, Totally Monthly Fee ... $5,000.00 ..." On 09/11/24 at 10:00 a.m., the administrator reported the family was moving Resident #2 to a higher level of care. They were asked if any grievances were filed related to Resident #2. They reported there was no grievances. There were times Resident #2 would refuse a shower and then want to shower later. They were asked to submit documentation of Resident #2's showers. They reported they did not have any documentation of a shower or if the resident refused a shower. They were asked how they would know if the resident received a shower. They stated they would not know. They reported they thought the resident showered two times a week on the 2:00-10:00 p.m., shift. They were asked about the pre-admission assessment. They reported the functional assessment was performed prior to admission.	C1304		

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 09/12/2024

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
C1304	Continued From page 4 They reported Resident #2 admitted on 12/08/24 and they were at the highest level of care. They reported Resident #2's representative gave notice and submitted it in writing. They reported the billing stopped the day the resident moved out on April 18, 2024. They reported they had talked with corporate and they agreed the rent would be pro-rated for the month of April. They were asked to submit the move-out summary. They reported they had no move-out summary. The administrator reported the resident would not be held to the 30-day notice if they were moving to a higher level of care and the center should issue Resident #2 a refund. On 09/12/24 at 2:05 p.m., the administrator reported they spoke with corporate related to the discrepancy in monies. They reported if their calculations were correct, they would owe a refund of $1,000.00.	C1304		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of	C1505		

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 09/12/2024

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
C1505	Continued From page 5 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 and interview, the center failed to ensure the staff initiated emergency services quickly and failed to adhere to the center's policy and procedures for medical emergencies and/or change of condition for one (#1) of one sampled resident with complaints of chest pain. Findings: A "Medical Emergencies" policy, not dated, read in part, " ...The resident will receive emergency medical care when needed to prevent further injury or illness. Procedure 1. Caregivers immediately summon the community Administrator should a resident exhibit signs and	C1505		

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 09/12/2024

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
C1505	Continued From page 6 symptoms of a medical emergency. 2. The Administrator makes a determination as to the severity of the situation. 3. The community summons emergency medical services by calling 911, when the resident exhibits signs and systems [sic] of distress and/or emergency condition. Examples include, but are not limited to: new onset of chest pain ...shortness of breath. The policy also read, 7. A staff member remains with the resident until paramedics transport out of the community. The policy also read, 11. A narrative chart entry is made in the resident's chart regarding the circumstances which led up to the call (Data), what care was provided by the staff, including any first aid (Action), as well as the resident's response to the action (Response). 12. An incident report is completed." A "Change of Condition" policy, not dated, read in part, when a resident exhibits a change in condition, action will be taken to coordinate appropriate care. Procedure 1. When a resident displays a change in condition, caregivers notify the Administrator. 2. If a change progresses to an emergency at any time call 911. 3. Examples of a change in condition may include, but not be limited to ...shortness of breath or exertion, complaints of pain or discomfort ...4. If there is an actual change in condition the resident's physician is notified ...Notify the resident's responsible person of the change in status and action taken ..." A charting note for Resident #1, documented, " ...Date 08/19/24, 3:09 PM, Resident c/o chest pains. Sent to [name removed-hospital] via EMS ...." This was the only documentation for this incident in the clinical record. There was no narrative charting related to the incident, what	C1505		

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 09/12/2024

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
C1505	Continued From page 7	C1505		

care was provided by the staff, and no resident response to the action, and no incident report completed per policy and procedure for medical emergencies. There was no documentation of vital signs, notification of family members and/or physician, or the actual time the resident was transported to the hospital.

An" Emergency Run Report" for Resident #1, dated 08/19/24, documented, "Dispatch priority: Lights and siren emergent (immediate response) ... DNR form...Received 15:46 [3:46 p.m.], at patient 16:04 [4:04 p.m.] Unit dispatched to nursing home for a pt having chest pain ...Upon arrival on scene pt is seated by the front door in wheel chair no acute distress noted. Pt is alert and oriented to person, place, time, and event. Pt states she has been having chest pain and headache for appx 30 minutes. Pt is loaded and secured to EMS stretcher without incident. Pt is loaded and secured in ambulance without incident. An 18G IV is established to the left ac in one attempt ...324 mg ASA is administered for potential cardiac issue ...pt becomes suddenly unresponsive GCS is 3. 12 lead maintains sinus rhythm. FSBS 121. Transfer care 16:30 [4:30 p.m.] to ER.

