OKLAHOMA
State Department
of Health

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

June 1, 2023

License Number: AL2401

Ms. Jennifer Shaw, Administrator
Brookdale Enid
4613 West Willow Road
Enid, OK 73703

RE: Survey Event ID: H8XH11

Dear Ms. Shaw:

On **May 22, 2023**, 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.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on May 22, 2023.

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

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Brookdale Enid**
Address: **4613 West WillowRoad**
City, State, Zip: **Enid, OK 73703**
Provider #: **AL2401**
Complaint #: **OK00059486**
Investigation Date(s): **05/18/23, 05/19/23 and 05/22/23**

ALLEGATION(S)

1. The facility failed to ensure medications were administered according to physician's orders.
2. The facility failed to ensure adequate staff to provide care for dependent residents.

An unannounced on-site investigation was initiated 05/18/2023 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls were observed for odors and unmet needs of residents. Staff were observed to interact and assist residents with toileting, transfers, and mobilization to and from activities of choice and to enter or exit the garden areas. A medication administration observation was completed for random residents.

Resident records were reviewed including assessments, care plans, physician orders, nursing notes, medication administration records, treatment records, dietician notes, staffing records, time sheets, and incident reports.

Residents were interviewed related to the medications available and administration, and staff competency and availability to assist with needs. They were asked if they received their care in a timely manner.

Staff members were interviewed regarding medication administrations, the process to ensure medication procurement, and staffing ratios to meet the needs of the residents. They were asked about their ability to provide the appropriate care in a timely manner.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Carrie Randall Digitally signed by Carrie Randall Date: 2023.05.23 14:02:44 -05'00'

Carrie Randall, RN, Clinical Health Facility Surveyor

Date report completed: 05/23/2023

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 05/22/2023

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 on 05/18/23, 05/19/23, and 05/22/23. A complaint investigation (#OK00059486) was conducted in conjunction with the survey. Listed below are abbreviations that will be used thorughout this document. CNA-certified nursing assistant ED-Executive Director L-left MAT-medication administration technician OK-Screen-Oklahoma National Background Check program OSDH-Oklahoma State Dpertment of Health RN-Registered Nurse SNF-skilled nursing facility	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to complete a significant change assessment for one (#3) of eight sampled residents reviewed for resident assessments.	C 522		

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C 522	Continued From page 1 The "Assisted Living Resident Condition and Care Overview" report, dated 05/18/23, documented the census was 26. Findings: An "RN Comprehensive Assessment" policy, last revised 07/01/04, read in part, "...the RN Area Manager or Designee will complete the comprehensive assessment within 14 days of move in...and promptly after a significant change in condition..." Resident #4 had diagnoses which included high blood pressure, dementia, and major depressive disorder. A significant change assessment, dated 05/10/22, documented the resident was oriented to self, needed assistance of one staff for bathing, two staff for dressing and toileting, and one to two staff assistance for transferring. A "Return from Hospital SNF/Note," dated 01/09/23, read in parts, "...Resident transported into community via gurney...Resident will admit to [name] Hospice services for end of life care..." A "Plan of Accommodation," dated 01/09/23, read in part, "...[Resident #4]...admitted to [name] hospice on 01/09/23..." The clinical health record did not contain documentation a significant change assessment had been completed when Resident #4 was admitted to Hospice services. On 05/22/23 at 2:40 p.m., the RN was asked if the significant change assessment, dated 05/01/22, was the last assessment that had been	C 522		

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C 522	Continued From page 2 completed. They stated, "Yes." The RN acknowledged a significant change assessment should have been completed when Hospice services start.	C 522		
C 951 SS=E	310:663-9-5(a) - USE 6000 STAFF QUALIFICATIONS (a) All of the assisted living center's employees shall be subject to the requirements for criminal arrest checks applicable to nurses aides under 63 O.S. Supp. 1997, Section 1-1950.1. 63-1-1950.1(B) 1. Except as otherwise provided by subsection C of this section, before any employer makes an offer to employ or to contract with a nurse aide or other person to provide nursing care, health-related services or supportive assistance to any individual except as provided by paragraph 4 of this subsection, the employer shall provide for a criminal history background check to be made on the nurse aide or other person pursuant to the provisions of this section. If the employer is a facility home or institution which is part of a larger complex of buildings, the requirement of a criminal history background check shall apply only to an offer of employment or contract made to a person who will work primarily in the immediate boundaries of the facility, home or institution. 2. Except as otherwise specified by subsection D of this section, an employer is authorized to obtain any criminal history background records maintained by the Oklahoma State Bureau of Investigation which the employer is required or	C 951		

