OKLAHOMA
State Department
of Health

Delivery via email to: director@fountainbrookliving.com

July 13, 2021

License Number: AL5537

Mr. Dalton Bryan, Administrator
Fountainbrook Assisted Living and Memory Support
11510 SE 15th Street
Midwest City, OK 73130

Survey Event ID: D7ED11

Dear Mr. Bryan:

On **June 28, 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.

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;

OKLAHOMA
State Department
of Health

(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.

OKLAHOMA
State Department
of Health

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 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) 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,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.07.13 11:48:42 -05'00'

Katie Stagner, 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: **MWC, OK 73130**
Provider #: **AL5537**
Complaint #: **OK00056254**
Investigation Date(s): **06/21/21 through 06/24/21 and 06/28/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to follow COVID-19 infection control guidelines.	**US**

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

An unannounced on-site investigation was initiated on 06/21/2021 at 11:45 a.m.

A sample of 20 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 unsubstantiated related to this allegation.

An investigation specific to COVID-19 infection control was conducted. At the time of the survey, no staff complained about having enough personal protective equipment (PPE) including masks during the pandemic. Records were reviewed and no positive staff worked. Positive staff isolated at home. The only staff who went to memory support and assisted living were licensed practical nurses for assessments of residents. Any resident who tested positive were isolated in their rooms.

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.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 07/06/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Fountainbrook Assisted Living and Memory Support**
Address: **11510 SE 15th Street**
City, State, Zip: **MWC, OK 73130**
Provider #: **AL5537**
Complaint #: **OK00056266**
Investigation Date(s): **06/21/21 through 06/24/21 and 06/28/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to follow proper infection control procedures.	**US**

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

An unannounced on-site investigation was initiated on 06/21/2021 at 11:45 a.m.

A sample of 20 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 unsubstantiated related to this allegation.

An investigation specific to COVID-19 infection control was conducted. At the time of the survey, no staff complained about having enough personal protective equipment (PPE) including masks and shields during the pandemic. Records were reviewed and no positive staff worked. Positive staff isolated at home. Any resident who tested positive were isolated in their rooms. During the pandemic, the other resident's quarantined in their rooms. Disinfectants used at the center were listed on the Centers for Disease Control and Prevention. Housekeeping had separate staff and carts assigned to memory support and to assisted living.

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.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 07/06/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Fountainbrook assisted living and memory support**
Address: **11510 SE 15th Street**
City, State, Zip: **MWC, OK 73130**
Provider #: **AL5537**
Complaint #: **OK00057260**
Investigation Date(s): **06/21/21 through 06/24/21 and 06/28/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to protect and ensure the safety of the residents.	S

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

An unannounced on-site investigation was initiated on 06/21/2021 at 11:45 a.m.

A sample of 2 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, Tag 1512 for details.

An investigation specific to resident safety and protection with supervision and monitoring and was conducted.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. 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.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 07/06/2021

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 _____	06/28/2021

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 An abbreviated survey was conducted 06/21/21 through 06/24/21, and 06/28/21 to investigate complaints #OK 00056254, #OK 00056266, and #OK 00057260. Total residents: 54	C 000		
C1512 SS=K	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	C1512		

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C1512	Continued From page 1 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: On 06/22/21, an Immediate Jeopardy (IJ) situation was determined to exist when the center failed to provide supervision and intervene for resident #1 to prevent multiple elopements. At 3: 35 p.m., the Oklahoma State Department of Health (OSDH) verified the existence of the IJ situation. At 3:50 p.m. the administrator (via telephone) and director of nursing (DON) were notified of the IJ situation related to the multiple elopements of resident #1.	C1512		

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C1512	Continued From page 2 At 5:10 p.m., the administrator and DON submitted an acceptable plan of removal. The plan of removal documented the following: Fountain Brook assisted living and memory support, plan of removal *Resident identified has been moved to memory care unit, room 416, on 06/22/2021 at 1:00 p.m. *RN (registered nurse) consultant will update State assessment form for significant change and update resident's care plan on 06/23/2021 at 1:00 p.m. *Staff will be in-serviced on elopement risk and fountainbrook's elopement policy on 06/23/2021 by 5:00 p.m. No staff will work until they have been inserviced on these areas. *Resident Care Director will update identified resident's elopement risk for on 06/22/2021. *Resident Care Director/designee to evaluate all assisted living residents for elopement risk. Any found will be addressed for safety by transferring to memory care, 1-1 sitter, or 30 day notice to transfer out. Completed by 5:00 p.m. on 06/23/2021. *Maintenance director/designee will evaluate all exit doors to ensure alarmed or secured properly. 06/23/2021 by 5:00 p.m. *Maintenance director/designee will check all doors daily x 7 days to ensure operating properly, then weekly afterward. *Elopement risk assessments will be completed on all new move ins on or before move in. *Any resident that elopes will be placed on one on one supervision for 24 hours after incident and transferred to memory care for safety. On 06/24/21 at 5:22 p.m. the plan of removal had not been completed. There were 19 missing inservices which had not been completed. An	C1512		

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	AL5537	A. BUILDING: _____ B. WING _____	06/28/2021

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

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C1512	Continued From page 3	C1512		

addendum was requested from the DON.

