
Delivery via email to: FountainED@silverpointsenior.com

July 7, 2025

License Number: AL5537

Rishell Gresham, Administrator
Fountainbrook Assisted Living and Memory Support
11510 Se 15th Street
Midwest City, OK 73130

RE: Survey Event ID: EZF411

Dear Ms. Gresham:

On **June 20, 2025**, agents from our office concluded a State Licensure survey with a complaint investigation at your facility. The deficiencies found during that visit 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 **June 20, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care**. 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) 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face-to-face, or virtual 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: IDRCoordinator@health.ok.gov

or mail 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.

Respectfully,

Tempal Killman

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

Enclosure

INVESTIGATIVE REPORT

Facility: Fountainbrook Assisted Living and Memory Support
Address: 11510 SE 15th Street
City, State, Zip: Midwest City, OK, 73130
Provider #: AL5537
Complaint #: OK00073532
Investigation Date(s): 06/18/25 through 06/20/25

ALLEGATION(S)
1. The center failed to provide an environment free of pest.

An unannounced on-site investigation was initiated 06/18/2025 at 7:45 a.m.

A sample of 10 residents, including any identified residents, 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 Summary of Complaint Investigation: A tour of the facility was conducted on and throughout the survey. The facility was observed for concerns related to pest. Records reviewed included employee records, residents' health records, nurses' notes, incident reports, grievances, resident service contracts, service plans, pest management records, and facility policies. Residents were asked questions about concerns related to pests in the center. Staff were asked about pest concerns and pest management practices.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 06/27/2025

INVESTIGATIVE REPORT

Facility: Fountainbrook Assisted Living and Memory Support
Address: 11510 SE 15th Street
City, State, Zip: Midwest City, OK, 73130
Provider #: AL5537
Complaint #: OK00074499
Investigation Date(s): 06/18/25 through 06/20/25

ALLEGATION(S)

1. The center failed to assess, monitor and intervene in a timely manner for a change in condition.

An unannounced on-site investigation was initiated 06/18/2025 at 7:45 a.m.

A sample of 10 residents, including any identified residents, 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 Summary of Complaint Investigation: A tour of the facility was conducted on and throughout the survey. The facility was observed for concerns related to resident decline and care. Records reviewed included employee records, residents' health records, nurses' notes, incident reports, grievances, resident service contracts, service plans, and facility policies. Residents and family representatives were asked questions about concerns related to resident care. Staff were asked about residents' decline, assessing for a decline, and documenting the decline.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 06/27/2025

INVESTIGATIVE REPORT

Facility: Fountainbrook Assisted Living and Memory Support
Address: 11510 SE 15th Street
City, State, Zip: Midwest City, OK, 73130
Provider #: AL5537
Complaint #: OK00083509
Investigation Date(s): 06/18/25 through 06/20/25

ALLEGATION(S)
1. The center failed to ensure residents were not abused.
2. The center failed to ensure the right to make personal choices.
3. The center failed to have and/or implement an effective discharge policy and procedure.

An unannounced on-site investigation was initiated 06/18/2025 at 7:45 a.m.

