OKLAHOMA
State Department
of Health

Delivery via email to: admin@westbrookgardens.com

June 7, 2022

License Number: AL4401

Ms. Sally Perry, Administrator
Westbrook Gardens SLC
1215 Westbrook Blvd
Purcell, OK 73080

Survey Event ID: XLWM11

Dear Ms. Perry:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **May 4, 2022**. 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.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.06.07 09:58:27 -05'00'

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: Westbrook Gardens
Address: 1215 Westbrook Blvd
City, State, Zip: Purcell, Ok
Provider #: AL4401
Complaint #: OK00058734
Investigation Date(s): 05/03/22 and 05/04/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility has failed to provide services or monitor/assess residents with insulin dependent diabetes.	US
2. The facility has failed to provide a pest free environment.	US
3. The facility retaliates against staff and does not respond to staff concerns specific to resident care.	US

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

An unannounced on-site investigation was initiated on Tuesday, May 3, 2022 at 12:30 p.m.

A sample of three 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation related to monitoring and assessing diabetics was conducted.

Clinical records of the sampled residents, were reviewed for care plans, assessments, physician orders, and progress notes. Medications were reviewed, they had been administered as ordered by the physician. One sampled resident had previously had a medical concern which had been resolved. Resident council minutes and

Incident reports were reviewed there were no complaints related to monitoring and assessing for medications identified.

A tour of the facility was conducted upon entrance and throughout the investigation. Staff were observed interacting with the residents in a respectful and dignified manner. One identified resident was observed multiple times in the dining room eating snacks. Observations were made of a snack cart and cabinet in the break room with peanut butter, crackers, and juices for the residents for in between meals and evening snacks. During the facility tour the residents were observed to be clean and well-groomed. The facility was observed to be clean and without odors. One identified resident was observed multiple times in the common area and in the dining room, their clothing was clean. The residents' closets were observed to have clean clothing in them.

Staff were interviewed and reported one identified resident loves to eat and was quite an eater. Residents reported the food was good and they receive plenty of it. Staff reported they serve special diets for the residents who need them. Staff reported we have a snack cart for residents who need a snack in the evening. Residents reported the facility does their laundry unless they choose to do it themselves.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation related to having a pest free environment was conducted.

Clinical records of the sampled residents, were reviewed for care plans, assessments, physician orders, and progress notes. The facilities pest control receipts were observed. The facility had one room that had been sprayed for pest in August of 2021. The whole facility had been sprayed monthly for pest control and as needed. Resident council minutes and Incident reports were reviewed there were no complaints related to pest in the facility.

During the facility tour no pest were observed in any of the common areas or in any of the residents' rooms. The facility was observed to be clean and without odors. The identified rooms were observed to be pest free.

Residents reported they have had no pest that they were aware of. One identified resident in the identified room reported they had pest several months ago but the room had been sprayed and they have not had any issues since then. One identified resident's arms were observed to be free from any scratches or sores related to any pest. Staff reported they have not seen any pest in the facility.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation related to staff concerns of retaliation over resident care was conducted.

Clinical records of the sampled residents were reviewed for care plans, assessments, physician orders, and progress notes. Resident council minutes and Incident reports were reviewed no complaints related to resident care were identified.

Observations were made of multiple staff and residents in the common areas, in their rooms, and in the dining room. None of the staff or residents appeared to be afraid.

Multiple residents reported they have received good care at the facility. One resident reported the staff were all very nice and were hard workers. Staff reported they were not afraid to voice their concerns. Staff reported we report resident care concerns to the director of nursing. She then addresses any concerns we have. Staff reported they were not aware of any staff who had quit due to a lack of resident care or due to fear of retaliation.

Staff reported we have a communication pass down book where we report care areas of the residents which oncoming staff need to be aware of but we do not have a book for complaints.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation (#1, 2, and #3). No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Donna Ahlborn RN MSN CHFS

Donna Ahlborn RN MSN Clinical Health Facility Surveyor

05/09/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: Westbrook Gardens SLC
City, State, Zip: 1215 Westbrook Blvd
Provider #: AL4401
Complaint #: OK00058676
Investigation Date(s): 05/03/22 and 05/04/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to protect residents from verbal abuse, intimidation and failed to ensure residents/families could voice grievances without fear of retaliation.	US

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

An unannounced on-site investigation was initiated on Tuesday, May 3, 2022 at 12:30 p.m.

A sample of three 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 Centers for Medicare and Medicaid Services (CMS) 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: The deficient practice was unsubstantiated related to this allegation.

Clinical records of the sampled residents were reviewed for care plans, assessments, physician orders, and progress notes. Resident council minutes and incident reports were reviewed and no complaints related to resident abuse were identified.

Observations were made of multiple staff and residents in the common areas, in their rooms, and in the dining room. Staff members were observed to treat residents with kindness, dignity and respect. Staff were observed interacting with residents in a respectful and dignified manner.

Multiple residents reported they have received good care at the facility. One resident reported the staff were all very nice and were hard workers. Residents reported they were not afraid to voice their concerns. Residents reported no one at the facility had abused them or yelled at them. Staff reported they had been in-serviced on abuse and voiced an understanding of identifying abuse, prevention, and reporting.

Determination Summary and Follow-Up Action:

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

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Donna Ahlborn RN MSN CHFS

Donna Ahlborn RN MSN Clinical Health Facility Surveyor

Date report completed: 03/10/2022

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
	AL4401	A. BUILDING: _____ B. WING _____	05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTBROOK GARDENS SLC	1215 WESTBROOK BLVD PURCELL, OK 73080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An abbreviated survey was conducted on 05/03/22 and 05/04/22 to investigate complaints #OK00058676 and #OK00058734.	C 000		

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