Oklahoma State Department of Health
Creating a State of Health

October 3, 2019

License Number: AL2401

Ms. Joy Naylor, Administrator
Brookdale Enid
4613 West Willow Road
Enid, OK 73703

RE: Survey Event ID: YBIT11

Dear Ms. Naylor:

Enclosed is a report of the inspection conducted at your Assisted Living Center on **September 12, 2019.** No deficiencies were cited. Oklahoma Statutes 63-1-1910 require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: Brookdale Enid
Address: 4613 West Willow Rd
City, State, Zip: Enid, OK 73703
Provider #: AL2401
Complaint #: OK00054002
Investigation Date(s): 09/11/19 and 09/12/19

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents received adequate and appropriate medical care to include assessment and timely intervention of administration of physician ordered medications.	US

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

An unannounced on-site investigation was initiated on Wednesday, September 11, 2019 at 1:00 p.m.

A sample of eight 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 center's administration of medications that were ordered on an "as needed basis" was conducted.

On 09/11/19 a medication pass was observed. One resident requested and was administered Tylenol for pain.

Eight resident records were reviewed. One resident had numerous changes to antianxiety medication and Tylenol orders starting in June, 2019. The resident's MAR (medication administration record) documented the resident was administered the medications per physician order.

Four residents were asked specifically and all denied any concerns about medication administration by the staff.

Three staff stated a resident's family would call the center and tell the staff to give a medication when the resident was on the medication routinely and could not be administered the requested medication at the time the family wanted it to be given. The staff stated the resident was given the medications per physician order and when the resident was assessed and found to need medication for anxiety or pain.

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

Determination Summary and Follow-Up Action:

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.

Teena Cornett

Teena Cornett, RN CHFS IV

Date report completed: 09/13/2019

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
	AL2401	A BUILDING _____ B WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ENID	4613 WEST WILLOW ROAD ENID, OK 73703

(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 was conducted 09/11/19 and 09/12/19. Complaint #OK00054002 was investigated in conjunction with the survey. Resident census was 33. No deficient practice was cited.	C 000		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL2401	BROOKDALE ENID

Type of Survey (select all that apply)

2	3			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 36967	09/11/2019	09/12/2019	0.50	0.00	10.50	0.00	1.00	1.50
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Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

OCT 04 2019

Oklahoma State Department of Health
Creating a State of Health

REPORT REVISED - INITIAL CHOW

January 16, 2020

License Number: AL2401
Survey Event ID: YBIT11

Ms. Joy Naylor, Administrator
Brookdale Enid
4613 West Willow Road
Enid, OK 73703

Dear Ms. Naylor:

On **September 12, 2019**, agents from our office concluded an Initial survey for a Change of Ownership in conjunction with an investigation at your facility. You were advised of the findings of that investigation in our notice of **October 3, 2019;** however, the original report and letter did not properly identify that the survey was an ***initial survey for a Change of Ownership of the facility***.

The original STATE FORM report has been revised during the **January 16, 2020** administrative review of this case. A copy of the STATE FORM report is included and revised to indicate that this was an initial survey for a change of ownership conducted *09/11/19* and *09/12/19*. The corrected STATE FORM report is being provided for your records and no additional action on your part is required at this time.

If we can be of any further assistance, please contact us at 405-271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2401	A. BUILDING: _____ B. WING _____	C 09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ENID	4613 WEST WILLOW ROAD ENID, OK 73703

(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 Initial Survey for a Change of Ownership was conducted 09/11/19 and 09/12/19. Complaint #OK00054002 was investigated in conjunction with the survey. Resident census was 33. No deficient practice was cited. This survey was amended after an administrative review on January 16, 2020 Lisa McAlister, BSN, RN - Manager of Survey and Compliance	C 000		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL2401	BROOKDALE ENID

Type of Survey (select all that apply)

1	3			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
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SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

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Team Leader ID 1. 36967	09/11/2019	09/12/2019	0.50	0.00	10.50	0.00	1.00	1.50
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Total SA Supervisory Review Hours..... 1.50

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

JAN 23 2020