OKLAHOMA
State Department of Health

**Delivery via email to:** RobMar2@brookdale.com

October 21, 2024

License Number: AL2601

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

**Survey Event ID: VOOK11**

Dear Mr. Marchbanks:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **October 15, 2024**. No deficiencies were cited. Oklahoma Statutes 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) 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

# INVESTIGATIVE REPORT

**Facility: Brookdale Chickasha**
**Address: 801 Country Club Rd**
**City, State, Zip: Chickasha, OK, 73018**
**Provider #: AL2601**
**Complaint #: OK00066492**
**Investigation Date(s): 10/15/24**

| ALLEGATION(S) |
| --- |
| The facility failed to provide a safe environment that is free of accident hazards. |

An unannounced on-site investigation was initiated 10/15/2024 at 8:00 a.m.

A sample of three 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:**

Resident apartments were observed to have carpet intact without buckling or ripples.

Maintenance logs were reviewed for concerns with carpeting.

Staff and residents were interviewed regarding a safe environment.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/16/2024

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of Health

# INVESTIGATIVE REPORT

**Facility: Brookdale Chickasha**
**Address: AL2601**
**City, State, Zip: Chickasha, OK, 73018**
**Provider #: AL2601**
**Complaint #: OK00066798**
**Investigation Date(s): 10/15/24**

| ALLEGATION(S) |
| --- |
| The facility failed to ensure unqualified personnel were not providing wound care. |

An unannounced on-site investigation was initiated 10/15/2024 at 8:00 a.m.

A sample of three 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 review of records was conducted to include resident medical records, medication administration records, job descriptions, and employee certifications and license.

Staff and residents were interviewed regarding staff qualification.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/16/2024

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| 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 _____ | C 10/15/2024 |

| 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<br><br>A complaint survey (#OK00066492 and #OK00066798) was conducted on 10/15/24. No deficiencies were cited.<br><br>Facility Census: 24 | C 000 | | |

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