Oklahoma State Department of Health
Creating a State of Health

October 9, 2019

License Number: AL5506

Ms. Lisa Dimonico, Administrator
Brookdale Edmond Danforth
116 West Danforth
Edmond, OK 73003

Survey Event ID: RE5S11

Dear Ms. Dimonico:

On **September 25, 2019**, 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.

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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: Brookdale Edmond Danforth
Address: 116 West Danforth
City, State, Zip: Edmond, OK 73003
Provider #: AL5506
Complaint #: OK00054380
Investigation Date(s): 09/23/19 through 09/25/19

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were provided care according to care plans and contracts.	S
2. The center failed to have and/or implement their abuse policy	S

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

An unannounced on-site investigation was initiated 09/23/19 at 10:20 a.m.

A sample of four 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 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 substantiated related to this allegation. See the Statement of Deficiencies, Form, and Tag 1512 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form, and Tag 1970 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Teena Cornett

Teena Cornett, RN CHFS IV

Date report completed: 09/30/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5506	A. BUILDING: _____ B. WING _____	C 09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDMOND DANFORTH	116 WEST DANFORTH EDMOND, OK 73003

(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 09/23/19 through 09/25/19 to investigate complaint #OK00054380. Resident census was 36. The following deficient practices were cited.	C 000		
C1512 SS=G	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 Statues, 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: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or	C1512		

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C1512	Continued From page 1 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 neglected a cognitively impaired resident by failing to provide care or comfort measures after an acute change in condition. Staff did not notify a licensed nurse about 1 (#1) of 1 sampled resident who demonstrated signs and symptoms of pain and distress for an entire night shift. The resident was subsequently diagnosed with a fractured femur. This deficient practice resulted in isolated actual harm. Findings: The most recent assessment for resident #1, dated 05/10/19, documented diagnoses to include Alzheimer's Dementia, chronic kidney disease, high blood pressure, anemia and osteoarthritis. The assessment described the resident as only oriented to self and confused at times.	C1512		

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C1512	Continued From page 2 An incident report, dated 09/02/2019, documented resident #1 complained of right leg pain and was sent to the emergency room for further evaluation. Documentation from the hospital that treated resident #1 revealed the resident suffered a fractured right femur. The hospital record documented due to dementia, the resident was unable to say how the fracture happened. The record also documented, prior to the injury, the resident was not ambulatory and required staff to transfer from wheelchair to bed and back. Per record review, it could not be determined when the resident was transported to the emergency room, but ER records documented the time of 1:52p.m on 9/02/19. The emergency room noted the right leg was shortened and rotated and the resident was in severe pain. The Orthopedic Surgery Consult report, dated 9/03/19, documented resident #1 had a fracture pattern indicating a "twisting force" that caused a spiral/oblique fracture of the right distal femur. The resident had surgery to repair the fractured right femur, stayed several days in the hospital and then was sent to a skilled nursing unit. Documentation from the center showed the resident was supposed to be turned and checked for incontinent episodes and changed if necessary every two hours at night starting at 11:00 p.m. On 09/24/19, LTCA (long term care aide) #2 stated she worked the night resident #1 was injured, but she was not the one assigned to the	C1512		

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C1512	Continued From page 3	C1512		

resident. She stated LTCA #1 was assigned to the resident. She stated sometime early on in the night shift on 09/01/19, LTCA #1 had mentioned to her resident #1 was not acting right, something was wrong with her. Around 5:00 a.m., LTCA #1 asked her help to put resident #1 back to bed. LTCA #1 told her that the resident had become combative and had begun to slide out of bed, she could not prevent the resident from sliding out of bed because she was combative, so she helped the resident to the floor in a controlled, soft fall.

LTCA #2 stated she went to the room of resident #1 and observed the resident lying on the floor on her left side. She stated the resident was crying and moaning and obviously in distress. Both of the LTCAs picked the resident up out of the floor and put her back to bed. LTCA #2 stated the resident screamed out when they lifted her onto the bed. LTCA #2 stated she thought LTCA #1 called the nurse around 6:00 a.m. to report something was wrong with resident #1.