A sample of 10 residents, including any identified residents, 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 Summary of Complaint Investigation: A tour of the facility was conducted on and throughout the survey. The facility was observed for concerns related to resident care and the environment. Records reviewed included employee records, residents' health records, nurses' notes, incident reports, grievances, resident service contracts, service plans, rental agreements, and facility policies. Residents and family representatives were asked questions about concerns related to resident care, abuse, discharges, and resident rights. Staff were asked about discharge policies and procedures abuse, discharges, and resident rights.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 06/27/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5537	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2025
NAME OF PROVIDER OR SUPPLIER FOUNTAINBROOK ASSISTED LIVING AND MEMORY §		STREET ADDRESS, CITY, STATE, ZIP CODE 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 relicensure survey with complaints (#OK00073532, OK00074499, and #OK00083509) was conducted from 06/18/25 through 06/20/25. Deficiencies were cited as a result of the survey. Facility Census: 70 Listed below are the abbreviations that will be used throughout this document. BOM - business office manager CMA - certified medication aide CNA - certified nursing assistant OSDH - Oklahoma State Department of Health	C 000		
C 371 SS=D	310:663-3-6(a) MANAGEMENT OF RISK (a) If a resident's preference or decision places the resident or others at risk or is likely to lead to an adverse consequence, the assisted living center shall advise the resident and the resident's representative of such risk or consequences. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to advise a resident of the risks related to involuntary termination of their rental agreement for 1 (#1) of 3 residents sampled for involuntary termination of their rental	C 371		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 371	Continued From page 1 agreement. The executive director identified 70 residents resided in the center. Findings: On 06/18/25 at 11:40 a.m., Resident #1's apartment was observed. The following observations were made: a. the bathroom floor was damaged with exposed concrete, peeled and missing tiles in a 2 feet by 5 feet area in front of the shower; b. the baseboard was peeled from the wall near the toilet with exposed glue on the wall; and c. the shower rubber seal on the threshold was raised and broken. Resident #1's "Residential Rental Agreement," dated 07/24/24, read in part, "Prior to termination, the sponsor will give the resident written notice of the reason for the proposed termination and the resident will have three days in which remedy the situation to sponsor reasonable satisfaction. If the situation is remedied within the three day period to the reasonable satisfaction of sponsor, this agreement will not be terminated." Resident #1's comprehensive annual assessment, dated 07/25/24, showed their judgement was fair and they were confused at times. The assessment showed they had diagnoses which included depression and atrial fibrillation. A facility issued document titled "Notice of Termination," dated 06/04/25, showed a 30 day termination of the lease agreement was given to Resident #1 on 06/04/25 and effective on 07/04/25. The document showed the reason as	C 371		

Oklahoma State Department of Health

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C 371	Continued From page 2 "The residents apartment is unsanitary and has been destroyed by the resident." A review of Resident #1's health record did not document Resident #1 was advised of any risks related to unsanitary living conditions. On 06/18/25 at 11:40 a.m., Resident #1 stated they received a "Notice of Termination," dated 06/04/25, for the unsanitary conditions in their apartment. Resident #1 stated they had reported the damaged floors and baseboards to the facility staff which was caused by the shower leaking onto the floor. On 06/18/25 at 12:00 p.m., the executive director stated there was no documentation in Resident #1's health records they were advised of the risks related to the unsanitary living conditions in their apartment prior to the notice on 06/04/25.	C 371		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by:	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 3 Based on observation, record review, and interview, the center failed to ensure a significant change assessment was completed after a change in condition for 1 (#1) of 10 residents sampled for a change in condition. The executive director identified 70 residents resided in the center. Findings: On 06/18/25 at 11:40 a.m., Resident #1 was observed in their room using a wheelchair to ambulate. An undated center policy titled "Change in Condition," read in part, "When a resident exhibits a change in condition, action will be taken to coordinate appropriate care."..."Examples of change in conditions may include but not be limited to:"..."Decreased mobility"..."change in patterns of elimination."..."If the residents status change is more than a transient problem, a resident care conference is arranged." Resident #1's comprehensive annual assessment, dated 07/25/24, showed their judgement was fair and they were confused at times. The assessment showed they had diagnoses which included depression and atrial fibrillation, was continent of bowels and urine, and ambulated with a walker without assistance. Resident #1's six month facility assessment titled "Resident Functional Needs Assessment," dated 12/31/24, showed the resident was able to bear own full weight, could walk to the dining room and all activities inside and outside of the residence independently, and was continent of urine.	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 4 Resident #1's physician orders, dated 02/03/25, showed Resident #1 was prescribed Furosemide (a diuretic) 20 milligrams one time a day. On 06/18/25 at 11:40 am., Resident #1 stated they took a diuretic which made them urinary incontinent and urinate frequently. On 06/18/25 at 1:01 p.m., the maintenance director stated Resident #1 was incontinent of urine and had urinated in the dining room and common areas. They stated the resident would say it came from their wheelchair cushion and denied the incontinence. On 06/18/25 at 1:26 p.m., CNA #1 stated Resident #1 was incontinent at times and soiled themselves when in the dining room. On 06/18/25 at 2:04 p.m., the BOM stated Resident #1 was incontinent of urine. The BOM stated when Resident #1 was discreetly notified there was a urine smell and they could see the urinary incontinence, Resident #1 would deny the incontinence and refuse to allow assistance with changing or cleaning them. On 06/18/25 at 2:45 p.m., the health and wellness director stated Resident #1 was incontinent of urine due to taking a diuretic and used a wheelchair to ambulate. The health and wellness director stated Resident #1 was ambulating with a walker and was continent of urine when they were comprehensively assessed during an annual assessment on 07/25/24. The health and wellness director stated there should of been a significant change assessment completed and they just missed it because they were not paying attention.	C 522		

