OKLAHOMA
State Department
of Health

Delivery via email to: RobMar2@brookdale.com

June 4, 2024

License Number: AL2601

Mr. Robert Marchbanks, Administrator
Brookdale Chickasha
801 Country Club Road
Chickasha, OK 73018

RE: Survey Event ID: WMSX11

Dear Mr. Marchbanks:

On **May 29, 2024**, 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 29, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action 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 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,

Lisa Calvin

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2601	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHICKASHA	801 COUNTRY CLUB ROAD CHICKASHA, OK 73018

(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 05/24/24 and 05/28/24 through 05/29/24. Facility Census: 31 The following abbreviations are used throughout the document: BP - blood pressure CMA - certified medication aide HTN - hypertension MAR - medication administration record mg - milligram O2 - oxygen OSDH - Oklahoma State Department of Health P - pulse R - respiration Res - resident T - temperature VS - vital signs	C 000		
C 391 SS=D	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure food was stored with date and labels. The Executive Director identified 29 residents resided in the facility and received services from the kitchen.	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2601	A. BUILDING: _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 391	Continued From page 1 Findings: A facility "Storage of Perishable Food" policy, dated 5/10/05, documented in parts "...All pre-dished items must be covered, labeled, and dated..." On 05/24/24 at 09:30 a.m., a tour of the kitchen was conducted. On 05/24/24 at 09:34 a.m., the three door refrigerator was observed containing the following: a. two packages of boiled eggs, one open to air, without date or label, b. a large bowl of mixed salad covered with foil, without date or label, c. spaghetti sauce in a pour spout container dated 05/22/24, d. a container of tropical fruit without a date, e. a bag of diced tomato without label or date, and f. a gallon bag containing two triangular shaped items wrapped in red and white checkered paper. On 05/24/24 at 9:40 a.m., Cook #1 stated they check the refrigerator every morning for food that needs to be disposed of. They stated they did not do so this morning because they were running behind. They stated food needed to be labeled and dated or it would be thrown away.	C 391		
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	C1505		

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C1505	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure physician orders were followed regarding blood pressure parameters for one (#1) of eight sampled residents whose physician orders were reviewed	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2601	A. BUILDING: _____ B. WING _____	05/29/2024

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C1505	Continued From page 3 and medications were administered according to physician orders for one (#7) of seven sampled residents observed during medication pass. The Executive Director identified 29 residents resided in the facility. Findings: A facility "Vital Signs Policy", revised 11/2018, documented in parts "...VS readings for BP, P, T, and R outside of the normal range or parameters as specified by the physician/healthcare provider order, should be reported to the Health and Wellness Director (HWD)/nurse/designess as soon as possible..." A facility "Medication & Treatment - Administration/Assistance" policy, revised 03/31/22, documented in parts "...The individual assisting and or administering the medication should 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 #1 had diagnoses which included HTN. A physician order, dated 12/07/23, documented to check vital signs including BP, pulse, temp, and O2 saturation twice per day. The order documented to notify the provider if blood pressure was greater than 160/90, or less than 90/60 and if O2 saturation was less than 90%. A MAR for December 2023 documented vital signs that required provider notification 19 out of 49 opportunities. A MAR for January 2024 documented vital signs	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2601	A. BUILDING: _____ B. WING _____	05/29/2024

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C1505	Continued From page 4 that required provider notification one out of one opportunities. On 05/28/24 at 2:46 p.m., the Wellness Director stated the CMAs should notify the nurse of out of parameter vital signs and the provider contacted. They stated contact with the physician would be documented in the progress notes. They stated they were not notified of the vital signs in December 2023 or January 2024. 2. Res #7 had diagnoses which included HTN. A physician order, dated 01/29/24, documented to administer hydralazine 50 mg 1.5 tablet by mouth in the afternoon. On 05/28/24 at 1:12 p.m., CMA #1 was observed during medication pass for Res #1. The CMA was observed preparing a single 50 mg hydralazine tablet for administration and handing it to the resident. The CMA was stopped before administering the incorrect dose to the resident. On 05/28/24 at 1:14 p.m., CMA #1 was asked what dose the resident was supposed to receive, they stated 75 mg.	C1505		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2601	A. BUILDING: _____ B. WING _____	05/29/2024

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C1911	Continued From page 5 investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the faciilty failed to report a fall with major injury within one business day for one (#5) of eight sampled residents comprehensively reviewed. The Executive Director identified 29 residents resided in the facility. Findings: A "Reportable Events" policy, revised 04/2022, documented in parts "...the community/agency must adhere to all state specific, statutory and regulatory reporting requirements and time frames..." Res #5 had diagnoses which included HTN, gout,	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2601	A. BUILDING: _____ B. WING _____	05/29/2024

