

Delivery via email to: holly@ncsolutions.net; Admin@westbrookgardens.com

July 28, 2021

License Number: AL4401

Ms. Holly Mattingly, Administrator
Westbrook Gardens SLC
1215 Westbrook Blvd
Purcell, OK 73080

Survey Event ID: Y11711

Dear Ms. Mattingly:

On **July 13, 2021**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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. 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 will be completed for each violation; and
- (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,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.07.28 16:08:37 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Westbrook Gardens SLC
Address: 1215 Westbrook Blvd
City, State, Zip: Purcell, OK 73080
Provider #: AL4401
Complaint #: OK00057254
Investigation Date(s): 07/01/21, 07/12/21 and 07/13/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were not verbally abused and physically intimidated	S

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

An unannounced on-site investigation was initiated on Thursday, July 1, 2021 at 12:25 p.m.

A sample of eight residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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:

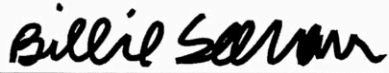
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1512 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, reading "Billie Seeman". The signature is written in a cursive, flowing style. Below the signature is a horizontal line.

Billie Seeman, RN, Clinical Health Facility Surveyor

Date report completed: 07/14/2021

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER WESTBROOK GARDENS SLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 WESTBROOK BLVD PURCELL, OK 73080		
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C 000	INITIAL COMMENTS An abbreviated survey was conducted on 07/01/21, 07/12/21 and 07/13/21 to investigate complaint #OK00057254. Total residents: 35	C 000		
C 522 SS=E	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 interview and record review, it was determined the center failed to ensure an annual comprehensive assessment was completed for two (#2 and #3) of three sampled residents. The center identified 35 residents who resided in the center. Findings: 1. Resident #2's clinical record documented the resident was admitted on 12/23/19. The clinical record revealed an annual assessment for the year 2020 had not been completed. 2. Resident #3's clinical record documented the resident was admitted on 03/02/19. The clinical	C 522		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 522	Continued From page 1 record revealed an annual assessment for the year 2021 had not been completed. On 07/12/21 at 3:53 p.m., the licensed practical nurse (LPN)/director of nursing (DON) was asked if she had found the missing annual assessments. She stated no.	C 522		
C1512 SS=E	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting:	C1512		

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C1512	Continued From page 2 a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to ~ ensure residents were protected from verbal abuse and intimidation by staff and; ~ ensure an allegation of verbal abuse was investigated for two (#2 and #4) of five sampled residents who were reviewed for abuse allegations. The center identified 35 residents who resided in	C1512		

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C1512	Continued From page 3 the center. Findings: The center's policy, titled, 'Abuse and Neglect', dated 03/10/20, documented, "...Every resident has the right to be free from abuse...Residents must not be subjected to abuse by anyone, including but not limited to employees...Every resident has the right to be free from mistreatment...The community reports alleged violations, conduct and investigation of all alleged violations, to proper authorities and takes necessary corrective actions... Abuse is defined as willful infliction of injury...intimidation or punishment with resulting physical, emotional or psychological harm, pain or mental anguish...types of abuse...Verbal: Using profanity, name calling, cruel teasing...Mental: Any act that makes a resident fearful, feel belittled or to make fun of a resident by mocking, imitating or ridiculing... All reports...reported immediately to the Administrator and Director of Nursing Care (DONC)...complete investigation...Staff is required to intervene, identify and correct situations where any type of abuse may occur..." The center's policy, titled, 'Resident Bill of Rights', dated 08/2020, documented, "...To ensure that all resident rights are respected and protected...Westbrook Gardens SLC will adhere to the Resident Bill of Rights as listed in the Resident Handbook as follows...be treated with dignity and respect...be treated fairly, courteously and with respect be [sic] staff...be free physical or psychological abuse from staff..."	C1512		

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C1512	Continued From page 4 The personnel files for the licensed practical nurse (LPN)/director of nursing (DON) and the community manager revealed they had received training on abuse and reporting. Resident #2 had diagnoses which included essential hypertension and atrial fibrillation. The resident's clinical record did not contain a current assessment. A quarterly self-med evaluation, dated 06/03/21, documented the resident had the mental capability to self administer her medications. The LPN/DO stated the resident was alert and oriented to person, place and time. Resident #4 had diagnoses which included heart failure and anxiety. A pre-admission assessment, dated 06/11/2020, documented the resident was alert, oriented to person, place and time, and revealed no history of mental health or abnormal behaviors. The assessment documented the resident's usual mood was calm. A quarterly self-med evaluation, dated 06/03/21, documented the resident had the mental capabilities to self administer her medication. A note which described an incident between the community manager, LPN, resident #2 and resident #4, dated 06/14/21, documented, "...It was reported to [Community manager] that [Resident #4] has been having other residents do her laundry, carrying things upstairs for her, tidying up her apartment (making her bed) and	C1512		