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C 701	Continued From page 5	C 701		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure water temperatures were no more than 115 degrees Fahrenheit in 3 of 4 sampled rooms observed for water temperatures. The executive director identified 70 residents resided in the center. Findings: On 06/19/25 at 2:35 p.m., water temperatures were tested on each hall in residents' bathrooms. The following observations were made: a. room 110, the water temperature was 123 degrees Fahrenheit; b. room 220, the water temperature was 122 degrees Fahrenheit; and c. room 404, the water temperature was 117 degrees. A center document titled "Water Temperature	C 701		

Oklahoma State Department of Health

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C 701	Continued From page 6 Log," dated 05/25/25, showed the water temperatures recorded in eight residents' rooms was between 119.1 degrees Fahrenheit to 119.6 degrees Fahrenheit. On 06/19/25 at 3:00 p.m., CMA #2 was asked about the water temperatures. They stated the water temperatures were accurate. On 06/19/25 at 3:05 p.m., the maintenance supervisor stated water temperatures in residents' bathrooms should be between 115 to 121 degrees Fahrenheit. They stated they tried to keep residents' bathrooms between 117 to 119 degrees Fahrenheit. On 06/19/25 at 3:25 p.m., the executive director stated they did not have policies or procedures on maintaining water temperatures in residents' bathrooms.	C 701			
C1304 SS=D	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract.	C1304			

