OKLAHOMA
State Department
of Health

Delivery via email to: Lmansel@brookdale.com

April 6, 2022

License Number: AL2001

Ms. Legend Tate, Administrator
Brookdale Weatherford
800 Gartrell Place
Weatherford, OK 73096

RE: Survey Event ID: IEVH11

Dear Ms. Tate:

On **March 23, 2022**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached. The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance.

However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;

- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

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

Sincerely,

Lisa Calvin

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

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Weatherford**
Address: **800 Gartrell Place**
City, State, Zip: **Weatherford, OK, 73096, Custer**
Provider #: **AL2001**
Complaint #: **OK00055402**
Investigation Date(s): **March 17th, 18th, 21st, 22nd, 23rd, 2022**

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to have and or implement their abuse policy	**US**
2. The facility failed to provide care according to the resident's contract	**US**
3. The facility failed to ensure residents received medications as ordered by the physician	**US**

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 03/17/2022 at 8:15am.

A sample of 6 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility failing to implement their abuse policy was conducted.

Observations were made throughout the survey of residents being treated with respect and dignity. Residents were clean, well groomed, assisted as needed and had no signs of abuse or neglect. Staff were observed re-directing residents if they were wandering in the hallways. Resident rooms were noted to have door knob locks on the inside of their rooms. Several residents were seen entering their rooms with keys.

Residents were asked if other residents entered their rooms without permission. No concerns were voiced and no altercations with other residents were reported.

Incident reports were reviewed and no reports were identified related to resident abuse. Clinical records were reviewed. No allegations of abuse were found.

At the time of the investigation, there was no deficient practice related to the facility failing to implement their abuse policy.

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

An investigation specific to the facility providing care according to the resident's contract was conducted

Observation of meals served in the dining room and individual resident rooms were made. Staff was observed to provide timely delivery of hall trays to residents. Staff assisted residents as needed. Facility refrigerators and freezers were observed to be well stocked. Staff was observed distributing snacks to residents.

Residents were interviewed and expressed that the food at the facility was "good". Residents stated that they could make alternate food choices and were satisfied with the variety of foods offered. Staff affirmed that there were alternate food selections available to residents upon request. The Dining Service Coordinator was interviewed regarding meal times, snack times, weekly menus, and alternate food choices.

Copy of weekly menus and menus for alternate food selections were reviewed.

At the time of the investigation, there was no deficient practice related to the facility failing to provide care according to the resident's contract.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to facility ensuring residents receiving medications as ordered by the physician was conducted.

Observation of medication pass was conducted. Residents were observed taking medications under direct supervision. Medication was observed to be safely stored in the rooms of self-medicating residents.

Residents that received medications per the facility were interviewed and stated that they received their medications as ordered. Residents that self-administered medications reported that facility staff conducted monthly medication counts with them. Staff reported a process for receiving and delivering medications to self-administering residents, and for following physician orders for medication administration.

Sampled clinical records, including a closed record, were reviewed for assessments, care plan, physician orders, medication and treatment administration, and progress notes. Quarterly Self-Administration Reviews and Individual Resident Drug Receipt Ledgers for self-medicating residents were reviewed. Facility policies and procedures were reviewed.

At the time of the investigation, there was no deficient practice related to the facility ensuring residents received medications as ordered by the physician.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegations #1, #2, and #3. 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 state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Ernestine Scovens

Ernestine Scovens RN, CHFS

Date report completed: 03/28/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Weatherford**
Address: **800 Gartrell Place**
City, State, Zip: **Weatherford, OK, 73096, Custer**
Provider #: **AL2001**
Complaint #: **OK00055963**
Investigation Date(s): **March 17th, 18th, 21st, 22nd, 23rd, 2022**

ALLEGATION	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure medications were administered as ordered by the physician	**US**

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 03/17/2022 at 8:15am.

A sample of 3 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility ensuring that medications were administered as ordered by the physician was conducted.