An investigation dated, 08/20/24, documented, on 08/19/24, [RCC] came and told me [administrator] that [Resident #1] came to nursing station stating that they did not feel well and was having chest pain and felt like they were having a heart attack. RCC instructed ACMA to get a set of vitals and call 911. RCC then came to my office to let me know what was going on and what she told staff to do as she was getting off for the day. On 08/20/24, [Operations assistant] told me [administrator] that it took over 25min for the ambulance to come and they had to call a second

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 09/12/2024

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
C1505	Continued From page 8	C1505		

time for an ambulance. RCC and the administrator called ACMA #1 (no longer employed) into my office to ask what happened with [Resident #1] and the ambulance. ACMA #1 stated that she called [name removed-ambulance service] continued with her work and then went to take a smoke break. Operations assistant had went [sic] to nurses' station and seen that [Resident #1] was still here in the building so he then told [CNA #1] who was at the nursing station to bring [Resident #1] up front and they need to call an ambulance again and they stated they forgot to dispatch an ambulance but they were sending an ambulance now. Upon completion of investigation (the administrator) and RCC had a clinical in-service to change policy on what to do when we send a resident out for emergencies.

On 09/11/24 at 2:28 p.m., the administrator was asked if staff notified her when Resident #1 was sent out to the hospital. They reported they was in the facility at the time and reported they had a call at 3:18 p.m., that their house was on fire so they left. They were asked if they charted anything related to the incident. They reported they did not. They were asked if staff notified the physician. They did not know. They were asked if they had assessed or seen the resident. They reported they did not. They were asked if they documented notification of the resident's representative. They reported they would look but did not find it. They were asked if they had an incident report related to this transfer to the hospital. They reported they do not do an incident report for sending a resident out to the hospital. They were asked if the staff had to make two calls to the ambulance service. They reported they did call twice. The administrator was asked if they investigated this incident. They reported they in-serviced the staff. They were asked if they contacted the ambulance

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 09/12/2024

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
C1505	Continued From page 9 service and they reported that was the only persons they had not spoken with. They were asked what was the time frame between the first and second call to the ambulance service. They stated 20-30 minutes. On 09/11/24 at 3:00 p.m., the RCC was asked about the day Resident #1 was sent out to the hospital. They reported they were coming out of the office and Resident #1 had a funny look on her face and she said her chest was hurting and could not breathe. They grabbed a chair for Resident #1. They reported they instructed ACMA #1 to call 911 and get the vital signs and assigned a CNA to get the paperwork to send Resident #1 out and then informed the administrator. RCC then left for the day.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: leah@thebrentwoodseniorliving.com

October 28, 2024

License Number: AL1601

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

Survey Event ID: 9OIY11

Dear Ms. Bell:

On **September 12, 2024,** 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 2, 2024**.

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,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date:** 10/15/24 **Facility Name:** The Brentwood Senior Living **License Number:** AL1601 **Survey Event ID:** 9OIY11 **Date Survey Completed:** 09/12/24

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1304	Based on record review and interview, the center failed to ensure accurate billing for services outlined in the center's service agreement for one (#2) of one sampled resident reviewed for billing services.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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 administrator reported they spoke with corporate related to the discrepancy in monies. They reported if their calculations were correct, they would owe a refund of $1,000.00.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Brentwood corporate finance team will review all current billing for services to ensure accurate charges.
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?	Brentwood corporate finance team will review billing for services to ensure accuracy every 90 days to ensure continued accuracy. Date of completion of current review: 11/01/24
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.	Brentwood corporate finance team will review billing for services to ensure accuracy every 90 days to ensure continued accuracy. Date of completion of current review: 11/01/24
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/01/24

OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature OAC 310:663-25-4(F)	**Date** 10-15-24

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date:** 10/15/24 **Facility Name:** The Brentwood Senior Living **License Number:** AL1601 **Survey Event ID:**9OIY11 **Date Survey Completed:** 09/12/24

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	**Based on record review and interview, the center failed to ensure the staff initiated emergency services quickly and failed to adhere to the center's policy and procedures for medical emergencies and/or change of condition for one (#1) of one sampled resident with complaints of chest pain.**

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	**All staff will be in-serviced on facility policies regarding medical emergencies and change of a resident's condition, including when to initiate medical emergency services. Date of completion: 11/01/24.**
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 staff will be in-serviced on facility policies regarding medical emergencies and change of a resident's condition, including when to initiate medical emergency services. Date of completion: 11/01/24.
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 administrator or designated person assigned by the administrator will review each resident's medical record that has an emergency situation or a change of condition for the next 90 days to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The administrator or designated person assigned by the administrator will review each resident's medical record that has an emergency situation or a change of condition for the next 90 days to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/01/24
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date** Enter a date of signature. 10-15-24
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: leah@thebrentwoodseniorliving.com

November 25, 2024

License Number: AL1601

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

Survey Event ID: 9OIY12

Dear Ms. Bell:

On **November 25, 2024,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **September 12, 2024,** have now been corrected effective **November 1, 2024.**

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

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 11/25/2024

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 An offsite/paper revisit was conducted on 11/25/24. The facility was in substantial compliance.	{C 000}		

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