Oklahoma State Department of Health

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C1304	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to document incidents of damage to the environment and maintain the environment in good repair for 1 (#1) of 10 sampled residents who were reviewed for environmental concerns. The executive director identified 70 residents resided in the center. Findings: On 06/18/25 at 11:40 a.m., Resident #1's apartment was observed. The following observations were made: a. the bathroom floor was damaged with exposed concrete, peeled and missing tiles in a 2 feet by 5 feet area in front of the shower; b. the baseboard was peeled from the wall near the toilet with exposed glue on the wall; and c. the shower rubber seal on the threshold was raised and broken. Resident #1's "Residential Rental Agreement," dated 07/24/24, read in part, "MAINTENANCE AND REPAIRS. Sponsor shall bear all expenses of repairing and maintaining the unit;..."The following services and amenities are 'Covered Services' and their cost are included in Monthly Rental/Service Fee."..."Routine and usual repair and maintenance of furnishings and appliances in the unit." Resident #1's comprehensive annual	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 8 assessment, dated 07/25/24, showed their judgement was fair and they were confused at times. The assessment showed they had diagnoses which included depression and atrial fibrillation. A review of Resident #1's health record, incidents, and work orders from 07/25/24 through 06/20/25 did not document the needed repairs to the resident's bathroom or incidents alleging the resident caused damage to the residence. On 06/18/25 at 11:40 a.m., Resident #1 stated they received a "Notice of Termination," dated 06/04/25, for the unsanitary conditions in their apartment. Resident #1 stated they had reported the damaged floors and baseboards to the facility staff which was caused from the shower leaking water onto the floor. Resident #1 stated the center had never discussed the concern related to the environment prior to the "Notice of Termination," dated 06/04/25. On 06/18/25 at 12:00 p.m., the executive director stated there was no documentation in Resident #1's health records of a lack of agreement with the center's rental agreement for any damages to the residence. On 06/18/25 at 1:00 p.m., house keeper #1 stated Resident #1's bathroom looked bad. They stated the baseboard was peeled off the wall, the tile was peeled up in front of the shower in an area about 4 feet by 2 feet. They stated it had been in disrepair for four or five months and they were unsure why it had not been repaired. They stated the resident caused the damage due to flooding the unit intentionally five times. On 06/18/25 at 1:10 p.m., the maintenance	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 9 director stated the repairs were not completed because the resident was issued a "Notice of Termination" notice and they just got away from them. They stated the center policy for the environment was it should be maintained like their loved one lived in it.	C1304		
C1501 SS=D	310:663-15.1 & 63 OS 1-1918(B)(1) RESIDENT RIGHTS - Civil Liberties 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)(1) (1) Every resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed upon and the facility shall encourage and assist in the exercise of these rights;	C1501		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5537	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2025
NAME OF PROVIDER OR SUPPLIER FOUNTAINBROOK ASSISTED LIVING AND MEMORY §		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1501	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident's right to self determination was followed for 1 (#1) of 3 sampled residents reviewed for resident rights to self determination. The executive director identified 70 residents resided in the center. Findings: An undated center policy titled "Personal rights," read in part, "Staff respects each resident's personal rights, which includes, but are not limited to the right:..."leave or depart the community at anytime and to not be locked into any room, building, or on community premises by day or night." Resident #1's comprehensive annual assessment, dated 07/25/24, showed their judgement was fair and they were confused at	C1501		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5537	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/20/2025
NAME OF PROVIDER OR SUPPLIER FOUNTAINBROOK ASSISTED LIVING AND MEMORY §			STREET ADDRESS, CITY, STATE, ZIP CODE 11510 SE 15TH STREET MIDWEST CITY, OK 73130		
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C1501	Continued From page 11 times. The assessment showed they had diagnoses which included depression and atrial fibrillation. A center form titled "Incident Report," dated 06/03/25, showed Resident #1 was outside the facility watching the thunderstorms. There was a tornado warning and the sirens were alerting of a danger. Resident #1 refused to come inside when staff informed them of the possible danger. Resident #1 voiced their refusal to come inside. CNA #2 tried to force Resident #1 to come inside by pushing their wheelchair. Resident #1 was refusing to go inside and grabbed CNA #2 by the throat choking them in order to prevent CNA #2 from forcing them back inside to go to the designated storm shelter area. Resident #1 threw themselves onto the ground in front of the facility to prevent CNA #2 from forcing the resident to go inside the facility. The police were notified and helped the resident get back into their wheelchair. On 06/18/25 at 10:11 a.m., CNA #2 stated Resident #1 was outside during a tornado warning and all other residents were being moved into the designated storm shelter area. They stated additional staff tried to convince the resident to come inside and the resident refused. CNA #2 stated they tried to pull the resident's wheelchair against the resident's will to force them to come inside to safety. CNA #2 stated the resident was cursing and refusing to come inside and the resident braced their foot against a pillar to prevent them from pulling their wheelchair inside the facility. CNA #2 stated that when they tried to remove the resident's foot from the pillar, the resident grabbed the them by the throat and was choking them. They stated the resident then through themselves from the wheelchair and would not allow them to assist them back into the	C1501			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5537	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2025