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C1512	Continued From page 5 delivering meals to her apartment. Mid-morning [Resident #4] and [Resident #2] were observed waiting and pacing by the front doors. A person...arrived with a large package and a few other items. Upon entering the building, it was noted the [Resident #4] had a water dispenser and pillow shams on her walker. [Resident #2] had an unwrapped and unfolded comforter on her walker. [Community manager] approached [Resident #2] and folded the comforter and placed it on [Resident #4] walker. At this time, it was explained with the comforter hanging off of the walker that she could trip or fall by getting her walker caught in the comforter or that she may stumble over it. [Resident #4] was irritated and didn't want to carry the comforter, she wanted...[Resident #2] to take it up to her apartment for her. [Community manager] explained that it was HER comforter and that she could place it on HER walker to take it to her apartment. [Community manager] and [LPN] met and discussed the on-going problem with [Resident #4] manipulating residents to take care of her and to do task that she is capable of. It was decided we meet with [Resident #4] and explain that it isn't other resident's responsibilities to take care of her. If she is in need of assistance, we are there to help her. [LPN] and [Community manager] knocked and announced themselves upon entering [Resident #4]'s apartment. [Resident #2] was observed sitting on the couch out of breath and panting and [Resident #4] was sitting in her chair reading a book. [Resident #4]'s bed was completely re-made with the new comforter and shams on her bed. [LPN] asked about who made her bed?	C1512		

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C1512	Continued From page 6 [Resident #2] and [Resident #4] both began explaining that [Resident #4] wasn't able to make it but she did try to help some. [Community manager] explained that this is assisted living and we have staff that will assist her that it isn't another resident's responsibility to take care of her. [Resident #4] stood up and placed her hands on her hips and yelled that "no one will tell her wait [sic] to do!" She wavered a little and [Community manager] asked her to sit down and she stated she "will not sit down!" and [Community manager] stepped closer to her and told her that it will stop today of her asking/guiling other residents to take care of her responsibilities. It was further explained that a resident could be injured by lifting, carrying and doing things that they shouldn't be doing by taking care of her. [Community manager] explained that it is assisted living and part of that was socializing and that sitting in a dark (blinds shut & lights off) wasn't healthy and that she needs to do more for herself and if she is unable to manage a task by herself that she should ask WBG [Westbrook Gardens] staff to help her. [Community manager] notified...[Resident #2]'s daughter of the occurrence and we are doing our best to have [Resident #4] ask WBG staff for assistance rather than having other residents take care of [Resident #4]. She appreciated the call...further explained that her mom had ask her to pick up some items for her at the store and she now realizes that she was picking thing s up for [Resident #4] and not her mother. She did get reimbursed for the money spent." A nurse's note, dated 06/14/21 at 2:44 p.m., documented the LPN/DON and the community manager went to speak with resident #4 due to staff reporting other residents were doing a lot of	C1512		

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C1512	Continued From page 7 favors for resident #4, such as cleaning her apartment, making her bed, doing her laundry. The note documented, "...[Community manager and [resident #4] proceeded to have...loud argumentative discussion about ALF [assisted living facility] and not having other residents do things for her, but if she needed help for her to call upon staff." The state reportable incident reports were reviewed and revealed the above incident had not been reported to the Oklahoma State Department of Health. On 07/01/21 at 2:25 p.m., resident #4 was asked how the staff treated her. She stated they all treated her well except the administrator. She was asked the name of the administrator. She stated the community manager's name. She stated there had been an incident involving the community manager, herself and another resident. She stated she had gotten a new comforter and resident #2 was going to help her bring it to her room. The resident stated the community manager "jerked" it off of resident #2's walker and threw it on resident #4's walker. She stated after the incident with the comforter, resident #2 was in resident #4's apartment, when the LPN and the community manager entered the apartment. She stated the community manager was "chewing out" resident #2. She then stated the community manager told her all you do is sit in the chair and watch TV and have others do for you. Resident #4 stated the community manager was yelling at her and they had words back and forth. She stated she stood up from her chair and she thought the community manager was going to hit her. She stated the community manager stated, "You don't think I know what goes on in	C1512		