At 5:47 p.m., the DON submitted an acceptable addendum to the plan of removal. The addendum documented the same as above, but with the following addendum:
Fountain Brook assisted living and memory support plan of removal addendum 06/24/2021
*Staff will be inserviced on Elopement risk and Fountainbrook's Elopement policy on 06/25/21 by 5:00 p.m. No staff will work until they have been inserviced on these areas.

The Immediate Jeopardy was removed on 06/25/21 at 5:00 p.m,, when all components of the Plan of Removal had been completed. The deficiency remained at a pattern level with a potential for more than minimal harm.

Based on observation, interviews, and record review, it was determined the facility failed to provide supervision to prevent multiple elopements for one (#1) of two sampled residents who were at risk for elopement. The resident eloped from the facility four times and was found on busy city streets and close to a pond.

Findings:

The center's policy, titled Elopement/Missing resident, dated 02/2019, documented, "...When the resident is located...Assess resident for any harm...Complete an incident report, including exterior temperatures, and contact the appropriate supervisors and/or designated agents...Complete assessments needed for a significant change in the resident.

A new referral form for FountainBrook, undated, documented resident #1 was in the hospital with

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C1512	Continued From page 4	C1512		

confusion. The form documented, "He was driving, but gets lost. He will most likely need memory care."

Resident #1 was admitted on 04/12/21 with diagnoses to include atrial fibrillation (A-fib), hypertension (HTN) and dementia with a history of lumbar compression fracture and skin cancer (CA).

The service agreement, dated 04/12/21, documented General Policies, there are certain security features at Fountain Brook to help ensure the safety of the residents.

A comprehensive assessment, dated 04/12/21, documented he was alert, oriented x 3 (person, place, time), forgetful, with good judgement. The resident had good mobility, strength and gait. He was weight bearing, ambulatory without assistance, and independent with all activities of daily living (ADL's) to include bathing, eating, dressing, transferring, toileting and ambulation. His History of Elopement Risk was documented as Not applicable (N/A). The assessment was signed by the resident and LPN.

An Elopement Risk Assessment dated 04/12/21 documented, Check only those statements which apply to the resident. Checking any of statement number 2 through 5 in conjunction with statement 1 automatically placed the resident at risk for elopement. This risk shall be addressed in the Health Services Plan.

This information can be obtained from family, care team, or clinical record.

1. Resident has a medical diagnosis that indicates Alzheimer's, dementia, psychiatric

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C1512	Continued From page 5	C1512		

diagnosis or delirium. (Not marked)
2. Resident has a history of wandering or pacing while trying to (o)pen (sic) doors, windows and or gates. (Not marked)
3. Resident expresses anger at nursing home or assisted living placement or verbalizes desire to leave community without just cause. (Not marked)
4. Resident has a past history of elopement from the home or facility environment. (Not marked)
5. Resident has a past history of devising schemes or making plans for elopement. (Not marked)
6. None of the above statement numbered 1-5 apply to this resident. (Marked) Signed by LPN.

A care plan, dated 04/13/21, did not address elopement. Dementia was care planned as impaired memory.

A nursing progress note, dated 06/04/21 at 2:58 p.m., documented, "Resident has been found walking around out side of facility. Resident has increased confusion. Redirected into facility...Resident has been seeking exit all day. Resident has been placed on Q [every] 30 min [minute] safety checks due to warnding [sic]. [Increased] confusion noted, concerned resident stating in Kansas. UA [urinalysis] results are negative." (There was no incident report for this incident. This was the first time the resident was found outside of the center.)

An incident report, dated 06/04/21, documented, "Resident managed to leave facility and was found by staff on 15th Street, pass [sic] Anderson Rd at about 6pm. Resident was very confused, but able to redirect. Resident stated that he left out of the front door of the main entrance. After reviewing the cameras, resident was sitting in the

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C1512	Continued From page 6	C1512		

West Common area watching an evening movie, got up, walked off, then left out of a side door that was having some malfunction at the time..." (Second time outside the center.)

A nursing progress note, dated 06/12/21 at 11:30 a.m., documented, "Res [Resident] was found by staff walking down 15th Street. Res was able to redirect. [Increased] confusion noted. 15 min [checks] initiated....Staff to closely monitor resident."