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C1501	Continued From page 12 chair. They notified the police and police came and assisted the resident back into their chair. On 06/18/25 at 10:58 a.m., cook #1 stated they were moving all residents to the designated tornado shelter area when Resident #1 was outside the facility watching the storms. They stated they tried to convince the resident to come inside and the resident refused using foul language. They stated they told CNA #2 of the concern. On 06/18/25 at 11:30 a.m., the executive director was asked about the incident on 06/03/25 involving Resident #1. The executive director stated there were tornado sirens, tornado warnings, and Resident #1 was outside watching the storms. They stated multiple staff tried to convince the resident to come inside to the designated shelter area. They stated CNA #2 tried to force the resident to come inside by pushing the resident in their wheelchair against the resident's will. They stated Resident #1 choked CNA #2 and put themselves onto the ground from their wheelchair to prevent CNA #2 from forcing the resident to go inside to the shelter area. They stated Resident #1 could make their own choices and CNA #2 should not have attempted to push the resident's wheelchair against the resident's will. They stated CNA #2 should of notified emergency services. On 06/18/25 at 11:40 a.m., Resident #1 stated they were outside the center watching the storms when CNA #2 tried to push them against their will to go inside due to tornado warning. They stated they voiced their refusal and CNA #2 continued to attempt to pull their wheelchair backwards . Resident #1 stated they grabbed CNA #2 by the throat trying to prevent them from pushing them	C1501		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5537	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2025
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C1501	Continued From page 13 inside the facility to the shelter. Resident #1 stated they ended up on the ground in front of their wheelchair because nobody tells them what to do. They stated the police helped them back into their wheelchair.	C1501		
C1505 SS=D	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 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.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5537	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2025
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C1505	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure a change in condition was documented in a resident's health record for 1 (#3) of 3 residents sampled for change in condition; The executive director identified 70 residents resided in the center. Findings: An undated center policy titled "Narrative Charting," read in part, "Narrative charting will be maintained to promote clear communication regarding resident care."... "1. The format for narrative charting is: a. D [equals] Data Enter all the essential facts related to resident status. b. A [equals] Action State the actions/interventions made in response to the data c. R [equals] Response Follow up and document the resident's response to the action taken." Resident #3's significant change assessment, dated 07/29/24, showed Resident #3 was admitted on 02/06/21 with diagnoses which included dementia with out behaviors and fracture of the left femur. The assessment showed the	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5537	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2025
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C1505	Continued From page 15 resident was confused, forgetful, and their judgement was fair. Resident #3's hospital record, dated 12/30/24, showed the resident was admitted to the hospital and diagnosed with endocarditis, cellulitis of the right upper limb, and bacteremia. The record showed the resident was discharged to skilled nursing at a different facility on 01/23/25. Resident #3's complete health record was reviewed from 07/29/24 through 06/19/25. There was no other documentation in the resident's health record of the resident being treated for a wound on their right arm and no documentation of the resident being assessed. On 06/20/25 at 2:35 p.m., the executive director stated CMA #1 reported to the health and wellness director on 11/27/24 in their presence, Resident #3 had a wound on their arm and was declining. They stated Resident #3 was transported to the hospital for evaluation on 11/29/24 by family. The executive director stated there was no documentation in Resident #3's health record the wound was assessed or treated. On 06/20/25 at 3:35 p.m., corporate consult nurse #1 stated there was no documentation in Resident #3's health record the wound on the resident's arm was treated or assessed prior to hospitalization on 11/29/24. On 06/20/25 at 3:55 p.m., CMA #1 stated they reported to the health and wellness director about a week prior to the Resident #3 being transported to the hospital 11/29/24, Resident #3 was yellow in color, confused, and was out of character. They stated the health and wellness director told	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5537	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2025
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C1505	Continued From page 16 them to assess the resident's vitals. CMA #1 stated the following day the wound on the resident's arm was dressed and had drainage. They stated another staff member spoke with the family and the family transported Resident #3 to the hospital for evaluation on 11/29/24.	C1505		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5537	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2025
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C1911	Continued From page 17 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure a reportable incident of abuse was reported to the OSDH within 1 business day for 1 (#1) of 3 sampled residents reviewed for reporting incidents to the OSDH. The executive director identified 70 residents resided in the center. Findings: An undated center policy titled "Incident Reports," read in part, "Injury and unusual incidents will be reported in compliance with state regulatory requirement." An OSDH form titled "Incident Report Form," dated 06/05/25, showed a combined initial and final report of an allegation of abuse/mistreatment was made on 06/03/25. The report showed Resident #1 was alleged to choke CNA #2 during a tornado warning. The facsimile confirmation showed it was received at the OSDH on 06/05/25 at 3:56 p.m. On 06/18/25 at 12:00 p.m., the executive director stated the incident should of been reported to the OSDH within 24 hours of the incident.	C1911		