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C1512	Continued From page 8 my facility." The resident was asked if the community manager raised her voice when she was speaking to her. She stated, "Oh yes, and so did I." At 2:40 p.m., resident #2 was asked if she knew the name of the administrator. She also identified the community manager as the administrator. She stated there had been an incident with her trying to help another resident with her comforter. She stated the community manager took the comforter off of her walker and "slammed it down" on resident #4's walker and told her she was not allowed to do work for other people. The resident then stated she went to resident #4's apartment. She stated the LPN and community manager came to the apartment. She stated resident #4 allowed them to enter the apartment. She stated she was sitting on the couch and the LPN and community manager were standing near the entrance. The resident stated the community manager stated to her, "So, now you are here to help put it on the bed." She stated the community manager "went off" and started saying, "We do not allow this." "Do you want to get paid for doing things." "Well here is the thing that she just sits up here and expects everyone to do things for her." Resident #2 stated the community manager told resident #4, all you do is sit in front of the TV and have other people do things for you. She also stated the community manager stated other residents were doing resident #4's laundry. Resident #2 stated resident #4 stood up and the community manager moved towards resident #4	C1512		

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C1512	Continued From page 9 and was saying things about resident #4 to her. She was asked what the community manager was saying. She stated, "Insults" about resident #4. Resident #2 stated the community manager had a different personality but she felt the situation was "uncalled for." The resident stated the community manager stated "I am going to call your daughter." She stated she felt like a three year old and the community manager was going to tell on her. Resident #2 stated the encounter upset both her and resident #4 and she thought the community manager might "Put her out" but things were fine now and she was not going to worry about it. Resident #2 was asked if she had done things for resident #4. She stated she tried to bring resident #4 some milk but the staff would not let her. At 3:34 p.m., resident #1 who was identified by the LPN to be alert and oriented to person, place, time and situation was asked if she had done laundry for resident #4. She stated no. She was asked if she had ever been yelled at by the staff. She stated yes, the community manager had yelled at her because the community manager thought she was trying to help another resident. She stated she also witnessed the community liaison yell at a visitor for not wearing a mask. At 3:55 p.m., resident #3 who was identified by the LPN to be alert and oriented to person, place, time and situation was asked how the staff treated her. She stated the community manager was a "bully." She stated the community manager would get in your face. The resident stated the community manager came busting in her	C1512		

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C1512	Continued From page 10 apartment without knocking because she thought the she was smoking. On 07/12/21 at 2:56 p.m., the LPN/DON was asked if there had been an incident between the two residents and the community manager. She stated yes. She was asked if she witnessed the incident. She stated yes. She stated she knew the community manager would not allow resident #2 to assist resident #4 with the comforter due to safety issues. The LPN stated she was going to speak with resident #4 and the community manager went with her. The LPN stated when they got to the apartment resident #2 was on the couch and resident #4 was in her recliner. She stated resident #2 was short of breath. The LPN stated resident #4 and the community manager had a conversation and both the community manager and the resident were upset and both of them were loud. She stated resident #4 stood up and put her hands on her hips and stated, "No one talks to me that way." The LPN was asked what that meant. She stated with a higher tone. The LPN stated the community manager told the resident to sit down. She stated resident #4 stated she did not have to sit down, that this was her apartment. The LPN was asked if the community manager moved closer to the resident during this interaction. She stated yes, the community manager took two steps closer to the resident during the time she was telling the resident to sit down. She stated they continued for a few more minutes and she told the community manager it was time to leave.	C1512		

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C1512	Continued From page 11 The LPN was asked if the community manager threatened to call resident #2's daughter. She stated yes. She was asked if the community manager raised her voice when she was speaking with resident #4. She stated yes. She was asked if it was appropriate to raise your voice when speaking to a resident. She stated no. She was asked if this was considered verbal abuse. She stated yes. She was asked if she reported it to the administrator. She stated the community manager was the administrator. She stated she did not have anyone to report it to because the community manager was the next person above her. At 3:15 p.m., the administrator was asked why the residents and staff thought the community manager was the administrator. She stated she did not know. She stated they knew she was the community manager's boss. The administrator was asked about the incident involving resident #2 and #4), the LPN, and the community manager. She stated she was aware that Adult Protective Services came out and that both the LPN and the community manager told her about the incident. She stated resident #2 loved to be helpful and resident #4 loved to be waited on. The administrator stated resident #1 and resident #2 had taken meals to resident #4. She stated the community manager told resident #4 it was her responsibility to take the new comforter to her apartment. The administrator stated when the LPN and the	C1512		