Observation of medication pass was conducted. Residents were observed taking medications under direct supervision. Medication was observed to be given in a timely manner.

Residents were interviewed and stated that they received their medications as ordered. Licensed nursing personnel described the process for transcribing new physician orders to the resident's MAR and

communicating changes to staff responsible for administering medications. Staff was able to describe the procedure for receiving medications from the pharmacy.

Sampled clinical records were reviewed for assessments, care plan, physician orders, medication and treatment administration, and progress notes. New orders were seen to be noted by licensed nursing staff and transcribed to resident's Medication Administration records in a timely manner. Medications given were accurately signed off on the MAR. Resident Drug Receipt Ledgers were reviewed. Facility policies and procedures were reviewed.

At the time of the investigation, there was no deficient practice related to the facility ensuring that medications were administered as ordered by the physician

Determination Summary and Follow-Up Action:

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

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Ernestine Scovens

Ernestine Scovens RN, CHFS

Date report completed: 03/28/2022

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Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Weatherford**
Address: **800 Gartrell Place**
City, State, Zip: **Weatherford, OK, 73096, Custer**
Provider #: **AL2001**
Complaint #: **OK00057109**
Investigation Date(s): **March 17th, 18th, 21st, 22nd, 23rd, 2022**

ALLEGATION	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to provide care and services according to the residents' contract	**US**

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 03/17/2022 at 8:15am.

A sample of 5 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility providing care and services according to the residents' contract was conducted.

Observations were conducted throughout the survey of staff providing care as needed and upon residents' request. Residents were observed to be neat, clean, and well-groomed. Resident rooms and hallways were observed to be clean and free of clutter. No lingering odors were observed throughout the facility. Housekeeping was observed cleaning residents rooms. No obvious safety concerns were noted in resident

bathrooms. Maintenance staff was observed removing items from walkways in the facility courtyard. No over growth of weeds and/or foliage was noted in the courtyard.

Residents were interviewed and reported no complaints related to receiving assistance with baths and/or showers. Staff interviewed stated that baths or showers for dependent residents were given twice a week and that supervisors were notified if residents refused. Staff reported that some residents were given baths or showers by third-party providers.

Sampled clinical records were reviewed for resident assessments and care plans. Resident service contracts were reviewed. Third-party provider ADL sheets were reviewed.

At the time of the investigation, there was no deficient practice related to the facility providing care and services according to the residents' contract.

Determination Summary and Follow-Up Action:

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

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Ernestine Scovens

Ernestine Scovens RN, CHFS

Date report completed: 03/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2001	A. BUILDING: _____ B. WING _____	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEATHERFORD	800 GARTRELL PLACE WEATHERFORD, OK 73096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey and complaint investigation (#OK00057109, OK00055963 and OK00055402) was conducted on 03/17/22 ,03/18/22, 03/21/22, 03/22/22 and 03/23/22. The following abbreviations may have been used in the writing of this report. bilat = bilateral CMA = Certified Medication Aide CNA = Certified Nursing Assistant CT = Computerized Tomography ED = Executive Director EMS = Emergency Medical Services ER = Emergency Room ext = extremity HWC = Health & Wellness Coordinator HWD = Health & Wellness Director MAT = Medication Administration Technician MAR=Medication Administration Record OSDH = Oklahoma State Department of Health pcp = primary care physician res = resident resd = resident Rt = right UA = urinalysis WBC = white blood cell WNL = within normal limits	C 000		
C1505 SS=J	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	C1505		

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C1505	Continued From page 1 adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: On 03/18/22 at 09:20 a.m., the OSDH confirmed the existence of an immediate jeopardy related to staff failed to assess, monitor, and intervene for a resident who had a change in condition after a fall with a head injury. On 05/01/21 a resident had a fall and was sent to the emergency room. The resident returned on 05/01/21 and was placed on 72 hour observation per facility policy. The resident was sent to the Emergency Room on	C1505		