Delivery via email to: FountainED@silverpointsenior.com

July 18, 2025

License Number: AL5537

Ms. Rishell Palmer, Administrator
Fountainbrook Assisted Living And Memory Support
11510 SE 15th Street
Midwest City, OK 73130

RE: Survey Event EZF411

Dear Ms. Palmer:

On **June 20, 2025**, a Licensure inspection with a complaint investigation 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 in a timely manner. **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 **July 18, 2025**.

We will conduct a revisit to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

Enclosure



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/16/2025

Facility Name: Fountain Brook AL & MS

License Number: AL5537-5537

Survey Event ID: EZF411

Date Survey Completed: 6/20/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C371

Based on: Observation, record review, and interview, the center failed to advise a resident of the risks related to involuntary termination of their rental for 1(#1) of 3 residents sampled for involuntary termination of their rental agreement.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: To remain in compliance with all Federal and State Regulations, the community has taken or is planning to take actions set forth in the in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance, All alleged deficiencies cited have been or are to be corrected by 07/18/2025.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Termination of rental agreement was rescinded by Executive Director on 6/20/2025. Resident still resides in the community and risk agreement was put in place on 07/15/2025. ED was educated and inserviced by VPO.

ED will ensure that any rental agreement terminations meet the guidelines outline in the lease agreement. ED will reach out to Vice President of Operations ensure the termination is acceptable according to our company policies.

ED must reach put to VPO before issuing a notice of termination to any resident to ensure all measures have been taken. VP must be in agreement before moving forward.

Before issuing a Notice to Vacate, it is required to obtain prior approval by discussing the matter with the Vice President of Operations or designated member of the Home Office Team.

ED and VPO to have weekly meetings addressing any concerns/issues.

Correction is incorporated in the lease agreement, ED just have to follow it precisely going forward.

Inservice documentation – When to Call Protocol

7/18/2025

Administrator's Signature Rishell Gresham

Date 7/16/2025

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.
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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.



INSTANT INSERVICE ATTENDANCE ROSTER

Date: 07/15/2025

Instructor: Ashley Shipman

Topic: When to Call Protocol

ATTENDEE NAME		ATTENDEE SIGNATURE	
1.	<i>Rachel Anderson</i>		<i>Rachel Anderson</i>
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

When to Call Protocol

<u>Event</u>	<u>When to Call</u>	<u>Who Should Call</u>	<u>Who Should Be Called</u>
Prospective move in that does not meet regulatory acceptance and retention criteria	Prior to accepting resident	ED or HWD	VP of Operations Corp. Clinical Ops
Denial of move-in prior to informing family if related to a health or medical condition	Promptly – Prior to communication with family	ED or HWD	VP of Operations Corp. Clinical Ops
Move-in of residents under 65 years of age	Prior to accepting resident for move-in	ED or HWD	VP of Operations Corp. Clinical Ops
Residents with a known history of violence or aggressive behavior	Prior to accepting resident for move-in	ED or HWD	VP of Operations Corp. Clinical Ops
Residents with a primary or secondary diagnosis of dementia who will reside in Assisted Living	Prior to accepting resident for move-in	ED or HWD	VP of Operations Corp. Clinical Ops
Death following a fall	Promptly	ED or HWD	VP of Operations Corp. Clinical Ops CEO
Fall with fracture, head injury or loss of consciousness	Promptly	ED or HWD	VP of Operations Corp. Clinical Ops
Resident requires higher level of care than you can provide	Before declining to accept a resident back, accepting, or issuing notice	ED or HWD	VP of Operations Corp. Clinical Ops
Attempted Suicide or Verbalization of intent to harm self or others	Promptly	ED or HWD	VP of Operations Corp. Clinical Ops
Elopement	Promptly	ED or HWD	VP of Operations Corp. Clinical Ops CEO
Adverse Family Reaction	As soon as possible	ED	VP of Operations Corp. Clinical Ops
Any resident or team member requiring self-report to THHS	As soon as possible	ED	VP of Operations Corp. Clinical Ops
Outbreak of Communicable Disease involving 2 or more residents	Promptly	ED or HWD	VP of Operations Corp. Clinical Ops
Allegation or suspected Abuse, Neglect or Exploitation of a resident	Promptly	ED or HWD	VP of Operations Corp. Clinical Ops CEO
Involuntary psych hold of a resident for any reason	Promptly	ED or HWD	VP of Operations Corp. Clinical Ops