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C1512	Continued From page 12 community manager went to resident #4's apartment; resident #2 was worn out. The administrator was asked why the LPN and the community manager went to speak with resident #4. She stated the community manager told resident #4 she could not ask other residents to do stuff for her due to safety reasons. She stated the community manager reported to her that resident #4 stated, "No one was going to talk to her that way." She was asked what that meant. She stated tell her what to do. She was asked if she had followed up with the residents involved in the incident. She stated no. At 3:27 p.m., the community manager stated residents had been taking meals to resident #4 and doing her laundry. The community manager was asked if she had documentation of the residents doing resident #4's laundry and taking her meals. She stated no, only the document from 06/14/21. The community manager was asked about the new comforter for resident #4. She stated the comforter was unfolded and hanging off of resident #2's walker, so she removed the comforter from resident #2's walker, folded it and placed it on resident #4's walker. She stated the LPN and herself decided they needed to speak with resident #4 about having other residents do things for her. She stated resident #2 was sitting on the couch panting with her arms to her side. The community manager stated they asked if she was okay and resident #2 stated she was fine. The community manager stated resident #2 was asked if she made resident #4's bed with the new comforter.	C1512		

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C1512	Continued From page 13 Resident #4 stated resident #2 wanted to make the bed. The community manager stated she told resident #4 the center's staff could help her with things and that resident #2 was not here to make her bed or take care of her. The community manager stated resident #4 stood up and put her hands on her hip and yelled at her, "You don't tell me what to do, my friends can help if they want to." The community manager stated she told resident #4 to look at resident #2 she was worn out. She stated the resident also stated she was tired of her telling her what to do. The community manager was asked if she moved closer to the resident when she was speaking with her. She stated yes, she moved a foot closer. She was asked if she raised her voice to the resident. She stated she used a "firm voice." She was asked if she had threatened to call resident #2's daughter. She stated no, she had said she needed to call resident #2's daughter but not in a threatening manner. The community manager was asked if she threw the comforter onto resident #4's walker. She stated no, she folded it. She was asked if resident #2 was upset after the incident. She stated, "Yes, it was uncomfortable for her." At 3:53 p.m., the LPN was asked again if the community manager raised her voice when she was speaking with resident #4. She stated yes. She was asked what the community manager said to resident #2 about calling her daughter. She stated the community manager told resident	C1512		

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C1512	Continued From page 14 #2, "Do you want me to call your daughter and have a talk with her?" She was asked if resident #2 seemed upset about the incident. She stated she was pretty anxious by the time it was all over with. At 4:33 p.m., the administrator was asked to define verbal abuse. She stated by the way something is interpreted, the way something is said, belittling someone and using curse words. She was asked if she considered what was reported to her as an allegation of abuse. She stated it depended, she was not there. She was asked if she followed up with resident #4 after she was made aware of the incident. She stated no, the resident was gone for about a week. She stated the staff did not tell her the resident was gone until she returned. She stated she did not follow up with the resident when she returned. She stated everything seemed fine when she returned. On 07/13/21 at 11:47 a.m., the administrator was asked how she would define an allegation. She stated someone alleged someone said or did something to them.	C1512		
C6000 SS=E	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with	C6000		

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C6000	Continued From page 15 subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and	C6000		

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C6000	Continued From page 16 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services. This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the center failed to provide a criminal history background check for two (employee #4 and #5) of four sampled employees. This had the potential to affect all 35 residents. The center identified 35 residents resided in the center. Findings: The center's policy, titled, 'Personnel Files', dated 05/2020, documented, "...Each employee will have a personnel file which may include but not be limited to the following...Criminal Background check..."	C6000		

