Oklahoma State Department of Health
Creating a State of Health

November 27, 2019

License Number: AL5537

Mr. Delbert Reed, Administrator
Fountainbrook Assisted Living And Memory Support
11510 Se 15th Street
Midwest City, OK 73130

RE: Survey Event ID: OK3L11

Dear Mr. Reed:

On **October 24, 2019,** agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on October 24, 2019.

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 (attached). 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 and monitoring will be completed for each violation;

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5537	A. BUILDING: _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINBROOK ASSISTED LIVING AND MEI	11510 SE 15TH STREET MIDWEST CITY, OK 73130

(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 10/22/19 through 10/24/19. Current census was 72. The following deficient practices were cited.	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regards to kitchen cleanliness and covered facial hair: 310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulations of dust, dirt, food residue, and other debris. 310:257-3-20. Effectiveness (a) Except as provided in (b) of this Section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. These failed practices had the widespread potential for more than minimal harm for a 72 residents who received their nutrition from the kitchen. Findings:	C 391		

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C 391	Continued From page 1 On 10/23/19 at 11:08 a.m., the following findings were observed in the kitchen: 310:257-7-82 (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. - an accumulation of grease and food splatter around and on the steam box and small freezer located beside the deep fat fryer; -an accumulation of grease and food splatter on the back splash located behind the grill and the gas cook top; -an accumulation of grease and food debris on the shelf located under the grill and the shelf located under the gas cook top; and -an accumulation of food debris and food crumbs on the cart which held clean plates and bowls. The dining service director stated the kitchen was cleaner now than when he had started. He further stated he had cleaned the shelf under the grill the previous evening but had not cleaned the shelf under the gas cook top at that time. The dining service director agreed the cart which held the clean dishes needed to be cleaned. 310:257-3-20 (a) ...food employees shall wear...beard restraints...that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment; utensils, and linens; and unwrapped single-service and single-use articles. On 10/23/19 at 11:08 a.m., the dining service director was observed without a beard restraint	C 391		

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C 391	Continued From page 2 covering his facial hair as he prepared food to be served to the residents. He stated he had been surveyed at previous jobs and had never been told he had to cover his facial hair. On 10/24/19 at 12:56 p.m., cook/employee #1 was observed standing in the food preparation/serving area without a beard restraint covering his facial hair. He stated he had not been thinking when he assisted the main cook prepare food earlier without a beard restraint covering his facial hair.	C 391		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment form for 6 (#1, 3, 5 through #8) of 10 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #1	C 543		

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C 543	Continued From page 3 Resident #1 moved into the center on 01/12/18 with diagnoses to include diabetes mellitus, hypertension, and arthritis. His most current annual assessment, dated 09/19/19, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. RESIDENT #3 Resident #3 moved into the center on 06/29/18 with diagnoses to include Alzheimer's, adult failure to thrive, and anxiety. His significant change assessment, dated 11/20/18, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. RESIDENT #5 Resident #5 moved into the center on 09/27/12 with diagnoses to include dementia, macular degeneration, and atrial fibrillation. Her most current annual assessment, dated 03/20/19, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. RESIDENT #6 Resident #6 moved into the center on 10/01/17 with diagnoses to include chronic obstructive pulmonary disease, chronic hypoxia, and hypertension. Her most current annual assessment, dated 10/03/19, had not contained a signature to indicate a personal interview had	C 543		

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C 543	Continued From page 4 been conducted between the resident or the resident's representative and the person who had completed the assessment. RESIDENT #7 Resident #7 moved into the center on 05/05/16 with diagnoses to include chronic obstructive pulmonary disease and asthma. Her most current annual assessment, dated 12/16/18, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. RESIDENT #8 Resident #8 moved into the center on 01/04/19 with diagnoses to include dementia, atrial fibrillation, and hypertension. His comprehensive assessment dated the same date, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. On 10/24/19 at 3:00 p.m., licensed practical nurse #1 stated she had not known the comprehensive assessments were not signed by the above residents or the resident's representative. She further stated she did not know why the assessments were not signed at the time the assessments had been conducted.	C 543		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5537	FOUNTAINBROOK ASSISTED LIVING AND MEMORY SUPPORT

Type of Survey (select all that apply)

2

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)
1. 35195	10/22/2019	10/24/2019	0.75	0.00	20.00	0.00	10.50	3.25
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**

DEC 0 2 2019

Oklahoma State Department of Health
Creating a State of Health

December 20, 2019

License Number: AL5537

Ms. Seana Sutterfield, Administrator
Fountainbrook Assisted Living and Memory Support
11510 Se 15th Street
Midwest City, OK 73130

RE: Survey Event OK3L11

Dear Ms. Sutterfield:

On October 24, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. 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 **December 15, 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,

Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/27/2019
Facility Name: FountainBrook Assisted Living and Memory Support
License Number: AL5537
Survey Event ID: AL5537
Date Survey Completed: 10/24/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391	Based on: observation and interview, it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regards to kitchen cleanliness and covered facial hair.