When to Call Protocol

Unusual/unexpected death of a resident	Promptly	ED or HWD	VP of Operations Corp. Clinical Ops CEO
Resident-to-Resident physical altercation	Promptly	ED or HWD	VP of Operations Corp. Clinical Ops
Visit from Government Agency such as OSHA or DOL	Promptly	ED	VP of Operations CEO Controller HR
Licensing Visit	Promptly	ED	VP of Operations Corp. Clinical Ops CEO
Emergency situations such as Fire, Power outage, Phone outage, Earthquake, Flood, Elevator outage	Promptly	ED	VP of Operations CEO
Resident medication error resulting in injury or hospitalization	Promptly	ED or HWD	VP of Operations Corp. Clinical Ops
Motor vehicle accident involving community vehicle	Promptly	ED	VP of Operations CEO Controller
Claim of sexual harassment involving a resident or employee	Promptly	ED or HWD	VP of Operations CEO Controller HR
Media coming to community	Promptly	ED or CRD	VP of Sales & Marketing VP of Operations CEO
Receipt of legal claims against the community/company	Promptly	ED or BOM	VP of Operations Controller

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 7/15/2025	
	Facility Name: Fountain Brook AL and MS	
	License Number: AL5537-5537	
	Survey Event ID: EZF411	
Date Survey Completed: 6/20/2025		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C522	Based on: Observation, record review, and interview, the center failed to ensure a significant change assessment was completed after a change in condition for 1 (#1) of 10 residents sampled for a change in condition.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: To remain in compliance with all Federal and State Regulations , the community has taken or is planning to take actions set forth in the in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance, All alleged deficiencies cited have been or are to be corrected by 07/18/2025.		
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?		HWD is attending weekly meetings with ED and Clinical Director which includes auditing of documentation completion in the system and RN consult is also following up with HWD by reviewing the resident's charts.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		To ensure other residents are affected, an Instant In-Service was issued by ED and CDOCO for HWD on 07/01/2025 regarding Change of Condition assessments according to our company policy. Change of Condition Assessment for resident #1 was completed on 07/01/2025. See attached
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?		Weekly audits will be conducted by ED and monthly audits will be conducted by ED and Clinical Director, if any issues or concerns arise they will be documented and addressed as needed.
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.		Ongoing audits will continue to ensure all areas of concerns are addressed. Results of weekly audits will be reviewed at QA meetings. To ensure other residents are affected, meetings will be continued weekly with ED and HWD and a monthly meeting with ED, CDOCO, and HWD. Based off findings, ED/CDOCO will audit Aline. Findings will be reviewed during QA Meeting. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		7/18/2025
OSDH Response: Element accepted Yes ☐ No ☐		

Administrator's Signature Rishell Gresham		Date 7/15/2025	
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.			



INSTANT INSERVICE ATTENDANCE ROSTER

Date: 7/01/25

Instructor: Quentin Barlow, CEO

Topic: Change of Condition

Please See Attachment (Print Pg. 34 – 36)

ATTENDEE NAME	ATTENDEE SIGNATURE
1. <u>Kay Mobley</u>	<u>Kay Mobley, CPA</u>
2.	
3.	
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6.	
7.	
8.	
9.	
10.	

- o. Wheezing
 - p. Shortness of breath or exertion
 - q. Complaints of pain or discomfort
 - r. Edema or swelling
 - s. Change in usual range of vital signs
 - t. Reaction/side effect to medications
 - u. Weight loss
 - v. Depressive behaviors
 - w. Falls
4. If there is an actual change in condition the resident's physician is notified. Always have the resident's complete chart, list of meds, current vital signs (if available), and concise list of problems available when calling the physician.
 5. If this is part of an ongoing problem and home health or hospice are following the resident, contact the home health or hospice nurse and explain the situation at hand.
 6. Document the date and time of contacts, and with whom you spoke. Clearly document any new orders and repeat back to the physician.
 7. Immediately enter the new orders on the resident's service plan and/or medication administration record if the order pertained to medications.
 8. Notify the resident's responsible person of the change in status and action taken.
 9. Keep the Health & Wellness Director abreast of the resident's response to the new orders.
 10. Report the status change and new physician orders to each shift.
 11. If the resident status change results in a prohibited health condition, a conference will take place with the Health & Wellness Director to determine the resident's suitability for retention. The Health & Wellness Director will file for an exception if required.

POLICY: Change in Condition

When a resident exhibits a change in condition, action will be taken to coordinate appropriate care.