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C1911	Continued From page 6 and diabetes. A progress note, dated 04/14/24 at 7:00 p.m., documented Res #5 had a fall resulting in a head wound. A hospital note, documented Res #5 sustained a head injury and laceration requiring sutures. A state report, dated 04/14/24, was not received by OSDH until 04/18/24. On 05/29/24 at 11:58 a.m., the ED stated the incident report was missed and they were aware it was submitted late.	C1911		

OKLAHOMA
State Department
of Health

Delivery via email to: RobMar2@brookdale.com

June 17, 2024

License Number: AL2601

Mr. Marchbanks, Administrator
Brookdale Chickasha
801 Country Club Road
Chickasha, OK 73018

RE: Survey Event WMSX11

Dear Mr. Marchbanks:

On **May 29, 2024,** agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1505:** The POC for C1505 does not address notification to the physician.

Please provide an Amended plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/11/2024** **Facility Name:** Brookdale Chickasha **License Number:** AL2601 **Survey Event ID:** WMSX11 **Date Survey Completed: 5/29/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: observation, record review, andinterview, the facility failed to ensure food was stored with date and labels.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Chickasha regarding the Statement of Deficiencies dated 05/29/2024. 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?	Food that was not stored, dated and labeled correctly was discarded on 5/24/2024.
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.
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 will in-service dining associates on the Storage of Perishable Food- DS-04.014 policy. Dining Service Coordinator or designee will audit the food storage weekly to ensure food is stored, dated and labeled correctly each week for 6 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.	ED will audit the food storage log weekly. ED or designee will review food storage log weekly for compliance for 6 weeks. Monitoring results will be reviewed at QA meetings monthly for 3 months. Monitoring will be documented and signed by the ED or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/12/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. LWHA	**Date 6/13/2024**	

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.

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: 6/11/2024** **Facility Name:** Brookdale Chickasha **License Number:** AL2601 **Survey Event ID:** WMSX11 **Date Survey Completed: 5/29/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: observation, record review, and interview, the facility failed to ensure physician orders were followed regarding blood pressure parameters for one (#1) of eight sampled residents whose physician orders were reviewed and medications were administered according to physician orders for one (#7) of seven sampled residents observed during medication pass.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Chickasha regarding the Statement of Deficiencies dated 05/29/2024. 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 (#1) no longer has parameters related to the administration of her HTN medication. Resident (#7) correct dosage of medication was ordered and obtained from the pharmacy on 5/28/2024.
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 medications were reviewed to ensure correct dosage was on hand.
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 in-serviced Health and Wellness Director, Health and Wellness Coordinator and all associates on Residents Rights. Health and Wellness Director in-serviced all CMAs and Medication Adminstration Technicians on Medication & Treatment Administration/Assistance Policy and Vital Sign Policy. Health and Wellness Director or designee will track parameter orders on parameter log and review vital signs twice per week to ensure compliance. Health and Wellness Director or designee will do weekly medication cart audits to ensure that proper dosage of medication is available.
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	HWD or designee will review weekly cart audits and parameters log weekly for 6 weeks. Area Nurse Manager or designee will review cart audit and parameters logs for compliance. Monitoring results will be reviewed at QA meetings monthly for 3 months.

c. How monitoring records will be kept to evidence the correction.	Monitoring will be documented and signed by Area Nurse Manager or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/12/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. LWHA OAC 310:663-25-4(F)	**Date 6/13/2024**

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: 6/11/2024

Facility Name: Brookdale Chickasha

License Number: AL2601

Survey Event ID: WMSX11

Date Survey Completed: 5/29/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1911	Based on: record review and interview, the facility failed to report a fall with major injury within one business day for one (#5) of eight sampled residents comprehensively reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Chickasha regarding the Statement of Deficiencies dated 05/29/2024. 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 (#5) incident was submitted on 4/18/204.
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.
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 Health and Wellness Director have been in-serviced on the Reportable Events Policy and Oklahoma State Regulations 310:663-19-1 Incident Reports. Executive Director or designee will review all incident reports during stand-up to ensure State Reportable have been completed and submitted within 1 business day.
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 Reportables binder weekly. Executive Director or designee will review Reportables binder weekly for compliance for 6 weeks. Monitoring results will be reviewed at QA meetings monthly for 3 months. Monitoring will be documented and signed by Area Nurse Manager or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/12/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 6/13/2024**

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: RobMar2@brookdale.com

June 18, 2024

License Number: AL2601

Robert Marchbanks, Administrator
Brookdale Chickasha
801 Country Club Road
Chickasha, OK 73018

RE: Survey Event WMSX11

Dear Mr. Marchbanks:

On **May 29, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your Amended 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 12, 2024**.

