OKLAHOMA
State Department
of Health

Delivery via email to: fountained@silverpointsenior.com

November 5, 2021

License Number: AL5537

Mr. Alex Baggs, Administrator/Executive Director
Fountainbrook Assisted Living And Memory Support
11510 Se 15th Street
Midwest City, OK 73130

Survey Event ID: FGI411

Dear Mr. Baggs:

On **October 20, 2021,** 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.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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) 426-8200 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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may <u>not</u> use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

OKLAHOMA
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- 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) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. 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,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Fountainbrook Assisted Living and Memory Support**
Address: **11510 SE 15th Street**
City, State, Zip: **Midwest City, Okla. 73130**
Provider #: **AL5537**
Complaint #: **OK00057855**
Investigation Date(s): **10/19 and 10/20, 2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to allow visitors, and failed to notify residents' representatives with changes in condition.	S
2. The center failed to provide adequate medical care.	S

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

An unannounced on-site investigation was initiated on 10/19/2021 at 09:01 a.m.
A sample of 3 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag1505 and 1507 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567 Tag 1507 for details.

Part of allegation #2 was substantiated. Residents' family members were interviewed and had no concerns about residents care provided. Safety checks, toileting checks, and shower documentation was reviewed. Residents were observed to be clean and appropriately dressed. Staff were observed interacting with and assisting

residents at meal time. An investigation specific to adequate care for dependent residents was conducted. No deficient practice was identified specific to care provided for dependent residents.

Determination Summary and Follow-Up Action:

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

Thank you for bringing these concerns to our attention.

Mary Cooper By Pam Condon

Mary Cooper RN/CHFS

Date report completed: 10/27/2021

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 _____	C 10/20/2021

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

(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 (OK00057855) was conducted on 10/19/21 and 10/20/21. Deficient practice was cited. Listed below are abbreviations that will be used throughout this document. AL-Assisted Living CNA-Certified Nursing Assistant DON-Director of Nursing LED-Life Enrichment Director LPN-Licensed Practical Nurse IU-International Units mg-milligram OSDH-Oklahoma State Department of Health PCR-polymerase chain reaction po-by mouth POA-Power of Attorney Res-Resident Vit-Vitamin	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in	C1505		

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C1505	Continued From page 1 terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the center failed to notify residents family or legal representative of change in condition (positive COVID-19 test) for three (#1, #2, and #3) of three sampled residents reviewed for notification of a change in condition. The Administrator identified 55 residents who resided in the center. Findings: 1. Resident (Res) #1 admitted to the center with diagnoses which included, Parkinson's, dementia, right hip fracture with repair, and chronic kidney disease.	C1505		

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	AL5537	A. BUILDING: _____ B. WING _____	C 10/20/2021

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

(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
C1505	Continued From page 2 A "physician's communication order," dated 08/23/2021, documented "...covid positive...verbal order: Zinc 220mg po daily, Vit C 1000mg po daily, Vit D3 2000IU po daily..." A "Notes Report," dated 08/25/2021 at 1:55 p.m., read in parts, "...res. Continues on covid charting. Notified the family and gave an update on status..." No documentation was provided that Res #1's family was notified on 08/22/2021 about Res #1 testing positive for COVID. On 10/20/21 at 4:12 p.m., Res #1's family member was asked when he was notified about the positive covid test. He replied, within a couple of days, hospice notified him. 2. Resident (Res) #2 was admitted to the center with diagnoses which included, dementia, interstitial lung disease, and chronic kidney disease. A "physician's communication order," dated 08/23/2021, read in parts, "...covid positive...verbal order: Zinc 220mg po daily, Vit C 1000mg po daily, Vit D3 2000IU po daily..." A "Notes Report" dated 08/25/2021 at 1:59 p.m., read in parts, " ...Res. cont on covid charting. Notified the [family member] and gave update on status ..." No documentation was provided that Res #2's POA was notified on 08/22/2021 about Res #2 testing positive for COVID.	C1505		