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C6000	Continued From page 17 The center's policy, titled, 'Reference Checks and Criminal Background checks', dated 05/2020, documented, "...All employees will be subject to the requirements for criminal background and reference checks...The Administrator will conduct a criminal background check..." The center's employee handbook, documented, "...Background checks are required on all employees of Westbrook Gardens..." A review of employee #4's file revealed the employee and quit working for the center in 09/2020 and was re-hired on 02/25/21. The center did not submit the employee to OK Screen for a background check upon re-hire. A notice from the Oklahoma State Department of Health (OSDH), dated 06/19/21, documented employee #4 had a change in his registry results, which may have resulted in a change in his eligibility to be employed. A review of employee #5's file revealed the employee was hired on 06/08/2020 and did not have a background check done within sixty days of hire. On 07/13/21 at 9:45 a.m., the administrator was asked about the background checks. She stated the community manager had been on the phone with OSDH about the employees and provided a clearance letter dated 07/13/21 for employee #5 and provided a clearance letter dated 05/22/18 for employee #4 which was from his previous employment with the center. At 9:52 a.m., an employee from the OK Screen department from OSDH was contacted. She	C6000		

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C6000	Continued From page 18 stated employee #5 received clearance on 07/13/21 and employee #4 had an application started on 07/12/21 but it was not submitted. She stated she showed the employee had not been removed from the center's roster when he quit in September of 2020.	C6000		



OKLAHOMA
State Department
of Health

Delivery via email to: Admin@westbrookgardens.com; holly@nscsolutions.net

August 6, 2021

License Number: AL4401

Ms. Holly Mattingly, Administrator
Westbrook Gardens Slc
1215 Westbrook Blvd
Purcell, OK 73080

Survey Event ID: Y11711

Dear Ms. Mattingly:

On **July 13, 2021**, a complaint investigation was 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 **August 15, 2021**.

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.

Sincerely,

Tempal Killman

Digitally signed by Tempal
Killman
Date: 2021.08.06 07:59:25 -05'00'

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

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Oklahoma State Department of Health

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C 000	INITIAL COMMENTS An abbreviated survey was conducted on 07/01/21, 07/12/21 and 07/13/21 to investigate complaint #OK00057254. Total residents: 35	C 000		
C 522 SS=E	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 interview and record review, it was determined the center failed to ensure an annual comprehensive assessment was completed for two (#2 and #3) of three sampled residents. The center identified 35 residents who resided in the center. Findings: 1. Resident #2's clinical record documented the resident was admitted on 12/23/19. The clinical record revealed an annual assessment for the year 2020 had not been completed. 2. Resident #3's clinical record documented the resident was admitted on 03/02/19. The clinical	C 522	Refer to POC Template Y 11711 C 522	

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

Kelly Mattingly, RN, Adm.

7/30/21

Y11711

If continuation sheet 1 of 19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/13/2021
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C 522	Continued From page 1 record revealed an annual assessment for the year 2021 had not been completed. On 07/12/21 at 3:53 p.m., the licensed practical nurse (LPN)/director of nursing (DON) was asked if she had found the missing annual assessments. She stated no.	C 522		
C1512 SS=E	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting:	C1512	<i>Refer to POC Template Y11711 C1512 also - 6 pgs of Supportive documents for C1512</i>	

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C1512	Continued From page 2 a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to ~ ensure residents were protected from verbal abuse and intimidation by staff and; ~ ensure an allegation of verbal abuse was investigated for two (#2 and #4) of five sampled residents who were reviewed for abuse allegations. The center identified 35 residents who resided in	C1512		

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C1512	Continued From page 3 the center. Findings: The center's policy, titled, 'Abuse and Neglect', dated 03/10/20, documented, "...Every resident has the right to be free from abuse...Residents must not be subjected to abuse by anyone, including but not limited to employees...Every resident has the right to be free from mistreatment...The community reports alleged violations, conduct and investigation of all alleged violations, to proper authorities and takes necessary corrective actions... Abuse is defined as willful infliction of injury...intimidation or punishment with resulting physical, emotional or psychological harm, pain or mental anguish...types of abuse... Verbal: Using profanity, name calling, cruel teasing...Mental: Any act that makes a resident fearful, feel belittled or to make fun of a resident by mocking, imitating or ridiculing... All reports...reported immediately to the Administrator and Director of Nursing Care (DONC)...complete investigation...Staff is required to intervene, identify and correct situations where any type of abuse may occur..." The center's policy, titled,'Resident Bill of Rights', dated 08/2020, documented, "...To ensure that all resident rights are respected and protected...Westbrook Gardens SLC will adhere to the Resident Bill of Rights as listed in the Resident Handbook as follows...be treated with dignity and respect...be treated fairly, courteously and with respect be [sic] staff...be free physical or psychological abuse from staff..."	C1512			