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C1505	Continued From page 2 05/04/21 for labored breathing, hallucinations, pain in left side, and lethargy. The resident passed away in the hospital on 05/10/21. On 03/18/22 at 12:20 p.m., the ED was informed of the existence of the immediate jeopardy. A request was made for an acceptable plan to remove the immediacy. On 03/21/22 at 09:47 a.m., the plan of removal was accepted by the OSDH. The plan of removal was as follows: "...How will the corrective action be accomplished for those residents found to have been affected? " Resident identified during the complaint survey is no longer at the community. How will the corrective action be accomplished for other residents? "To identify other resident who could be affected by the alleged deficient practice, the RN Area Nurse Manager and HWD assessed current residents for change of condition. Change of condition were evaluated and documented for residents who exhibit significant deviation in physical or mental status such as: Change in medical condition, Change in behavior, Change in cognitive ability. "Current residents who have had falls since May 1, 2021 have been assessed and monitored for injury and interventions have been implemented as described in the policies and guidelines. What measures will be put into place or systematic changes made so that the alleged deficient practice will not recur? " Licensed nursing associates will be in serviced on the below policies:	C1505		

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C1505	Continued From page 3 o Falls Management Policy - CS-30-1 o Head Injury Policy - CS-100-5 o Alert Charting Guidelines o Fall Interventions Guidelines o Falls Management Info Graphics o Change of Condition - CS-20-1 o Documentation Guidelines o Job Descriptions for HWD/HWC " Essential Functions. Assists in the supervision of community-based licensed nursing staff, medication technicians/CMA's and Resident Care Associates. o Job Descriptions for CNA/Med Tech " Direct care associates will be in-serviced on the below clinical guidelines on 3/19/22 by 2:30pm: o Nurse Call Guidelines for Associates - 29 o Change of Condition - CS-20-1 o Head Injury Policy - CS-100-5 o Job Descriptions for CNA/Med Tech " Essential Functions 1. Receives and communicates report to management on resident status at the beginning and end of each shift and as needed. Notifies the management of any changes in resident medical condition/status. " Licensed nurses in the community will be in-serviced on the policies and guidelines as stated above by the RN Area Manager. " Associates that are not able to be contacted and inserviced by 3/19/22 will be inserviced prior to starting their next shift. " The Executive Director or designee will be responsible for training new associates on: o Job descriptions o Nurse Call Guidelines for Associates - 29 o Change of Condition - CS-20-1 o Head Injury Policy - CS-100-5	C1505		

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C1505	Continued From page 4 How will the community monitor its performance to verify that solutions are sustained? "Weekly for the next two months, the RN Area Nurse Manager or designee will conduct a review of falls, change of conditions and alert charting. Follow up action will be taken as indicated. "The District Director of Clinical Services or designee will conduct clinical site visits at least twice per year to identify areas of compliance. Follow up action will be taken as indicated." On 03/21/22 at 2:35 p.m., after review/verification of the plan of removal was completed, the immediacy was lifted. The deficient practice remained at a level of actual harm at a pattern. Based on record review, observation, and interview the center failed to, 1. assess, monitor and intervene when a resident had a change in condition (lethargy, confusion, and lack of appetite) for one (#5) of four sampled residents who had falls with head injuries, and 2. ensure 72-hour observations were completed after a fall with a head injury for three (#9, #10 and #11) of four sampled residents who had falls with head injuries, and 3. ensure medication was administered correctly for one (#12) of nine residents observed during medication pass. The center's "Fall prevention and Management Policy", last revised 10/2018, read in part "...Level 3 interventions to consider may include the use of special equipment or access to 3rd party provider services and include the following..." The center's "Documentation Policy," last revised 12/2020, read in part, "...Health and Wellness	C1505		