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 _____	C 10/20/2021

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

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C1505	Continued From page 3 3. Resident (Res) #3 was admitted to the center with diagnoses which included, anxiety, senile degeneration of the brain, and adult failure to thrive. A "Notes Report," dated 08/26/2021 at 1:30 p.m., read in parts, "...res. continues on covid charting. Notified the family and gave an update on status..." No documentation was provided that Res #3's family was notified on 08/22/2021 about Res #3 testing positive for COVID. At 11:13 a.m., Res #3's family member was asked how the center notified her visitation was restricted due to the outbreak. She stated, "It was mixed up. I came on Monday (08/23/21) then went home due to no visitation at that time." She was asked when the center notified her Res #3 had tested positive for COVID. She stated, "It took a couple of days for them to let me know, the hospice nurse told me." On 10/20/21 at 09:11 a.m., the DON provided a handwritten list with residents' names and phone numbers (undated). The DON said LPN #1 had notified these families about COVID positive tests performed on 08/22/21, but had not documented in the clinical files. The DON said she received this information from LPN #1 on 10/19/21. Res #1, #2 and #3 were on the list of names.	C1505		
C1507 SS=E	310:663-15-1 & 63 OS 1-1918(B)(7) RESIDENT RIGHTS - Reasonable Accommodation Each assisted living center and its staff shall be familiar with and shall	C1507		

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C1507	Continued From page 4 observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(7) (7) Every resident shall have the right to reside and to receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered; This REQUIREMENT is not met as evidenced by: Based on interview, and record review the center failed to ensure hospice services and visitation was not restricted for; a. residents who received hospice services and, b. residents who resided in the assisted living center during a COVID-19 outbreak. The administrator identified 55 residents resided in the center. Findings:	C1507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1507	Continued From page 5	C1507		

"SilverPoint Senior Living Coronavirus/COVID-19 Preparedness and Response Plan," dated 03/2021, read in parts, "...Continue to prohibit all visitors unless medically necessary...Notify all staff, residents and family/responsible parties...Visitors...Restriction of visitation is not allowed, even during an outbreak. a. Necessary medical personnel will be allowed in the community (home health, hospice, etc.) at all times..."

Visitation log titled, "Guest sign-In/Sign Out," documented from 08/24/21 to 09/03/21 no visitors had signed in for visitation to the center.

On 10/19/21 at 9:46 a.m., the DON was asked if the center restricted visitation when there was covid in the building. She replied, appointments were set, and visits were allowed outside at the windows. The DON was asked if third party providers were allowed in the center during lockdown. She replied, no.

At 10:25 a.m., LPN #2 (hospice nurse) was asked if there was a time when she was not allowed to come as scheduled during the outbreak. She replied, yes, they would do virtual visits.

At 3:10 p.m., CNA #1 was asked if visitation was stopped on the AL side during the outbreak. She replied, there was no visitation at all.

At 3:25 p.m., the visitation log was reviewed with the DON. She was asked if there was any visitation allowed from 08/24/21 to 09/03/21 in the AL side at this time. She replied, she couldn't remember but thought the whole building was shut down.

On 10/20/21 at 11:07 a.m., the LED was asked if

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 _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1507	Continued From page 6	C1507		

he could provide information on the outbreak in memory care on 08/22/21. He stated, "The initial case was sent out to the hospital for a fall on Saturday. Some other residents began to show signs and symptoms of covid so we started doing a rapid test on everyone in memory care. Some residents tested positive that night, then we scheduled full respiratory swabs."

The LED was then asked what happened next. He replied, we quarantined positive residents to their rooms and was told by the (previous) Director to start calling families and put visitation signs on the doors.

He was asked if visitation was changed on the 22nd. He replied, they were instructed to do window visits, face time and zoom. All residents in memory care and assisted living were tested on 08/25/2021. The assisted living did not have any positive results.

At 12:42 p.m., the administrator was asked if the center followed the OSDH guidance for visitation. He replied, yes. He was asked why was the AL restricted if there were no positive cases. He stated, "I started on September 1st, reopened on September 2nd. I knew it shouldn't be shut down."