An incident report, dated 06/12/21, documented, "Resident was found by staff on 15th Street, in the Oakwood East Subdivision by the pond at about 11:30am. Resident was confused, but able to redirect. Resident stated that he left out of the front door of the main entrance. After reviewing the cameras, resident did not leave out of the front door. There was a door in the Dining Room that was unlocked after incident. It is believed that resident may have gotten out of that door. This is the second incident of resident getting out of facility..." (Third time outside the center.)

A medical doctor (MD) communication form, dated 06/15/21, documented increased confusion, exit seeking. MD response: follow up (F/U) BMP in 1 week.

A nursing progress note, dated 06/16/21 at 11:30 a.m., documented, Res managed to leave while movers had door propped open while moving in furniture. Res was found on 15th Street in Oakwood East subdivision pass [sic] the pond. Res able to redirect. 15 min checks initiated...POA [Power of Attorney] came to visit and spend one on one time [with] resident. Res will continue 30 min checks. Res having some [increased] confusion and thinks he's in Kansas

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	AL5537	A. BUILDING: _____ B. WING _____	06/28/2021

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C1512	Continued From page 7	C1512		

where he recently moved from. Res stated he's wanting to visit girlfriend and has important business to take care of. New order - UA [with] C&S [culture & sensitivity]. Staff educated to keep close eye on resident."

An incident report, dated 06/16/21, documented, "Resident was found by staff on 15th Street, in the Oakwood East Subdivision pass [sic] the pond at about 11:30am. Resident was confused, but able to redirect. Resident stated that he left out of the front door of the main entrance. After reviewing the cameras, resident did not leave out of the front door. There were movers on 200 Hall moving in furniture to 213, the door was propped open, and resident managed to exit that door..." (Fourth time outside the center.)

On 06/21/21 at 12:10 p.m. resident #1 was asked if there were enough activities. He stated, "Yeah, if I want to." He was asked what he liked to do. He stated, "Work on my old pick-up." It has over 200,000 miles on it.

On 06/22/21 at 8:30 a.m. resident #1 was asked if he liked to go outdoors. He stated, he liked to be outdoors and work on things.

At 9:05 a.m. an employee was asked about resident #1. He stated he'd been working when the resident was exit seeking. He was asked if he knew what caused the resident to elope and/or exit seek. He stated, he (resident #1) was trying to go home to Kansas to his girlfriend. He goes the same direction each time (eloped).

At 10:22 a.m. employee #2 was asked about resident #1. She stated she had heard about him escaping. She stated he was always checking the doors (exit seeking) and trying to get out

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 _____	06/28/2021

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
C1512	Continued From page 8	C1512		

(even at night). She stated a week before last (06/12/21) they thought he was on 30 minute checks and when they went to find him, they couldn't find him. LPN#1 (oncall) was notified and she found him down the street by the pond and brought him back to the center. She stated the front door didn't latch properly.

At 10:43 a.m. employee #1 was asked how resident (#1) was monitored. He stated it wasn't just one person assigned, but whoever saw him. He stated it's usually the long term care aide (LTCA), but if it's agency staff (LTCA) then it would be him (CMA).

At 11:08 a.m. the LPN/DON stated the resident's (#1) exit seeking behavior started 06/03/21 during the night shift. They reported he wasn't sleeping and went to the door in the dining room, but he was redirected.

She stated the progress note and incident report documented two separate situations on 06/04/21. The resident had been confused and exit seeking all day and was found walking around outside the center. (First time resident outside center).

She stated, the camera revealed at 5:51 p.m. the resident (#1) got up from watching tv/movie and went straight out the side door. The door did not alarm. (Second time resident outside center). He was missing for about 9 minutes. He walked about a mile to Anderson Road.

She was asked what was done to ensure the safety of the resident. She stated he was placed on 15 minute checks and placed on the memory care unit.

She stated this was not documented, but when

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C1512	Continued From page 9	C1512		

he was returned to the center around 6 p.m. he was placed on the memory care until the night shift. He returned to his room as a 1:1 with an agency CMA.

She stated on 06/12/21, LPN #1 saw him walking down the sidewalk on 15th street after her break. The dining room door had been left unlocked. No one in the center noticed he was missing until he was brought back. Unable to determine how long he had been missing.

She was asked what was done to ensure his safety. She stated he was placed on 15 minute checks and engaged in activities.

After review of the incident report, dated 06/16/21, she stated activities was taking another resident to a scheduled appointment and saw him walking down 15th street past the pond. He had left through hall 200's doors due to movers. She was asked how long he had been gone for. She stated, "Maybe 2 minutes."

She stated they would be moving him to memory care today, June 22, 2021.

She was asked if there were any interventions implemented following each elopement. She stated, 15 minute checks, educated staff, watch doors, activities 1:1 to work with hands and keep busy. The resident would sleep during the day and be up at night and now he's on a better sleep schedule. She stated a UA was obtained with negative results.

