OKLAHOMA
State Department
of Health

Delivery via email to: ldimonico@brookdale.com

June 9, 2022

License Number: AL5506

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

Survey Event ID: 8RBU11

Dear Ms. Dimonico:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **June 2, 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,

Lisa Calvin

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

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Edmond Danforth**
Address: **116 West Danforth**
City, State, Zip: **Edmond, OK, 73003**
Facility ID: **AL5506**
Complaint #: **OK00058881**
Investigation Dates: **06/01/22 through 06/02/22**

ALLEGATION	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to assess, monitor, and intervene to prevent resident illness or injury.	**US**

☐ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 06/01/2022 at 5:35 p.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 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 the facility failing to assess, monitor, and intervene to prevent resident illness or injury was conducted.

Environmental tours were conducted throughout the survey. Staff were observed assisting residents with activities of daily according to their personal service plans. There were no residents observed on the floor. Residents who were identified as being at risk for falls were observed with fall interventions in place. Residents' clinical records were reviewed. It was documented the facility assessed, monitored, and intervened

after an incident and to prevent illness and/or injury. A family representative was asked about their family member's care. They stated their stay had been great. They stated their family had a fall and the facility stepped in to help. A staff member was asked how often residents were assisted with activities of daily living. They stated they had staff in the building 24 hours a day. They stated the amount of care a resident required depended on the residents' personal service plan.

At the time of the investigation, there was no deficient practice identified regarding the facility failing to assess, monitor, and intervene to prevent resident illness or injury.

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.

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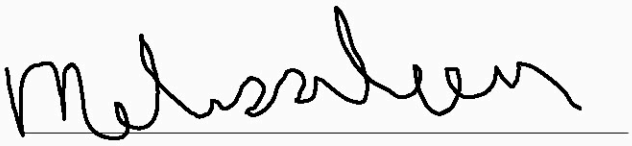

Melissa Cooper, Health Facility Surveyor

Date report completed: 06/02/2022

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
	AL5506	A. BUILDING: _____ B. WING _____	C 06/02/2022

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 complaint investigation (#OK00058881) was conducted from 06/01/22 through 06/02/22. No deficiencies were cited.	C 000		

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