Procedure

1. When a resident displays a change in condition, caregivers notify the Health & Wellness Director.
2. If a change in status progresses to an emergency at anytime, call 911.
3. Examples of change in condition may include, but not be limited to:
 - a. Refusal of meals
 - b. Decreased mobility/range of motion
 - c. Change in patterns of elimination
 - d. Weakness
 - e. Decreased coordination
 - f. Change in level of consciousness
 - g. Decreased communication/response
 - h. Decreased ability to communicate signs
 - i. Decline in cognitive function
 - j. Motor agitation or retardation
 - k. Hallucinations or other unusual behavior
 - l. Nausea
 - m. Vomiting
 - n. Elevated or subnormal temperature

12. If the resident requires skilled monitoring due to the status change, the Health & Wellness Director consults with the physician to obtain an order for home health.
13. The Health & Wellness Director documents, schedules and follows through with any continuing physician appointments and medical care.
14. If the resident status change is more than a transient problem, a resident care conference is arranged.
15. If the change in status involves a change in ambulatory status, the resident will be retained in a non-ambulatory-approved room.



INSTANT INSERVICE ATTENDANCE ROSTER

Date: 07/15/2025

Instructor: Quentin Burleson

Topic: Key Principles of Charting by Exception

Charting by exception (CBE) is an efficient documentation method often used in healthcare settings, including health and wellness departments. It focuses on documenting only significant findings or deviations from the norm, rather than recording all details of patient care. Here's a quick training overview:

1. Focus on Abnormalities:

- Document only significant deviations from the established baseline or normal findings. This helps streamline the charting process and reduces redundancy.

2. Timeliness:

- Document findings promptly after resident interactions to maintain accurate records and ensure continuity of

3. Leadership Specific

Regular Audits:

- Perform regular audits of documentation to ensure compliance with CBE practices and identify areas for improvement.

ATTENDEE NAME	ATTENDEE SIGNATURE
1. Kay Mobley	Kay Mobley, LPA
2. Angela Hinkle RCC	Angela Hinkle RCC
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July 2025

July 2025							August 2025						
Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa
6	7	1	2	3	4	5	3	4	5	6	7	1	2
13	14	15	16	17	18	19	10	11	12	13	14	15	16
20	21	22	23	24	25	26	17	18	19	20	21	22	23
27	28	29	30	31			24	25	26	27	28	29	30

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Jun 29	30	Jul 1	2	3	4	5
10:30am DNA, tracker Task review	10:30am DNA, tracker Task review 2:00pm FountainBrook Bi weekly Sales (Microsoft Teams)	10:30am DNA, tracker Task review 1:00pm Nursing (FountainBrook Assisted Living &	ED Report 10:30am DNA, tracker Task review 1:30pm Clinical Weekly Meeting (Microsoft	10:30am DNA, tracker Task review	10:30am DNA, tracker Task review	10:30am DNA, tracker Task review
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10:30am DNA, tracker Task review	10:30am DNA, tracker Task review 2:00pm FountainBrook Bi weekly Sales (Microsoft Teams)	10:30am DNA, tracker Task review 11:00am J and J music - 1:00pm Nursing 2:15pm Gathan -	ED Report Review Employee Files for CPR and Compt. - 10:30am DNA, tracker 1:30pm Canceled:	10:30am DNA, tracker Task review	10:30am DNA, tracker Task review	10:30am DNA, tracker Task review
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10:30am DNA, tracker Task review	10:30am DNA, tracker Task review	10:30am DNA, tracker Task review 1:00pm Nursing (FountainBrook Assisted Living &	ED Report 10:30am DNA, tracker Task review 1:30pm Clinical Weekly Meeting (Microsoft	10:30am DNA, tracker Task review		



INSTANT INSERVICE ATTENDANCE ROSTER

Date:

7/01/25

Instructor:

Quentin Burleson, CEO

Topic: Assessment(s) Schedule

(b) The assisted living center shall complete the comprehensive assessment in accordance with the following:

- (1) within fourteen (14) days after admission of the resident;
- (2) once every twelve (12) months thereafter; and
- (3) promptly after a significant change in the resident's condition.

Please See Attachment.

ATTENDEE NAME		ATTENDEE SIGNATURE	
1.	Kay Mobley	Kay Mobley, LPA	
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