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C 951	Continued From page 3 authorized to request by the provisions of this section. 3. The employer shall request the Bureau to conduct a criminal history background check on the person and shall provide to the Bureau any relevant information required by the Bureau to conduct the check. The employer shall pay a fee of Fifteen Dollars ($15.00) to the Bureau for each criminal history background check that is conducted pursuant to such a request. 4. The requirement of a criminal history background check shall not apply to an offer of employment made to: a. a nursing home administrator licensed pursuant to the provisions of Section 330.53 of this title, b. any person who is the holder of a current license or certificate issued pursuant to the laws of this state authorizing such person to practice the healing arts, c. a registered nurse or practical nurse licensed pursuant to the Oklahoma Nursing Practice Act, d. a physical therapist registered pursuant to the Physical Therapy Practice Act, e. a physical therapist assistant licensed pursuant to the Physical Therapy Practice Act, f. a social worker licensed pursuant to the provisions of the Social Worker's Licensing Act, g. a speech pathologist or audiologist licensed pursuant to the Speech-Language Pathology and Audiology Licensing Act, h. a dietitian licensed pursuant to the provisions of the Licensed Dietitian Act, i. an occupational therapist licensed pursuant to the Occupational Therapy Practice Act, or	C 951		

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C 951	Continued From page 4 j. an individual who is to be employed by a nursing service conducted by and for the adherents of any religious denomination, the tenets of which include reliance on spiritual means through prayer alone for healing. 5. At the request of the employer, the Bureau shall conduct a criminal history background check on any person employed by the employer, including the persons specified in paragraph 4 of this subsection at any time during the period of employment of such person. 63-1-1950.1(C) 1. An employer may make an offer of temporary employment to a nurse aide or other person pending the results of the criminal history background check on the person. The employer in such instance shall provide to the Bureau the name and relevant information relating to the person within seventy-two (72) hours after the date the person accepts temporary employment. The employer shall not hire or contract with a person on a permanent basis until the results of the criminal history background check are received. 2. An employer may accept a criminal history background report less than one (1) year old of a person to whom such employer makes an offer of employment or employment contract. The report shall be obtained from the previous employer or contractor of such person and shall only be obtained upon the written consent of such person.	C 951		

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C 951	Continued From page 5 This LEVEL A is not met as evidenced by: Based on record review and interview, the center failed to complete background checks for three	C 951		

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C 951	Continued From page 6 (CNA #3, MAT #1 and the dining services coordinator) of seven sampled employees reviewed for background checks upon hire. The "Assisted Living Resident Condition and Care Overview" report, dated 05/18/23, documented the census was 26. Findings: A "Criminal Backgrounds Check" policy, last revised 12/2020, read in part, "...A criminal background check is completed prior to employment. New associates should be considered conditionally employed pending the result of a needed criminal or additional background investigation..." The employee roster documented CNA #3's date of hire was 10/13/22, MAT #1's date of hire was 11/29/22, and the dining services coordinator's date of hire was 08/11/22. CNA #3, MAT #1, and the dining services coordinator employee records did not contain documentation an OK-Screen background check had been completed at the time of employment. On 05/19/23 at 12:15 p.m., the ED #1 provided background checks, dated 05/19/23, for CNA #3, MAT #1, and the dining services coordinator. ED #1 stated they had been using Certiphi (federal background checks) and had just completed the OK-Screen background checks. ED #1 stated they were waiting on two fingerprint results for the dining services coordinator and CNA #3.	C 951		

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C1505	Continued From page 7	C1505		
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 8 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to investigate an injury of unknown origin (facial abrasion and bruising) for one (#3) of two sampled residents reviewed for unknown injuries. The "Assisted Living Resident Condition and Care Overview" report, dated 05/18/23, documented the census was 26. Findings: Resident #3 had diagnoses which included dementia, arthritis, and high blood pressure. An "Annual Resident Assessment" form, dated 06/09/22, documented the resident was forgetful, oriented to person, and had fair judgement. An OSDH "Incident Report Form," dated 10/22/22, read in part, "...initial and final report...Part B...When staff performing rounds, resident observed to have an abrasion to center forehead/glabella (sic) region and bruising below L under eye. When asked resident was unable to recall how the injury occurred...Part C...resident unable to recall nature of injury due to dementia. Staff reports they did not see [Resident #3] out [their] apartment during the night so it likely occurred from a fall during the night in the resident's apartment..." There was no documentation in the clinical record that Resident #3's unknown injury had been investigated. On 05/22/23 at 11:25 a.m., the RN was asked if Resident #3's unknown injury should have been investigated. They stated, "Yes." They were	C1505		