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C1512	Continued From page 4 The personnel files for the licensed practical nurse (LPN)/director of nursing (DON) and the community manager revealed they had received training on abuse and reporting. Resident #2 had diagnoses which included essential hypertension and atrial fibrillation. The resident's clinical record did not contain a current assessment. A quarterly self-med evaluation, dated 06/03/21, documented the resident had the mental capability to self administer her medications. The LPN/DO stated the resident was alert and oriented to person, place and time. Resident #4 had diagnoses which included heart failure and anxiety. A pre-admission assessment, dated 06/11/2020, documented the resident was alert, oriented to person, place and time, and revealed no history of mental health or abnormal behaviors. The assessment documented the resident's usual mood was calm. A quarterly self-med evaluation, dated 06/03/21, documented the resident had the mental capabilities to self administer her medication. A note which described an incident between the community manager, LPN, resident #2 and resident #4, dated 06/14/21, documented, "...It was reported to [Community manager] that [Resident #4] has been having other residents do her laundry, carrying things upstairs for her, tidying up her apartment (making her bed) and	C1512		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER WESTBROOK GARDENS SLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 WESTBROOK BLVD PURCELL, OK 73080		
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C1512	Continued From page 5 delivering meals to her apartment. Mid-morning [Resident #4] and [Resident #2] were observed waiting and pacing by the front doors. A person...arrived with a large package and a few other items. Upon entering the building, it was noted the [Resident #4] had a water dispenser and pillow shams on her walker. [Resident #2] had an unwrapped and unfolded comforter on her walker. [Community manager] approached [Resident #2] and folded the comforter and placed it on [Resident #4] walker. At this time, it was explained with the comforter hanging off of the walker that she could trip or fall by getting her walker caught in the comforter or that she may stumble over it. [Resident #4] was irritated and didn't want to carry the comforter, she wanted...[Resident #2] to take it up to her apartment for her. [Community manager] explained that it was HER comforter and that she could place it on HER walker to take it to her apartment. [Community manager] and [LPN] met and discussed the on-going problem with [Resident #4] manipulating residents to take care of her and to do task that she is capable of. It was decided we meet with [Resident #4] and explain that it isn't other resident's responsibilities to take care of her. If she is in need of assistance, we are there to help her. [LPN] and [Community manager] knocked and announced themselves upon entering [Resident #4]'s apartment. [Resident #2] was observed sitting on the couch out of breath and panting and [Resident #4] was sitting in her chair reading a book. [Resident #4]'s bed was completely re-made with the new comforter and shams on her bed. [LPN] asked about who made her bed?	C1512		

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C1512	Continued From page 6 [Resident #2] and [Resident #4] both began explaining that [Resident #4] wasn't able to make it but she did try to help some. [Community manager] explained that this is assisted living and we have staff that will assist her that it isn't another resident's responsibility to take care of her. [Resident #4] stood up and placed her hands on her hips and yelled that "no one will tell her wait [sic] to do!" She wavered a little and [Community manager] asked her to sit down and she stated she "will not sit down!" and [Community manager] stepped closer to her and told her that it will stop today of her asking/guiling other residents to take care of her responsibilities. It was further explained that a resident could be injured by lifting, carrying and doing things that they shouldn't be doing by taking care of her. [Community manager] explained that it is assisted living and part of that was socializing and that sitting in a dark (blinds shut & lights off) wasn't healthy and that she needs to do more for herself and if she is unable to manage a task by herself that she should ask WBG [Westbrook Gardens] staff to help her. [Community manager] notified...[Resident #2]'s daughter of the occurrence and we are doing our best to have [Resident #4] ask WBG staff for assistance rather than having other residents take care of [Resident #4]. She appreciated the call...further explained that her mom had ask her to pick up some items for her at the store and she now realizes that she was picking thing s up for [Resident #4] and not her mother. She did get reimbursed for the money spent." A nurse's note, dated 06/14/21 at 2:44 p.m., documented the LPN/DON and the community manager went to speak with resident #4 due to staff reporting other residents were doing a lot of	C1512		