OKLAHOMA
State Department
of Health

Delivery via email to: Director@FountainbrookLiving.com; FountainED@silverpointsenior.com

November 22, 2021

License Number: AL5537

Mr. Alex Baggs, Executive Director
Fountainbrook Assisted Living And Memory Support
11510 SE 15th Street
Midwest City, OK 73130

Survey Event ID: FGI411

Dear Mr. Baggs:

On **October 20, 2021,** 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 19, 2021**.

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) 426-8200.

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2021.11.22 15:12:17 -06'00'

Tempal Killman, Administrative Assistant
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/9/2021** **Facility Name:** Fountain Brook Assisted Living and Memory Care **License Number:** AL5531 **Survey Event ID:** FGI411 **Date Survey Completed: 10/20/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Based on interview, and record review, the center failed to notify residents family or legal representative of change in condition (positive COVID-19 test) for three (#1, #2, and #3) of three sampled residents reviewed for notification of a change in condition.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Resident's Power of Attorney and Primary Care Doctor will be notified within 24 hours of the resident's change of condition to include positive COVID-19 test results.

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's Power of Attorney and Primary Care Doctor will be notified within 24 hours of the resident's change of condition to include positive COVID-19 test results.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Resident's Power of Attorney and Primary Care Doctor will be notified within 24 hours of the resident's change of condition to include positive COVID-19 test results.
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?	Director of Health and Wellness or LPN on duty will ensure POA and Doctor notification is documented in Health Care notes for each resident requiring change of condition documentation.
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.	a. The correction will be evaluated for ninety days by examining care notes for any resident with a change of condition weekly by the Director of Health and Wellness and Executive Director. The RN Consultant will verify and examine residents with a change of condition monthly. b. All resident's displaying a change of condition, including positive COVID-19 results will be identified and discussed during the quarterly assurance meeting. c. For ninety days all residents requiring documentation of a change of condition and requiring notification of POA and Dr. will be monitored and kept in a separate checklist weekly by the Executive Director.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		11/19/2021	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Alex Baggs, Executive Director OAC 310:663-25-4(F)			**Date 11/18/2021**
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: 11/9/2021** **Facility Name:** Fountain Brook Assisted Living and Memory Care **License Number:** AL5531 **Survey Event ID:** FGI411 **Date Survey Completed: 10/20/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1507	Based on: Based on record review the center failed to ensure hospice services and visitation was not restricted for; a. residents who received hospice services and b. residents who resided in the Assisted Living center during a COVID-19 Outbreak.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The community will adhere to the OSDH COVID grid on current precautions and recommendations outlined for COVID-19 cases in Non Nursing Home LTC.

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?	The community will adhere to the OSDH COVID grid on current precautions and recommendations outlined for COVID-19 cases in Non Nursing Home LTC.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	At the time of an active outbreak residents requiring hospice services will be identified and a schedule of visitation will be coordinated with the resident's hospice representitive by the Director of Health and Wellness or Executive Director.
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 community will adhere to the OSDH COVID grid on current precautions and recommendations outlined for COVID-19 cases in Non Nursing Home LTC.
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.	a. During the time of any COVID-19 outbreaks the Director will consult the OSDH grid for current precautions and recommendations. b. Residents requiring hospice care will be identified and updated on a continuous basis and recorded during the quarterly QA meeting. c. During the time of an active COVID-19 outbreak the community will document in each residents care notes requiring hospice care if Hospice care is interrupted.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Click here to enter a date when corrective action will be completed.
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Alex Baggs, Executive Director**	**Date 11/18/2021**

OAC 310:663-25-4(F)

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

Delivery via email to: fountained@silverpointsenior.com

November 29, 2022

License Number: AL5537

Ms. Kristel Brewer, Administrator
Fountainbrook Assisted Living And Memory Support
11510 Se 15th Street
Midwest City, OK 73130

RE: Survey Event FGI412

Dear Ms. Brewer:

On **November 28, 2022,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **October 20, 2021,** have now been corrected effective **November 19, 2021.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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-C 11/28/2022

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

(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 revisit was conducted 11/28/22. All deficiencies from the 10/20/21 survey were cleared.	{C 000}		

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