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C1505	Continued From page 5 Director...nurse or designee should document in the resident record those events and changes of condition that require physician/healthcare provider notification, additional monitoring, or specific interventions..." The center's "Alert Charting Policy," last revised 01/2021, read in part, "...associates should observe and document the resident's response/condition for 72-hours in the resident record...Examples of Alert Charting. Examples of conditions or events that should prompt alert charting include, but are not limited to: Falls...Changes in level of consciousness: New onset or worsening confusion or lethargy should be monitored...Condition Resolved. The Nurse or designee on the last shift of the 72-hour period is responsible for documenting that the condition is resolved or that the documentation needs to be continued..." The center's "Head Injury Policy," last revised 02/2021, read in part, "...Continue to observe condition for 72 hours...If condition changes to require an Emergency Response, call 911 immediately...Charting Guidance: HWD/Nurse designee...will document the following information including but not limited to the following...Notification by HWD/Nurse Designee...of date/time and event...Notification of third party healthcare provider...Notification of legal representative (if indicated) and action taken..." The center's "Medication & Treatment-Administration Policy," last revised 11/2018; 03/31/2022 [from policy], read in part, "...Medication administration must be in accordance with the prescriber's orders...The individual administering medications	C1505		

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C1505	Continued From page 6 must...Check the label three (3) times to verify the right medication, right dosage, right time, and right method of administration before giving the medication..." 1. Res #5 had diagnoses which included, high blood pressure, chronic fatigue, and abnormal weight loss. Res #5's "Personal Service Plan", dated 01/11/21, " read in part, "...Resident uses a cane as a mobility aid...Resident is oriented to person place and time..." A document titled, "Post-Fall Evaluation Form Assisted Living/Memory Care", documented by MAT #2, dated 05/01/21, read in part, "Fall location: living room of apartment..said she was sore and hit her head...said her ankles hurt..." A hospital emergency room, "Clinical Report", dated 05/01/21, read in part, "...Chief Complaint: INJURY TO HEAD and HEAD and LOWER BACK sacrum...PHYSICAL EXAM...Extremities: (2-3+bilat lower ext edema (subacute-[physician] aware)...Clinical impression, Contusion to the head, lower back and right and left buttocks...Follow up with your doctor in three days if not better..." A center "General Progress Note", dated 05/03/21, read in part "...effective 5/01/21 at 10:30 a.m., resd had fall on this day and we sent to the ER stating that she had pain in her head. resd was brought back to the community by daughter. Head CT was WNL as was xray of sacrum and coccyx. Called and requested UA results that were done at the ER. Will be reevaluating level of care resd is needing and implementing more frequent wellness checks.	C1505		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEATHERFORD	800 GARTRELL PLACE WEATHERFORD, OK 73096

(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 family and pcp were notified of the fall..." A center "General Progress Note", dated 05/04/21, read in part, "...effective 05/02/21 at 14:19 [2:19 p.m.] staff reports resd is still sore from previous fall. resd is also lethargic. will continue to monitor..." A center "General Progress Note", dated 05/04/21, read in part, "...effective 05/03/21 at 14:21 [2:21 p.m.] resd remains lethargic and is showing lack of appetite. requested order for lab work on resd that was not completed upon ER visit. Hospital to come and draw labs 5/4/2021..." A center "General Progress Note", dated 05/04/21, read in part, "...Transfer Out Date/Time: 05/04/21 at 10:45 AM...[hospital]...ambulance... resd had labored breathing, hallucination pain in left side and lethargy...family was notified..." A hospital emergency room, "Clinical Report", dated 05/04/21, read in part"...Chief Complaint: DYSPNEA and HISTORY OF CONGESTIVE HEART FAILURE and CHEST PAIN generalized weakness...Recent medical care: the patient was seen recently by a health care provider. (Seen on 5/1 for a fall and UA was collected that looked to grown out Klebsiella but was not started on antibiotics and now she is increasingly weak.)...CLINICAL IMPRESSION Bacterial pneumonia with hypoxemia..." A "History and Physical" dated 05/04/21, read in part, "...CHIEF COMPLAINT; Shortness of breath...Extremities: with 2+ to 3+ edema. She had weeping at the level of the ankle...Assessment: Pneumonia...History of congestive heart failure..."	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2001	A. BUILDING: _____ B. WING _____	C 03/23/2022

