OKLAHOMA
State Department
of Health

Delivery via email to: fountained@silverpointsenior.com

September 22, 2022

License Number: AL5537

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

Survey Event ID: ZO3T11

Dear Ms. Brewer:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **September 16, 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 Analyst
Oklahoma State Department of Health

OKLAHOMA
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INVESTIGATIVE REPORT
LICENSURE

Facility: **Fountainbrook Assisted Living and Memory**
Address: **11510 SE 15th Street**
City, State, Zip: **MidWest City, OK, 73130**
Provider #: **AL5537**
Complaint #: **OK00059430**
Investigation Date(s): **09/15/22 through 09/16/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to assess and/or evaluate residents who require a higher level of care related to feeding requirements, elopement and fall risk.	**US**
2. The center failed to ensure a clean, sanitary environment.	**US**
3. The center failed to ensure adequate staff to care for dependent residents.	**US**
4. The center failed to ensure meals were provided in a timely manner.	**US**
5. The center failed to ensure call lights (buttons or pins) were answered in a timely manner.	**US**

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

An unannounced on-site investigation was initiated on 09/15/2022 at 11:30 a.m.

A sample of eight residents including any identified resident, 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 center failed to assess and/or evaluate residents who require a higher level of care related to feeding requirements, elopement and fall risk.

Tours were conducted throughout the survey. Clients were observed receiving assistance with transfers and activities of daily living. Clients were observed to have received the appropriate diets and were assisted as needed. Outside doors were observed with alarm systems in place.

A review of records documented pre-admission assessments had been conducted prior to admission.

Clients stated they received assistance as needed. Staff stated pre-admission assessments were conducted prior to admission to ensure clients' needs could be met safely.

At the time of the investigations, there was no deficient practice related to the center failing to assess and/or evaluate residents who require a higher level of care related to feeding requirements, elopement and fall risk.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the center failed to ensure a clean, sanitary environment was conducted.

Tours were conducted throughout the survey. The kitchen was observed to be clean and well kept. The laundry room was observed to be clean and odor free.

Clients stated they had no concerns with cleanliness in the facility. Staff stated they did routine cleaning in the kitchen and housekeeping and direct care staff ensured laundry services were provided.

At the time of the survey, there was no deficient practice related to the center failing to ensure a clean, sanitary environment.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the center failed to ensure adequate staff to care for dependent clients was conducted.

Tours were conducted throughout the survey. Clients were observed to receive care and assistance as needed. Adequate staff was observed on all shifts.

Clients stated they had adequate staff to meet their needs.

Staff stated they scheduled with occasional assistance of agency staffing and that department heads frequently assisted clients. Staff stated they staffed according the client needs.

At the time of the investigation, there was no deficient practice related to the center failing to ensure adequate staff to care for dependent residents.

Allegation #4: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the center failed to ensure meals were provided in a timely manner was conducted.

Observations of meal services were conducted throughout the survey. Clients were observed in the dining rooms with fluids. Clients were observed to be served meals timely.

Clients stated meals were served timely.

Staff stated department heads assisted with meal services to ensure meal were provided timely.

At the time of the investigation, there was no deficient practice related to the center failing to ensure meals were provided in a timely manner.

Allegation #5: Deficient practice was unsubstantiated related to this allegation**.**

An investigation specific to the center failed to ensure call lights (buttons or pins) were answered in a timely manner was conducted.

Tours were conducted throughout the survey. Clients were observed to receive care as needed.

Clients stated staff answered call lights timely. One client stated they once waited 30 minutes for staff to answer the call button, but their need at the time was not urgent.

Staff stated call lights should be answered timely. Staff stated all clients had a call pendant and when they pushed the pendant, it went to the staffs' walkie talkie to alert them.

At the time of the investigation, there was no deficient practice related to the center failing to ensure call lights were answered timely.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1, 2, 3, 4and #5. 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.

Rae Belt, RN, CHFS

Date report completed: 09/18/2022

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
	AL5537	A. BUILDING: _____ B. WING _____	C 09/16/2022

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 complaint investigation (#OK00059430) was conducted on 09/15/22 and 09/16/22. The facility was in substantial compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	C 000		

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