On 09/25/19, LTCA #1 stated she was the one assigned to care for resident #1 on the night she was injured. She stated she went to check the resident at 11:00 p.m. and noticed "something was not right." The resident was combative and telling LTCA #1 to not touch her leg. She stated she did not go check on the resident at 1:00 a.m. because "she knew something was wrong and did not want to disturb her." At 3:00 a.m., when she checked on the resident, the resident was crying, complaining of leg pain and combative. (Resident #1 was not observed or monitored from 11:00p.m. until 3:00a.m. even though LTCA #1 observed the resident to be crying, combative, agitated and "something was not right" at 11:00p.m.) At 5:00 a.m. she started to change the resident's incontinent brief. The resident was

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C1512	Continued From page 4 still in distress and became combative. LTCA #1 stated the resident began to slide out of bed and she could not stop her from falling out of bed, so she helped her to the floor in a controlled fall. LTCA #1 stated she went to find LTCA #2 for help to put the resident back to bed. She stated resident #1 was crying and just not herself. Both LTCAs put the resident back to bed. She stated she never called the nurse or anyone else to report the resident's distress. She told the day shift what happened and asked them to call the nurse.	C1512		
C1970 SS=D	310:663-19-4(a) POLICIES (a) Each assisted living center shall have a written policy statement that expressly prohibits the abuse or neglect of residents or misappropriation of resident property it serves. The policy shall include the facility's investigative procedures and actions to be taken when incidents of abuse or neglect of residents or misappropriation of resident's property occur. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to follow their abuse policy while conducting an investigation of an injury of unknown origin for 1 (#1) of 1 sampled resident who suffered a fractured femur. This failed practice had the isolated potential for more than minimal harm. Findings: The most recent assessment for resident #1,	C1970		

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C1970	Continued From page 5 dated 05/10/19, documented diagnoses to include Alzheimer's Dementia, chronic kidney disease, high blood pressure, anemia and osteoarthritis. The assessment described the resident as only oriented to self and confused at times. An incident report, dated 09/02/2019, documented resident #1 complained of right leg pain and was sent to the emergency room for further evaluation. Documentation from the hospital revealed the resident had suffered a fractured femur of unknown origin. On 09/23/19 at 3:20 p.m., the administrator stated the resident was unable to say what happened to her due to dementia, so she initiated an investigation. She interviewed all staff that worked the night resident #1 was injured, all staff who worked the evening shift before the resident was injured and the morning shift after the resident was injured. She provided her written documentation of the investigation. The investigation did not include dates and times when the interviews were conducted, or when the investigation was initiated. A policy provided by the center documented the administrator should keep a written record of the investigation including the dates and times of the interviews conducted during the course of the investigation. At 4:30 p.m., the administrator stated she should have documented the dates and times of the interviews and the date the investigation was initiated according to policy.	C1970		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5506	BROOKDALE EDMOND DANFORTH

Type of Survey (select all that apply)

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 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. 36967	09/23/2019	09/25/2019	0.50	0.00	7.00	0.00	5.00	4.00
2. 41872	09/23/2019	09/25/2019	0.25	0.00	0.00	7.00	3.00	0.00
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

OCT 10 2019

Oklahoma State Department of Health
Creating a State of Health

REPORT REVISED

November 1, 2019

License Number: AL5506
Survey Event ID: RE5S11

Ms. Lisa Dimonico, Administrator
Brookdale Edmond Danforth
116 West Danforth
Edmond, OK 73003

Dear Ms. Dimonico:

On **September 25, 2019**, agents from our office concluded an inspection at your facility. You were advised of the findings of that inspection in our notice of **October 9, 2019**.