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C1505	Continued From page 8 On 03/18/22 at 10:44 a.m., the HWD was asked how the protocol for falls worked on the weekends with no licensed staff here. She stated, "The CMA in charge reports to the nurse, we tell them (staff) to call the ambulance if needed, notify the doctor and family and get packet ready." At 10:45 a.m., Res #5's progress note, effective 05/02/21, was reviewed with the HWD. When asked, was the physician, hospice or family notified, she was unsure. The HWD was asked if a nurse should have assessed Res #5 with her change in condition. She replied, yes. At 10:47 a.m., Res #5's progress note, effective 05/03/21, was reviewed with the HWD. She was asked if Res #5 had a change in condition as documented, why wasn't Res #5 sent to the ER. The HWD stated, "We should have." A lab result received by the center on 05/03/21 was reviewed, titled "Urinalysis", dated 05/01/21, read in part. "...WBC 25-50...Culture ordered...Microbiology culture comments...Klebsiella rhinoscleromatis 05/03/21..." At 11:05 a.m., the HWD was asked if there was a follow up on the UA results that were received on 05/03/21 and lab that was requested by the nurse on 05/03/21. She stated, "The doctors office will send requisition for labs to the hospital lab." The HWD didn't know what lab had been ordered by the physician, and had no orders for treatment of Res #5's urinary tract infection. At 11:11 a.m., the HWD was asked if Res #5 was started on an antibiotic for her UTI. She replied, no I don't see one. The HWD was asked if	C1505		

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C1505	Continued From page 9	C1505		

lethargy and confusion would be a change in condition after a fall, she stated, "Yes." She was asked if a licensed nurse is in the center every weekend. She replied, No.

At 11:44 a.m., the HWD reported there was no documentation that a third party provider assessed Res #5 over the weekend.

At 11:52 a.m., the HWD was asked if the nurse is not here on the weekend is charting done on return. She replied, yes. When asked if unlicensed staff do observations on weekend and report to the nurse, she stated, "Yes."

2. Res #9 had diagnoses which included, anxiety, high blood pressure, and vascular dementia.

Res #9's "Fall Risk Evaluation", dated 03/18/22 at 11:28 a.m., read in part, "...Fall Risk Level 3..."

Res #9's "OSDH Incident Report Form," dated 03/12/22, read in part, "...Description of Incident...Resident found at 0500 [5:00 a.m.] on floor outside of her bathroom door. Staff noted Laceration to right eyebrow and bruising to right side of nose. Resident complained of headache...Resident is alert and oriented to self and place. She is independent with all ADL's. She utilizes a rolling walker for mobility outside of her apartment...Resident was transported to [hospital] for evaluation. Laceration to right brow was glued closed.

Res #9's "General Progress Note," dated 03/14/22 at 10:35 a.m., read in part, "...Effective [03/12/22 at 10:28 a.m.]... resd had fall this morning. Resd was coming out of the restroom and fell. Resd hit her head and sustained a

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C1505	Continued From page 10	C1505		

laceration on her right eye. Resd was sent to the ER where a CT was done of her head and come back negative. Laceration was treated... "

Res #9's "General Progress Note," dated 03/15/22 at 11:24 a.m., read in part, "...Effective [03/14/22 at 09:23 a.m.]... resd had fall over weekend. Resd sustained a laceration on her right brow. Resd doesn't not complain of pain at this time..."

On 03/18/22 at 11:17 a.m., the HWD acknowledged there was no documentation for Res #9's 72 hour observation on 03/13/22.

Res #10 had diagnoses which included, Alzheimer's disease, high blood pressure, and muscle weakness.

A "Fall Risk Evaluation," dated 01/14/22, documented Res #3 was a Level 3 fall risk.