She was asked how the resident representative was involved in decisions regarding interventions. She stated he was consulted about memory care and not until the third elopement 06/12/21 did he

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C1512	Continued From page 10	C1512		

seriously consider it because of finances, but was agreeable by 06/16/21, but he remained in assisted living rather than memory support.

She was asked how the staff was monitored to ensure they were implementing interventions. She stated the resident had been on 30 minute checks.

She was asked if the registered nurse (RN) had been notified of his exit seeking behavior and elopements. She stated she was not notified on 06/12/21 or 06/16/21. She stated the RN had been to the center since 06/04/21, but she didn't think she knew of either situation.

At 12:41 p.m. LPN #1 was asked why there was no incident report for 06/04/21 at 2:58 p.m. She stated, because the resident was on the property. He never left the property lines/boundaries. She was asked if anyone had seen him leave. She stated, "No." She was asked if anyone knew how long he had been outside unattended. She stated, "No."

The center's policy, titled elopement/missing resident, dated 02/2019, documented assess the resident for any harm. Complete the incident report, including exterior temperatures, and contact the appropriate supervisors and/or designated agents following established procedures. Complete assessments needed for a significant change in the resident.

At 1:32 p.m. the DON/LPN was asked if there was a more effective intervention than the 15 or 30 minute checks since he was still able to elope. She stated the doors and he should have been reassessed.

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C1512	Continued From page 11 The service agreement, dated 04/12/21, documented General Policies, there are certain security features at Fountain Brook to help ensure the safety of the residents.	C1512		

OKLAHOMA
State Department
of Health

Delivery via email to: Director@FountainbrookLiving.com

July 26, 2021

License Number: AL5537

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

Survey Event ID: D7ED11

Dear Mr. Bryan:

On **June 28, 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 **June 28, 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: 2021.07.26 12:32:40 -05'00'

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: 8/19/2013** **Facility Name:** FountainBrook AL/MC **License Number:** AL 5537 **Survey Event ID:** 00056254, 00056266, 00057260 **Date Survey Completed: 6/28/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1512	Based on: On 06/22/21, an Immediate Jeopardy (IJ) situation was determined to exist when the center failed to provide supervision and intervene for resident #1 to prevent multiple elopements.At 3: 35 p.m., the Oklahoma State Department of Health (OSDH) verified the existence of the IJ situation. At 3:50 p.m. the administrator (via telephone) and director of nursing (DON) were notified of the IJ situation related to the multiple elopements of resident #1.

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 was moved to the on-site Memory Care Unit on 06.22.2021. All staff have been in-serviced on Elopement Risk and management. Completed on 06.25.2021. All of the electro-magnetic locks have been repaired or replaced as necessary. Redundant battery operated alarms have also been placed on all the doors and have been added to the scheduled preventative maintenance check to ensure they will operate moving forward. The Ciscor Nurse call and security system has been updated to include all windows and doors and now announces to direct care staff when a door or window is opened and its location. Maintenance Director/designee to monitor for 7 days then weekly thereafter.
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 Assisted Living residents have been assessed for elopement risk, no other residents are at risk as of 6.28.2021. The assessment tool will be used for future residents to address elopement risk. Any future resident found to be an elopement risk will be addressed for safety, transferred to On-Site Memory Care Unit, 1:1 direct supervision and/or given a 30 day notice of discharge.
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?	All of the electro-magnetic locks have been repaired or replaced as necessary. Redundant battery operated alarms have also been placed on all the doors and have been added to the scheduled preventative maintenance

	check to ensure they will operate moving forward on a consistent basis. The Ciscor Nurse call and security system has been updated to include all windows and doors and now announces to direct care staff when a door or window is opened and its location. All staff have been in-serviced on Elopement Risk and management and this topic has been added to our on-boarding program for new staff.
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 topic of elopement risk and evaluation of residents for elopement will be a continued part of our quartly Quality Assurance meetings. Records of all QAQC Meetings are kept as Resident Records are for 5 years, available within 72 hours and the current 12 months to be kept in-house. The Executive Director or designee will monitor and evaluate the Quality Assurance Meetings to ensure the effectiveness of this Plan of Care for all residents with a risk for or potential for elopement. 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?	6/28/2021
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 7/19/2021**
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

Delivery via email to: FountainED@silverpointsenior.com

December 1, 2022

License Number: AL5537

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

Survey Event ID: D7ED12

Dear Ms. Brewer:

A revisit conducted **November 28, 2022**, revealed that your facility corrected deficiencies effective **July 23, 2022**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me 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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

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
	AL5537	A. BUILDING: _____ B. WING _____	R 11/28/2022

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{C 000}	INITIAL COMMENTS A revisit was conducted 11/28/22. All deficiencies from the 06/28/21 survey were cleared.	{C 000}		

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