The original STATE FORM (statement of deficiencies) report has been revised during administrative review of this case. A copy of the corrected STATE FORM report is included. Deficiencies identified during the inspection are not affected by these corrections and a new plan of correction is not required. The corrected STATE FORM report is being provided for your records and no additional action on your part is required at this time.

If we can be of any further assistance, please contact us at 405-271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

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C 000	INITIAL COMMENTS This Statement of Deficiencies was amended following an administrative review. Lisa McAlister, BSN, RN Manager of Survey and Compliance October 31, 2019 An abbreviated survey was conducted 09/23/19 through 09/25/19 to investigate complaint #OK00054380. Resident census was 36. The following deficient practices were cited.	C 000		
C1512 SS=G	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 Statues, 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	C1512		

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C1512	Continued From page 1 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: 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 neglected a cognitively impaired resident by failing to provide care or comfort measures after an acute change in condition. Staff did not notify a licensed nurse about 1 (#1) of 1 sampled resident who demonstrated signs and symptoms of pain and distress for an entire night shift. The resident was subsequently diagnosed with a fractured	C1512		

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C1512	Continued From page 2 femur. This deficient practice resulted in isolated actual harm. Findings: The most recent assessment for resident #1, dated 05/10/19, documented diagnoses to include Alzheimer's Dementia, chronic kidney disease, high blood pressure, anemia and osteoarthritis. The assessment described the resident as only oriented to self and confused at times but was interviewable and able to communicate. The assessment documented resident #1 was chairfast and that her usual mood was "calm." An incident report, dated 09/02/2019, documented resident #1 complained of right leg pain and was sent to the emergency room for further evaluation. Documentation from the hospital that treated resident #1 revealed the resident suffered a fractured right femur. The hospital record documented due to dementia, the resident was unable to say how the fracture happened. The record also documented, prior to the injury, the resident was not ambulatory and required staff to transfer from wheelchair to bed and back. Per record review, it could not be determined when the resident was transported to the emergency room, but ER records documented the time of 1:52p.m on 9/02/19. The emergency room noted the right leg was shortened and rotated and the resident was in "severe pain." The Orthopedic Surgery Consult report, dated 9/03/19, documented resident #1 had a fracture pattern indicating a "twisting force" that caused a spiral/oblique fracture of the right distal femur.	C1512		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDMOND DANFORTH	116 WEST DANFORTH EDMOND, OK 73003

(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
C1512	Continued From page 3 The resident had surgery to repair the fractured right femur, stayed several days in the hospital and then was sent to a skilled nursing unit. Documentation from the center showed the resident was supposed to be turned and checked for incontinent episodes and changed if necessary every two hours at night starting at 11:00 p.m. On 09/24/19 at 3:55p.m., LTCA (long term care aide) #2 stated she worked the night resident #1 was injured, but she was not the one assigned to the resident. She stated LTCA #1 was assigned to the resident. She stated sometime early on in the night shift on 09/01/19, LTCA #1 told her "there was something wrong" with resident #1. She stated LTCA #1 said "She seemed to be in pain and was not acting right." Around 5:00 a.m., LTCA #1 asked LTCA #2 to help put resident #1 back to bed. LTCA #1 told her that the resident had become combative and had begun to slide out of bed because she was combative, so she helped the resident to the floor in a controlled, soft fall. LTCA #2 stated she went to the room of resident #1 and observed the resident lying on the floor on her left side. She stated the resident was "moaning and obviously in pain." Both of the LTCAs picked the resident up off of the floor and put her back to bed. LTCA #2 stated resident #1 was "in pain" and "screamed when picked up." LTCA #2 stated she thought LTCA #1 called the nurse around 6:00 a.m. to report something was wrong with resident #1. On 09/25/19 at 12:35p.m., LTCA #1 stated she was the one assigned to care for resident #1 on the night she was injured. She stated she went to	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5506	A. BUILDING: _____ B. WING _____	C 09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDMOND DANFORTH	116 WEST DANFORTH EDMOND, OK 73003