An "OSDH incident report", dated 08/07/21, read in part, "...Description of Incident...resident was laying on living room floor near her bed and was bleeding from her ...forehead...she was transported to [local hospital]...She obtained 10 stitches to [area around left eye]...relevant resident history...Resident needs assist with all ADL's due to diagnosis of Dementia. She is alert and oriented to self only. Ambulates with walker...corrective measures implemented to prevent recurrence...72 hour post fall initiated ..."

Resident #10's "General Progress Note," dated 08/09/21 at 2:24 p.m., read in part, "...Effective Date: [08/07/21 at 2:22 p.m.] ...resd had fall this day sustained a head injury. resd was transported to ER via ambulance...resd was later brought back...resd had 10 stitches...will be implementing

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C1505	Continued From page 11 more frequent wellness checks ... On 03/18/22 at 11:20 a.m., the HWD acknowledged there was no documentation for Res #10's 72 hour observation on 08/08/21 and 08/10/21. Res #11 had diagnoses which included, dementia, high blood pressure, and osteoporosis. "Fall Risk Evaluation" dated 11/12/21 at 11:21 a.m., read in part, "...fall risk Level 3 ..." Res #11's "OSDH incident report," dated 02/06/22, read in part, " ...Description of Incident...Resident found lying on floor by her recliner, blood noted to back of head. EMS called for assessment...Relevant resident history...Resident has diagnosis of dementia... Alert and oriented x 1...summary of the investigation ...Transported to [hospital] where she received one staple in back of head. Staff will perform more frequent wellness checks on her during night shift and awaken toilet every 4 hours. Care plan updated and 72 hour post fall initiated ..." Res #11's "General Progress Note," dated 02/7/22 at 11:10 a.m., read in part, " ...Effective date: 02/06/22 at 11:04 a.m. ...resd has fall early in the morning in the restroom. resd hit her head and was sent to the ER where she was treated returned... later that morning with 1 staple ...Will be implementing more frequent wellness checks..." Res #11's "General Progress Note," dated 02/07/22 at 11:40 a.m., read in part, " ...Effective date: 02/07/22 at 11:36 a.m. ... Resident in good spirits and doesn't recall falling or going to the ER	C1505		

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C1505	Continued From page 12 or obtaining staple. No complaints of pain other than Rt hip at this time. Rt hip was xrayed and just shows sever [sic] arthritis and resident has complained of this pain previously ..." On 03/18/22 at 11:17 a.m., the HWD acknowledged there was no documentation for Res #11's 72 hour observation on 02/08/22 and 02/09/22. 3. Res #12 had diagnoses which included, osteoarthritis, low back pain, and high blood pressure. Res #12's "Physician's Order," dated 02/11/20, read in part, "...Voltaren Gel 1%...Apply 2 gram transdermally [sic] three times a day for Left knee pain ..." On 03/22/22 at 9:26 a.m., MAT #1 was observed to administer four grams of Voltaren gel to Res #12's left knee. At 10:54 a.m., the HWD stated resident #12's Voltaren gel order was to administer two grams three times a day. The MAR documented the resident received two grams to her left knee. At 11:20 a.m., MAT #1 was asked how much Voltaren gel she administered to Res #12. She stated, "It was my mistake. I gave her four grams by reading the [label] and, not checking the computer."	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: lmansel@brookdale.com

April 15, 2022

License Number: AL2001

Mr. Legend Tate, Administrator
Brookdale Weatherford
800 Gartrell Place
Weatherford, OK 73096

Survey Event ID: IEVH11

Dear Mr. Tate:

On **March 23, 2022,** a Relicensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. **Our acceptance does not absolve the facility's** responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **April 15, 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: 2022.04.15 11:31:51 -05'00'

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

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/12/2022** **Facility Name:** Brookdale Weatherford **License Number:** AL2001 **Survey Event ID:** IEVH11 **Date Survey Completed: 3/23/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505 SS=J	Based on: Staff failed to assess, monitor, and intervene for a resident who had a change in condition after a fall with a head injury during a complaint survey. The med tech failed to give the right dosage of a medication to a resident during annual survey.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Weatherford regarding the Statement of Deficiencies dated 03/23/2022. This POC is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