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?	Hair and Face nets will be worn at all times during kitchen service. Dining team will mop and wipe down all equipment. Deep Cleaning and degreasing of equipment will be done end of shift. Equipment has been moved to were cleaning can be more effective between and behind.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Dining Staff will be inserviced and trained on kitchen cleaniness procedure. Task Sheets will also be created for all Dining Team Members
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?	DSD will ensure all practices are met by conducting daily kitchen walk throughs and having dining team members sign off on there task sheets
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.	DSD will monitor dining staff on a shift basis reviewing task list and cleaning schedules. Deep Cleaning will be done nightly throughout entire kitchen. Lead Cook on shift will make sure cleaning is done. Inservice will be held bi weekly and a record will be kept of inservice topic and discussions. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/15/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 12/19/19

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

10012013

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: 11/27/2019** **Facility Name:** Fountainbrook Assisted Living and Memory Support **License Number:** AL5537 **Survey Event ID:** AL5537 **Date Survey Completed: 10/24/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 543	Based on: interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment form for 6 (#1, 3, 5through #8) of 10 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern.

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?	Nurses will redo the comprehensive assessments that were incomplete and ensure that a signature from resident or legal representative is obtained upon completion of interview.
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 charts have been reviewed by Nurses, Resident Care Director, and RN. Comprehensive assessments have been signed off per State guidelines.
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?	Nurses will be in-serviced on the appropriate procedure for completing comprehensive assessments to prevent the deficiency from occurring on another resident. Comprehensive assessments are due on admission, annually, and when there is a significant change. Nurses will ensure that all comprehensive assessments are filled out completely and obtain all signatures needed. RN will monitor and review assessments that are completed.
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.	Enter methods to ensure corrections are sustained: Comprehensive assessments will be completed on admission, annually, and when there is a significant change. This will be reviewed quarterly by RCD and RN. RCD and RN, along with all management staff, will evaluate in QA meeting to ensure 100% compliance. Resident Care Director will review charts on admit and monthly to confirm that comprehensive assessments are completed per State guidelines.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		12/15/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date** Enter a date of signature.	12/7/19
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.			

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FOUNTAINBROOK ASSISTED LIVING AND MEMORY S	11510 SE 15TH STREET MIDWEST CITY, OK 73130

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C 391	Continued From page 2 covering his facial hair as he prepared food to be served to the residents. He stated he had been surveyed at previous jobs and had never been told he had to cover his facial hair. On 10/24/19 at 12:56 p.m., cook/employee #1 was observed standing in the food preparation/serving area without a beard restraint covering his facial hair. He stated he had not been thinking when he assisted the main cook prepare food earlier without a beard restraint covering his facial hair.	C 391		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment form for 6 (#1, 3, 5 through #8) of 10 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #1	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5537	A. BUILDING: _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINBROOK ASSISTED LIVING AND MEMORY S	11510 SE 15TH STREET MIDWEST CITY, OK 73130

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C 543	Continued From page 3 Resident #1 moved into the center on 01/12/18 with diagnoses to include diabetes mellitus, hypertension, and arthritis. His most current annual assessment, dated 09/19/19, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. RESIDENT #3 Resident #3 moved into the center on 06/29/18 with diagnoses to include Alzheimer's, adult failure to thrive, and anxiety. His significant change assessment, dated 11/20/18, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. RESIDENT #5 Resident #5 moved into the center on 09/27/12 with diagnoses to include dementia, macular degeneration, and atrial fibrillation. Her most current annual assessment, dated 03/20/19, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. RESIDENT #6 Resident #6 moved into the center on 10/01/17 with diagnoses to include chronic obstructive pulmonary disease, chronic hypoxia, and hypertension. Her most current annual assessment, dated 10/03/19, had not contained a signature to indicate a personal interview had	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5537	A. BUILDING: _____ B. WING _____	10/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINBROOK ASSISTED LIVING AND MEMORY S	11510 SE 15TH STREET MIDWEST CITY, OK 73130

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C 543	Continued From page 4 been conducted between the resident or the resident's representative and the person who had completed the assessment. RESIDENT #7 Resident #7 moved into the center on 05/05/16 with diagnoses to include chronic obstructive pulmonary disease and asthma. Her most current annual assessment, dated 12/16/18, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. RESIDENT #8 Resident #8 moved into the center on 01/04/19 with diagnoses to include dementia, atrial fibrillation, and hypertension. His comprehensive assessment dated the same date, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. On 10/24/19 at 3:00 p.m., licensed practical nurse #1 stated she had not known the comprehensive assessments were not signed by the above residents or the resident's representative. She further stated she did not know why the assessments were not signed at the time the assessments had been conducted.	C 543		

Oklahoma State Department of Health
Creating a State of Health

December 30, 2019

License Number: AL5537

Mr. Delbert Reed, Administrator
Fountainbrook Assisted Living And Memory Support
11510 Se 15th Street
Midwest City, OK 73130

RE: Survey Event OK3L12

Dear Mr. Reed:

On **December 19, 2019,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 24, 2019,** have now been corrected effective **December 15, 2019.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL5537	A. BUILDING: _____ B. WING _____	R 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINBROOK ASSISTED LIVING AND MEI	11510 SE 15TH STREET MIDWEST CITY, OK 73130

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{C 000}	INITIAL COMMENTS A follow-up survey was conducted on 12/19/19. Current census was 72. All deficient practice was cleared.	{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
AL5537	FOUNTAINBROOK ASSISTED LIVING AND MEMORY SUPPORT

Type of Survey (select all that apply)

2	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				

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. 36191	12/19/2019	12/19/2019	0.50	0.00	2.00	0.00	1.00	0.50
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**