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/11/2024** **Facility Name:** Brookdale Chickasha **License Number:** AL2601 **Survey Event ID:** WMSX11 **Date Survey Completed: 5/29/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: observation, record review, andinterview, the facility failed to ensure food was stored with date and labels.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Chickasha regarding the Statement of Deficiencies dated 05/29/2024. 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?	Food that was not stored, dated and labeled correctly was discarded on 5/24/2024.
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.
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 will in-service dining associates on the Storage of Perishable Food- DS-04.014 policy. Dining Service Coordinator or designee will audit the food storage weekly to ensure food is stored, dated and labeled correctly each week for 6 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.	ED will audit the food storage log weekly. ED or designee will review food storage log weekly for compliance for 6 weeks. Monitoring results will be reviewed at QA meetings monthly for 3 months. Monitoring will be documented and signed by the ED or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/12/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. WHA	**Date 6/13/2024**	

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.

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: 6/11/2024** **Facility Name:** Brookdale Chickasha **License Number:** AL2601 **Survey Event ID:** WMSX11 **Date Survey Completed: 5/29/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: observation, record review, and interview, the facility failed to ensure physician orders were followed regarding blood pressure parameters for one (#1) of eight sampled residents whose physician orders were reviewed and medications were administered according to physician orders for one (#7) of seven sampled residents observed during medication pass.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Chickasha regarding the Statement of Deficiencies dated 05/29/2024. 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 (#1) no longer has parameters related to the administration of her HTN medication. Resident (#7) correct dosage of medication was ordered and obtained from the pharmacy on 5/28/2024.
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 medications were reviewed to ensure correct dosage was on hand.
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 in-serviced Health and Wellness Director, Health and Wellness Coordinator and all associates on Residents Rights. Health and Wellness Director in-serviced all CMAs and Medication Adminstration Technicians on Medication & Treatment Administration/Assistance Policy and Vital Sign Policy. CMA/Med Tech or designee will notify nurse or designee it vitals are outside of parameters and nurse or designee will notify physician. Health and Wellness Director or designee will track parameter orders on parameter log and review vital signs twice per week to ensure compliance. Health and Wellness Director or designee will do weekly medication cart audits to ensure that proper dosage of medication is available.
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;	HWD or designee will review weekly cart audits and parameters log weekly for 6 weeks. Area Nurse Manager or designee will review cart audit and parameters logs for compliance.

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.	Monitoring results will be reviewed at QA meetings monthly for 3 months. Monitoring will be documented and signed by Area Nurse Manager or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/12/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. 6/14/24 OAC 310:663-25-4(F)	**Date 6/13/2024**

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	6/17/2024	**Submitted by**	Robert Marchbanks, ED

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: 6/11/2024

Facility Name: Brookdale Chickasha

License Number: AL2601

Survey Event ID: WMSX11

Date Survey Completed: 5/29/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1911	Based on: record review and interview, the facility failed to report a fall with major injury within one business day for one (#5) of eight sampled residents comprehensively reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Chickasha regarding the Statement of Deficiencies dated 05/29/2024. 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 (#5) incident was submitted on 4/18/204.
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.
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 Health and Wellness Director have been in-serviced on the Reportable Events Policy and Oklahoma State Regulations 310:663-19-1 Incident Reports. Executive Director or designee will review all incident reports during stand-up to ensure State Reportable have been completed and submitted within 1 business day.
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 Reportables binder weekly. Executive Director or designee will review Reportables binder weekly for compliance for 6 weeks. Monitoring results will be reviewed at QA meetings monthly for 3 months. Monitoring will be documented and signed by Area Nurse Manager or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/12/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 6/13/2024**

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: RobMar2@brookdale.com

July 25, 2024

License Number: AL2601

Mr. Robert Marchbanks, Administrator
Brookdale Chickasha
801 Country Club Road
Chickasha, OK 73018

RE: Survey Event WMSX12

Dear Mr. Marchbanks:

On **July 24, 2024,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 29, 2024,** have now been corrected effective **July 12, 2024.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2601	A. BUILDING: _____ B. WING _____	R 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CHICKASHA	801 COUNTRY CLUB ROAD CHICKASHA, OK 73018

(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 On 07/24/24, an offsite/revisit was conducted. The deficiencies from 07/24/24 were cleared.	{C 000}		

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