(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
C1512	Continued From page 4	C1512		

check the resident at 11:00 p.m. and noticed "something was not right." The resident was combative and saying "don't touch" her leg. She stated she did not go check on the resident at 1:00 a.m. because "she knew something was wrong and did not want to disturb her." At 3:00 a.m., when she checked on the resident, the resident was complaining of leg pain and "was still combative." (Resident #1 was not observed or monitored from 11:00p.m. until 3:00a.m. even though LTCA #1 observed the resident to be combative, agitated and noted "something was not right" at 11:00p.m.) She stated she never called the nurse or anyone else to report the resident's distress. She told the day shift what happened and asked them to call the nurse.

In an effort to determine how the injury occurred, the administrator interviewed staff and provided documentation of interviews with staff members. It could not be determined when this investigation occurred because the documents were not dated, no time was listed and there were no hand written statements with signatures. The undated documents, suggesting a time-line one to two days before the fracture was identified and diagnosed on 9/02/19, documented the administrator interviewed different staff from different shifts and the following was noted by the administrator: resident #1 "yelled" and "didn't want to get up"; resident #1 was "screaming - bad mood" and staff didn't get her up for dinner"; "had no complaints of pain "looked tired"; resident #1 "was cranky but did not indicate pain" - "bad mood"; and then the notes went on to describe LTCA #1 stating at 11:00 p.m., resident #1 said "don't touch me." The notes further document LTCA #1 relayed to the administrator that at 1:00a.m., resident #1 said "my leg", however, LTCA #1 stated during an interview she did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5506	A. BUILDING: _____ B. WING _____	C 09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDMOND DANFORTH	116 WEST DANFORTH EDMOND, OK 73003

(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
C1512	Continued From page 5 check on resident #1 at 1:00a.m. because she knew something was wrong and didn't want to disturb the resident.	C1512		
C1970 SS=D	310:663-19-4(a) POLICIES (a) Each assisted living center shall have a written policy statement that expressly prohibits the abuse or neglect of residents or misappropriation of resident property it serves. The policy shall include the facility's investigative procedures and actions to be taken when incidents of abuse or neglect of residents or misappropriation of resident's property occur. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to follow their abuse policy while conducting an investigation of an injury of unknown origin for 1 (#1) of 1 sampled resident who suffered a fractured femur. This failed practice had the isolated potential for more than minimal harm. Findings: The most recent assessment for resident #1, dated 05/10/19, documented diagnoses to include Alzheimer's Dementia, chronic kidney disease, high blood pressure, anemia and osteoarthritis. The assessment described the resident as only oriented to self and confused at times. An incident report, dated 09/02/2019, documented resident #1 complained of right leg	C1970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5506	A. BUILDING: _____ B. WING _____	C 09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDMOND DANFORTH	116 WEST DANFORTH EDMOND, OK 73003

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C1970	Continued From page 6 pain and was sent to the emergency room for further evaluation. Documentation from the hospital revealed the resident had suffered a fractured femur of unknown origin. On 09/23/19 at 3:20 p.m., the administrator stated the resident was unable to say what happened to her due to dementia, so she initiated an investigation. She interviewed all staff that worked the night resident #1 was injured, all staff who worked the evening shift before the resident was injured and the morning shift after the resident was injured. She provided her written documentation of the investigation. The investigation did not include dates and times when the interviews were conducted, or when the investigation was initiated. A policy provided by the center documented the administrator should keep a written record of the investigation including the dates and times of the interviews conducted during the course of the investigation. At 4:30 p.m., the administrator stated she should have documented the dates and times of the interviews and the date the investigation was initiated according to policy.	C1970		

Oklahoma State Department of Health
Creating a State of Health

November 4, 2019

License Number: AL5506

Ms. Lisa Dimonico, Administrator
Brookdale Edmond Danforth
116 West Danforth
Edmond, OK 73003

Survey Event ID: RE5S11

Dear Ms. Dimonico:

On September 25, 2019, 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 **November 23, 2019**.

