Oklahoma State Department of Health
Creating a State of Health

December 13, 2019

License Number: AL5101

Ms. Kristy Belsee, Administrator
Brookdale Muskogee
3211 Chandler Road
Muskogee, OK 74403

RE: Survey Event ID: G3T311

Dear Ms. Belsee:

Enclosed is a report of the inspection and complaint investigation conducted at your Assisted Living Center on **November 19, 2019.** No deficiencies were cited. Oklahoma Statutes 63-1-1910 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) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Muskogee**
Address: **3211 Chandler Road**
City, State, Zip: **Muskogee, Ok 74403**
Provider #: **AL5101**
Complaint #: **OK00054455**
Investigation Date(s): **11/18/19 through 11/19/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to notify families with changes in condition.	US

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

An unannounced on-site investigation was initiated on Monday, November 18, 2019 at 10:56 a.m.

A sample of 3 residents including any identified resident 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 unsubstantiated related to this allegation.

An investigation specific to notifying families of change in condition was conducted.

The employees were observed as they provided supervision and cared for the residents' needs, while they ambulated throughout the center, during meals, and personal care. The employees were familiar with the residents' care needs.

Residents' family members stated they had been notified when their resident had a fall, change of condition, or experienced sickness. Employees stated a nurse was notified immediately if a resident had a change of condition or fall, and the nurse then notified the family. They also stated if a nurse was not on duty, the certified medication aide was notified, and she would notify the nurse, physician, and family. Both nurses

stated after a resident had a fall, the resident would be assessed for delayed on-set of injuries for seventy two hours.

Records were reviewed and documented the residents who had falls or other incidents had been assessed and families were notified of any physical changes. Incident reports documented the residents' emergency contacts had been notified of each incident. The policy and procedure documented the physician and the resident's emergency contact should be notified of any reported incident.

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 state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Billie Seeman RN, Clinical Health Facility Surveyor

Date report completed: 11/21/2019

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
	AL5101	A. BUILDING _____ B. WING _____	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE MUSKOGEE	3211 CHANDLER ROAD MUSKOGEE, OK 74403

(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 re-licensure survey was conducted on 11/18/19 through 11/19/19, in conjunction with an investigation of complaint #OK00054455. Current census was 35. No deficient practice was cited.	C 000		

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

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5101	BROOKDALE MUSKOGEE

Type of Survey (select all that apply)

2	3			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 25837	11/18/2019	11/19/2019	1.00	0.00	14.00	1.00	3.00	1.00
2. 36191	11/18/2019	11/19/2019	0.50	0.00	13.50	1.00	5.25	3.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

DEC 16 2019