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C1512	Continued From page 7 favors for resident #4, such as cleaning her apartment, making her bed, doing her laundry. The note documented, "...[Community manager and [resident #4] proceeded to have...loud argumentative discussion about ALF [assisted living facility] and not having other residents do things for her, but if she needed help for her to call upon staff." The state reportable incident reports were reviewed and revealed the above incident had not been reported to the Oklahoma State Department of Health. On 07/01/21 at 2:25 p.m., resident #4 was asked how the staff treated her. She stated they all treated her well except the administrator. She was asked the name of the administrator. She stated the community manager's name. She stated there had been an incident involving the community manager, herself and another resident. She stated she had gotten a new comforter and resident #2 was going to help her bring it to her room. The resident stated the community manager "jerked" it off of resident #2's walker and threw it on resident #4's walker. She stated after the incident with the comforter, resident #2 was in resident #4's apartment, when the LPN and the community manager entered the apartment. She stated the community manager was "chewing out" resident #2. She then stated the community manager told her all you do is sit in the chair and watch TV and have others do for you. Resident #4 stated the community manager was yelling at her and they had words back and forth. She stated she stood up from her chair and she thought the community manager was going to hit her. She stated the community manager stated, "You don't think I know what goes on in	C1512		

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C1512	Continued From page 8 my facility." The resident was asked if the community manager raised her voice when she was speaking to her. She stated, "Oh yes, and so did I." At 2:40 p.m., resident #2 was asked if she knew the name of the administrator. She also identified the community manager as the administrator. She stated there had been an incident with her trying to help another resident with her comforter. She stated the community manager took the comforter off of her walker and "slammed it down" on resident #4's walker and told her she was not allowed to do work for other people. The resident then stated she went to resident #4's apartment. She stated the LPN and community manager came to the apartment. She stated resident #4 allowed them to enter the apartment. She stated she was sitting on the couch and the LPN and community manager were standing near the entrance. The resident stated the community manager stated to her, "So, now you are here to help put it on the bed." She stated the community manager "went off" and started saying, "We do not allow this." "Do you want to get paid for doing things." "Well here is the thing that she just sits up here and expects everyone to do things for her." Resident #2 stated the community manager told resident #4, all you do is sit in front of the TV and have other people do things for you. She also stated the community manager stated other residents were doing resident #4's laundry. Resident #2 stated resident #4 stood up and the community manager moved towards resident #4	C1512		

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C1512	Continued From page 9 and was saying things about resident #4 to her. She was asked what the community manager was saying. She stated, "Insults" about resident #4. Resident #2 stated the community manager had a different personality but she felt the situation was "uncalled for." The resident stated the community manager stated "I am going to call your daughter." She stated she felt like a three year old and the community manager was going to tell on her. Resident #2 stated the encounter upset both her and resident #4 and she thought the community manager might "Put her out" but things were fine now and she was not going to worry about it. Resident #2 was asked if she had done things for resident #4. She stated she tried to bring resident #4 some milk but the staff would not let her. At 3:34 p.m., resident #1 who was identified by the LPN to be alert and oriented to person, place, time and situation was asked if she had done laundry for resident #4. She stated no. She was asked if she had ever been yelled at by the staff. She stated yes, the community manager had yelled at her because the community manager thought she was trying to help another resident. She stated she also witnessed the community liaison yell at a visitor for not wearing a mask. At 3:55 p.m., resident #3 who was identified by the LPN to be alert and oriented to person, place, time and situation was asked how the staff treated her. She stated the community manager was a "bully." She stated the community manager would get in your face. The resident stated the community manager came busting in her	C1512		

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C1512	Continued From page 10 apartment without knocking because she thought the she was smoking. On 07/12/21 at 2:56 p.m., the LPN/DON was asked if there had been an incident between the two residents and the community manager. She stated yes. She was asked if she witnessed the incident. She stated yes. She stated she knew the community manager would not allow resident #2 to assist resident #4 with the comforter due to safety issues. The LPN stated she was going to speak with resident #4 and the community manager went with her. The LPN stated when they got to the apartment resident #2 was on the couch and resident #4 was in her recliner. She stated resident #2 was short of breath. The LPN stated resident #4 and the community manager had a conversation and both the community manager and the resident were upset and both of them were loud. She stated resident #4 stood up and put her hands on her hips and stated, "No one talks to me that way." The LPN was asked what that meant. She stated with a higher tone. The LPN stated the community manager told the resident to sit down. She stated resident #4 stated she did not have to sit down, that this was her apartment. The LPN was asked if the community manager moved closer to the resident during this interaction. She stated yes, the community manager took two steps closer to the resident during the time she was telling the resident to sit down. She stated they continued for a few more minutes and she told the community manager it was time to leave.	C1512		