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C1505	Continued From page 9 asked if there was documentation the incident had been investigated. They stated, "No."	C1505		

OKLAHOMA
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Delivery via email to: jennifer.shaw@brookdale.com

June 12, 2023

License Number: AL2401

Ms. Jennifer Shaw, Administrator
Brookdale Enid
4613 West Willow Road
Enid, OK 73703

Survey Event ID: H8XH11

Dear Ms. Shaw:

On **May 22, 2023,** a Licensure 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 **July 10, 2023**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/9/2023** **Facility Name:** Brookdale Enid **License Number:** AL2401 **Survey Event ID:** H8XH11 **Date Survey Completed: 5/22/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522	Based on: record review and interview, the centerfailed to complete a significant changeassessment for one (#3) of eight sampledresidents reviewed for resident assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Enid regarding the Statement of Deficiencies dated 05/22/2023. 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?	Resident (#3) affected is deceased.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected. Area Nurse Manager will audit all current residents for change of condition to ensure significant change assessments have been completed if needed.
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?	District Director of Clinical Services will inservice RN, Area Nurse Manager and HWD on Change of Condition Policy and Procedure. Area Nurse Manager will review residents identified weekly on the At Risk Call for significant change assessments to ensure documentation weekly for 4 weeks.
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.	RN Area Nurse Manager or designee and HWD or designee will review the Weekly At Risk Form weekly. ED or designee will review Weekly At Risk Form for compliance for 4 weeks. Monitoring results will be reviewed at QA meetings. Monitoring will be documented and signed by Area Nurse Manger or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Jennifer Shaw	**Date 6/9/2023**

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: 6/9/2023** **Facility Name:** Brookdale Enid **License Number:** AL2401 **Survey Event ID:** H8XH11 **Date Survey Completed: 5/22/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C951	Based on: record review and interview, the centerfailed to complete background checks for three (CNA #3, MAT #1 and the dining servicescoordinator) of seven sampled employeesreviewed for background checks upon hire.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Enid regarding the Statement of Deficiencies dated 05/22/2023. 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?	Background checks were run through OKScreen and Final Approval received for three identified associates on May 22, 2023 before survey exited.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected. Background checks were run through OKScreen and Final Approval received for all current associates.
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?	Executive Director and Executive Director in Training will be in-serviced on background check regulation. New Hire Checklist for Oklahoma will be updated to include OKScreen background check process.
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.	Executive Director or designee will review new hire report and look for background checks in OKScreen for 4 weeks. District Director of Operations or designee will review new hire report and look for background checks in OKScreen for 4 weeks. Monitoring results will be reviewed at QA meetings. Monitoring results will be documented and signed by ED and District Director of Operations.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Jennifer Shaw	**Date 6/9/2023**

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: 6/9/2023** **Facility Name:** Brookdale Enid **License Number:** AL2401 **Survey Event ID:** H8XH11 **Date Survey Completed: 5/22/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: record review and interview, the centerfailed to investigate an injury of unknown origin(facial abrasion and bruising) for one (#3) of twosampled residents reviewed for unknown injuries.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Enid regarding the Statement of Deficiencies dated 05/22/2023. 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?	Resident (#3) affected is deceased.
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 current residents will have a skin assessment to ensure there are no injuries of unknown origin.
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?	HWD will be in-serviced on Injuries of Unknown Origin Investigation Form and Head Injury Policy. In-services all associates on Residents Rights and Shift-to-Shift "Hand-Off" Communication and Report Policy CS-100-26. ED or designess and HWD or designee will review reports and sign off daily.
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.	RN Area Nurse Manager or designee and HWD or designee will review the monthly Skin Observation Forms for unknown injury and ensure investigations have been completed as needed for 3 months. ED or designee will review Skin Observation Forms and investigations for compliance for 3 months. Monitoring results will be reviewed at QA meetings. Monitoring will be documented and signed by Area Nurse Manger or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Jennifer Shaw	**Date 6/9/2023**

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: jennifer.shaw@brookdale.com

August 29, 2023

License Number: AL2401

Ms. Jennifer Shaw, Administrator
Brookdale Enid
4613 West Willow Road
Enid, OK 73703

RE: Survey Event H8XH12

Dear Ms. Shaw:

On **August 28, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 22, 2023,** have now been corrected effective **July 10, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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 _____	R-C 08/28/2023

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 offsite/paper revisit was conducted on 08/21/23 and 08/28/23. 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