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 resident identified during the survey is no longer in the community.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents who have had falls since May 1, 2021 have been assessed and monitored for injury and interventions have been implemented as described in the policies and guidelines.
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?	Licensed nursing associates have been in-serviced on the below policies and guidelines:Falls Management Policy, Head Injury Policy,Alert Charting Policy, Fall Intervention Guidelines, Falls Management Info Graphics, Canage of Condition, Documentation Guidelines, Job Description for HWD/HWC job descriptions for CNA/Med Tec. Inservices to be performed by the Area Nurse Manager or designee. Direct care associates have been inserviced on the following guidelines: Job Descritpions for CNA/Med Tech, Nurse Call Guidelines for Associates, Change of Condition, and Head Injury Policy. The Executive Director will be responsible for training new associates on Nurse Call Guidelines, Change of Condition, and Head Injury. All Med Techs will be inserviced by the HWD/HWC on the Medication Administration Policy CS-40-7.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:	For the next two weeks, The RN Area Nurse Manager or designee will monitor performance at least twice weekly including review of falls, change in conditions and alert charting. The HWD or designee will monitor medication

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.	performance weekly by random medication passes for the next two weeks. Records of such audits will be maintained as well as any follow up action as indicated. Thereafter, such monitoring shall occur at least weekly for through May 23, 2022. . This plan of correction will be dicussed in a monthly Quality Assurance Meeting Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/15/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Legend Tate ED** Legend Tate ED OAC 310:663-25-4(F)	**Date 4/12/2022**

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: lmansel@brookdale.com

December 16, 2022

License Number: AL2001

Ms. Legend Tate, Administrator
Brookdale Weatherford
800 Gartrell Place
Weatherford, OK 73096

RE: Survey Event ID: IEVH12

Dear Ms. Tate:

Enclosed is the summary of deficiencies following the revisit of a State Licensure survey conducted at your Assisted Living Center on **December 13, 2022**. These deficiencies remain uncorrected from our original investigation conducted **March 23, 2022**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;

(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies. If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (POC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- **Remedy(ies) imposed by the Department,**
- **Alleged failure of the surveyor to comply with** a requirement of the survey process;
- **Alleged inconsistency of the surveyor in citing deficiencies among facilities; or**
- **Alleged inadequacy or inaccuracy of the informal dispute resolution process**

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 000}	INITIAL COMMENTS A revisit was conducted on 12/13/22. Listed below are abbreviations that will be used throughout this document. ED-Executive Director ER-Emergency Room HH-Home Health HWD-Health and Wellness Director Resd-Resident RN-Registered Nurse.	{C 000}		
{C1505} SS=D	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 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.	{C1505}		

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{C1505}	Continued From page 1	{C1505}		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the center failed to complete a 72 hour observation for a resident who had a fall with a reported head injury for one (#5) of three sampled resident reviewed for 72 hours observation.

The ED identified 25 residents resided in the center.

Findings:

Resident #5 had diagnoses which included high blood pressure, osteoporosis, and reflux disease.

A "Head Injury Flowsheet" attachment, revised 03/2018, documented if no apparent injury or minor injury to contact the HWD or designee. If the resident is on HH or Hospice contact and request RN evaluation. If the ER services are not needed or refused, document the refusal and continue to observe for 72 hours.