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C1512	Continued From page 11 The LPN was asked if the community manager threatened to call resident #2's daughter. She stated yes. She was asked if the community manager raised her voice when she was speaking with resident #4. She stated yes. She was asked if it was appropriate to raise your voice when speaking to a resident. She stated no. She was asked if this was considered verbal abuse. She stated yes. She was asked if she reported it to the administrator. She stated the community manager was the administrator. She stated she did not have anyone to report it to because the community manager was the next person above her. At 3:15 p.m., the administrator was asked why the residents and staff thought the community manager was the administrator. She stated she did not know. She stated they knew she was the community manager's boss. The administrator was asked about the incident involving resident #2 and #4, the LPN, and the community manager. She stated she was aware that Adult Protective Services came out and that both the LPN and the community manager told her about the incident. She stated resident #2 loved to be helpful and resident #4 loved to be waited on. The administrator stated resident #1 and resident #2 had taken meals to resident #4. She stated the community manager told resident #4 it was her responsibility to take the new comforter to her apartment. The administrator stated when the LPN and the	C1512		

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C1512	Continued From page 12 community manager went to resident #4's apartment; resident #2 was worn out. The administrator was asked why the LPN and the community manager went to speak with resident #4. She stated the community manager told resident #4 she could not ask other residents to do stuff for her due to safety reasons. She stated the community manager reported to her that resident #4 stated, "No one was going to talk to her that way." She was asked what that meant. She stated tell her what to do. She was asked if she had followed up with the residents involved in the incident. She stated no. At 3:27 p.m., the community manager stated residents had been taking meals to resident #4 and doing her laundry. The community manager was asked if she had documentation of the residents doing resident #4's laundry and taking her meals. She stated no, only the document from 06/14/21. The community manager was asked about the new comforter for resident #4. She stated the comforter was unfolded and hanging off of resident #2's walker, so she removed the comforter from resident #2's walker, folded it and placed it on resident #4's walker. She stated the LPN and herself decided they needed to speak with resident #4 about having other residents do things for her. She stated resident #2 was sitting on the couch panting with her arms to her side. The community manager stated they asked if she was okay and resident #2 stated she was fine. The community manager stated resident #2 was asked if she made resident #4's bed with the new comforter.	C1512		

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C1512	Continued From page 13 Resident #4 stated resident #2 wanted to make the bed. The community manager stated she told resident #4 the center's staff could help her with things and that resident #2 was not here to make her bed or take care of her. The community manager stated resident #4 stood up and put her hands on her hip and yelled at her, "You don't tell me what to do, my friends can help if they want to." The community manager stated she told resident #4 to look at resident #2 she was worn out. She stated the resident also stated she was tired of her telling her what to do. The community manager was asked if she moved closer to the resident when she was speaking with her. She stated yes, she moved a foot closer. She was asked if she raised her voice to the resident. She stated she used a "firm voice." She was asked if she had threatened to call resident #2's daughter. She stated no, she had said she needed to call resident #2's daughter but not in a threatening manner. The community manager was asked if she threw the comforter onto resident #4's walker. She stated no, she folded it. She was asked if resident #2 was upset after the incident. She stated, "Yes, it was uncomfortable for her." At 3:53 p.m., the LPN was asked again if the community manager raised her voice when she was speaking with resident #4. She stated yes. She was asked what the community manager said to resident #2 about calling her daughter. She stated the community manager told resident	C1512			

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C1512	Continued From page 14 #2, "Do you want me to call your daughter and have a talk with her?" She was asked if resident #2 seemed upset about the incident. She stated she was pretty anxious by the time it was all over with. At 4:33 p.m., the administrator was asked to define verbal abuse. She stated by the way something is interpreted, the way something is said, belittling someone and using curse words. She was asked if she considered what was reported to her as an allegation of abuse. She stated it depended, she was not there. She was asked if she followed up with resident #4 after she was made aware of the incident. She stated no, the resident was gone for about a week. She stated the staff did not tell her the resident was gone until she returned. She stated she did not follow up with the resident when she returned. She stated everything seemed fine when she returned. On 07/13/21 at 11:47 a.m., the administrator was asked how she would define an allegation. She stated someone alleged someone said or did something to them.	C1512		
C6000 SS=E	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with	C6000	Refer to Poc Template y11711 C6000	