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) 271-6868.

Sincerely,

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

LC/ks

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/22/2019** **Facility Name:** Brookdale Edmond Danforth **License Number:** AL5506 **Survey Event ID:** RE5S11 **Date Survey Completed: 9/25/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1512	Based on: C1512 Based on interview and record review, it was determined the center neglected a cognitively impaired resident by failing to provide care or comfort measures after an acute change in condition. Staff did not notify a licensed nurse about 1(#1)sampled resident who suffered a fractured femur. This failed practice had the isolated potential for more than minimal harm

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the plan of correction for Brookdale Edmond Danforth regarding the Statement of Deficiencies dated 9/25/19. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Defiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. We remain committed to the delivery of quality healthcare 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 is not currently at the community.
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 staff will be inserviced with our abuse & neglect policy. They will be inserviced on how they should react if they notice a resident is behaving out of the ordinary. If a change is noticed the staff needs to notify the nurse or nurse on call immediately.
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?	The Executive Director, the Health & Wellness Director &/or designee will randomly question associates about resident care & any changes with residents & log responses for the next 2 months.
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.	The Executive Director, the Health & Wellness Director &/or designee will question associates about our abuse & neglect policy to ensure they know the the appropriate way to make sure the needs of our residents are met. By randomly making rounds with our associates we can monitor how they are meeting the needs of the residents & note how they react if they notice a change. During our monthly QA meeting all present will discuss the findings of our questions of the associates & rounds that we have made. The findings will be kept with all our QA records for evidence that we followed through with this

	step. The Executive Director, Health & Wellness Director &/or designee will continue to educate all associates to make sure the needs of the residents are met.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/23/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Lisa DiMonico** OAC 310:663-25-4(F)	**Date 10/22/2019**

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: 10/22/2019** **Facility Name:** Brookdale Edmond Danforth **License Number:** AL5506 **Survey Event ID:** RE5S11 **Date Survey Completed: 9/25/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1970	Based on: Based on interview & record review, it was determined the center failed to follow their abuse policy while conducting an investigation of an injury of unknown origin for 1 (#1) sampled resident who suffered a fractured femur. This failed practice had the isolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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 is currently not at the community.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	During any investigations the ED or person conducting the interview will date & time investigation notes.
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?	The District Director of Operations will Inservice the Executive Director on Brookdale's policy for abuse & neglect.
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.	Any investigation notes in the next 3 months will be reported to the Director of Operations and/or designee to ensure compliance of the abuse & neglect policy. The Director of Operations &/or designee will review documents related to investigations submitted from the Executive Director over the next 3 months to ensure Brookdales abuse & neglect policy is being followed. During QA any investigations will be discussed to make sure Brookdales abuse & neglect policy is being followed. District Director of Operations or designee will monitor investigation notes for compliance. After the review all notes will be kept in a binder in a secure location
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/31/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Lisa DiMonico** OAC 310:663-25-4(F)	**Date 10/21/2019**

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

February 18, 2020

License Number: AL5506

Ms. Lisa Dimonico, Administrator
Brookdale Edmond Danforth
116 West Danforth
Edmond, OK 73003

Survey Event ID: RE5S12

Dear Ms. Dimonico:

A revisit conducted **February 4, 2020**, revealed that your facility corrected deficiencies effective **November 23, 2019**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me at (405) 271-6868.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL5506	A. BUILDING: _____ B. WING _____	R-C 02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDMOND DANFORTH	116 WEST DANFORTH EDMOND, OK 73003

(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 follow up survey for complaint #OK00054380 was completed on 02/03/2020 to 02/04/2020. Census was 30. Deficient practice was cleared.	{C 000}		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5506	BROOKDALE EDMOND DANFORTH

Type of Survey (select all that apply)

3	D			

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 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)
1 MC 41872	02/03/2020	02/04/2020	1.50	0.00	5.00	0.00	1.00	1.00
2.								
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**