A "Head Injury," policy, last revised 02/2021, read in parts, "...All residents sustaining a head injury receive immediate attention for serious injury...The attached Head Injury Flowsheet

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BROOKDALE WEATHERFORD	800 GARTRELL PLACE WEATHERFORD, OK 73096

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{C1505}	Continued From page 2 provides an illustration to aid the decision making process..." A "Resident Assessment," form, dated 08/08/22, read in parts, "...Alert...Oriented x 3..." A nurse "Progress Note," dated 09/21/22 at 2:04 p.m., read in parts, "...Resd had fall today while [the resident] was putting [their] pants on while standing. Resd fell backwards and stated the back of [their] head hit [their] standard walker...RN [name] came and assessed resd and [sic] observed no head injury and no need to send to the ER. Resd also refused the need to be sent..." A "Post-Fall Evaluation," dated 09/21/22 at 7:55 a.m., read in parts, "...Are you in pain..Yes...If yes please describe: LEFT ARM..." The progress notes contained no documentation Resident #5 had been monitored for 72 hours. On 12/13/22 at 11:26 a.m., the HWD was shown the head injury flow sheet and asked if the 72 hour observation had been completed for Resident #5. The HWD stated, "I don't know how [the resident] got missed, not here."	{C1505}		

OKLAHOMA
State Department
of Health

Delivery via email to: lmansel@brookdale.com; jennifer.shaw@brookdale.com

December 23, 2022

License Number: AL2001

Mr. Legend Tate, Administrator
Brookdale Weatherford
800 Gartrell Place
Weatherford, OK 73096

RE: Survey Event IEVH12

Dear Mr. Tate:

On **December 13, 2022**, a Licensure follow-up inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 23, 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

Digitally signed by Tempal Killman
Date: 2022.12.23 15:07:02 -06'00'

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

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/19/2022** **Facility Name:** Brookdale Weatherford **License Number:** AL2001 **Survey Event ID:** IEVH12 **Date Survey Completed: 12/13/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Based on record review and interview the center failed to complete a 72 hour observation for a resident who had a fall with a reported head injury for one (#5) of three sampled resident reviewed for 72 hour observation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following Plan of Correction for Brookdale Weatherford regarding the Statement of Deficiencies dated 12/13/2022. This POC is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related saction or fine. Rather, it is a submitted confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or fininding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

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 resident identified during the survey is alert/oriented X4. There have been no effects from his head injury noted.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents who have had falls recently have been assessed and monitored for injury and interventions have been implemented as described in Brookdale's clinical guidelines.
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?	1. All staff to be inserviced on falls management and specifically, Brookdale's Head Injury guidelines, Alert charting and documentation guidelines. 2. HWD/HWC/E.D. to be inserviced by the District Director Clinical Services on Brookdale's guidelines for falls management. 3. 72 hour follow up will be completed in PCC by staff on all falls, whether there is injury or not. 4. HWD will keep "hot charts" to remind her to check for the 72 hour post fall charing. 5. HWD, or designee, will pull the Incident Log weekly to ensure all follow up is completed for each incident.
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	Correction will be evaluated for effectiveness by weekly monitoring by the Area Nurse Manager for the next 6 weeks through pulling of falls in Falls Management System and checking for PCC documentation. All falls and interventions to be reported in the QA process permanently.

c. How monitoring records will be kept to evidence the correction.	Monitoring records will be kept with the QA notes for review for the next 3 months and reviewed by the Area Nurse Manager or District Director Clinical Services.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/23/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Legend Tate** Legend Tate ED OAC 310:663-25-4(F)	**Date 12/23/2022**

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: lmansel@brookdale.com; jennifer.shaw@brookdale.com

FINAL DETERMINATION NOTICE
Tracking # 7021 2720 0002 0354 7879

February 17, 2023

License Number: AL2001

Mr. Legend Tate, Administrator
Brookdale Weatherford
800 Gartrell Place
Weatherford, OK 73096

Survey Event ID: IEVH13

Dear Mr. Tate:

An offsite/paper revisit conducted **February 16, 2023**, revealed that your facility corrected deficiencies effective **January 23, 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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement 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
	AL2001	A. BUILDING: _____ B. WING _____	R-C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEATHERFORD	800 GARTRELL PLACE WEATHERFORD, OK 73096

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 02/16/23. The center was in substantial compliance.	{C 000}		

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