OKLAHOMA
State Department
of Health

Delivery via email to: arains1@brookdale.com

October 25, 2023

License Number: AL6001

Ms. Amanda Rains, Administrator
Brookdale Stillwater
1616 East McElroy Road
Stillwater, OK 74075

RE: Survey Event ID: VOHF11

Dear Ms. Rains:

On **October 10, 2023**, agents from our office concluded a State Licensure survey with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **October 10, 2023**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may 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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: **Brookdale Stillwater**
Address: **1616 East McElroy Road**
City, State, Zip: **Stillwater OK 74075**
Provider #: **AL6001**
Complaint #: **OK00060880**
Investigation Dates: **10/06/23, 10/09/23 through 10/10/23**

ALLEGATION(S)

The facility failed to ensure supervision was provided in an effort to prevent accidents.
The facility failed to prevent the development of new/worsening pressure wounds.

An unannounced on-site investigation was initiated 10/06/2023 at 4:26 a.m.

A sample of six residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

The halls were observed for staff assisting residents. The resident rooms were observed for fall interventions and pressure ulcer prevention devices. Staffing was observed for the correct number to provide residents with care according to their needs. Wound care was observed. Residents were observed for orthotic devices (Device that helps support and align a limb.) and staff care of the residents with those devices.

Clinical records including physician's orders, progress notes, personal service plans, laboratory results, contracts, skin assessments, third party forms, policies and procedures were reviewed.

Residents, and families were interviewed concerning fall interventions, pressure ulcer prevention, and the care and supervision provided by the center.

Staff were interviewed about interventions to prevent falls, interventions to prevent pressure ulcers, policies and procedures for falls and pressure ulcers.

The attached Statement of Deficiencies, Form 2567 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: 10/18/2023

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	AL6001	A. BUILDING: _____ B. WING _____	C 10/10/2023

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BROOKDALE STILLWATER	1616 EAST MCELROY ROAD STILLWATER, OK 74075

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C 000	INITIAL COMMENTS A relicensure survey was conducted on 10/06/23 and 10/09/23 through 10/10/23. A complaint investigation (#OK00060880) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CMA - Certified Medication Aide CNA - Certified Nurse Aide LPN - Licensed Practical Nurse MAT - Medication Administration Technician OSDH - Oklahoma State Department of Health RN - Registered Nurse	C 000		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the center	C1304		

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C1304	Continued From page 1	C1304		

failed to ensure night checks were completed for one (#2) of three sampled residents who were reviewed for falls.

The administrator identified 20 residents who resided in the center.

Findings:

The center's "Night Checks" policy, revised 11/2018, read in parts, "...Resident care staff should make night checks of the residents...Associates should perform night checks approximately every four (4) to six (6) hours or as determined by the residents' need...When performing night check, associates should open the door to the resident's apartment quietly and observe the resident from a reasonable distance. Assistance should be provided as necessary..."

Resident #2 had diagnoses which included Parkinson's Disease and overactive bladder.

A residency agreement, dated 09/20/22, read in parts, "...Staffing 24 hours a day...Associates are available 24 hours a day, seven days a week...The personal service assessment will be used to develop Personal Service Plan..."

A "Personal Service Plan", dated 07/21/23, documented Resident #2 had a fall on 03/11/23, 04/16/23, 06/23/23, and 06/27/23. The following interventions were in place: encourage to call for assistance, frequent visual checks, labs, and review of new medications.

An OSDH combined initial and final report, dated 06/27/23, documented an allegation of neglect. The report documented Resident #2 was found

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C1304	Continued From page 2 laying in the bathroom floor during 6:00 a.m. rounds by the care staff. The report documented the resident had a camera in their room, which revealed Resident #2 had fallen at 7:55 p.m. on 06/26/23. The report documented the video recorded a staff member opening the resident's door and turning the light off at 10:00 p.m. during shift rounds without entering the resident's room and Resident #2 was not found until 6:00 a.m. rounds the next day. On 10/10/23 at 11:28 a.m., the administrator stated Resident #2 had fallen in the evening of 06/26/23 and was not found until 6:00 a.m., on 06/27/23. The administrator stated based on the camera footage, the former CNA failed to follow the night check policy and check on Resident #2. They stated they had done an investigation and terminated the employee.	C1304		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can	C1505		

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C1505	Continued From page 3 understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure: a. a mechanical lift was used in a safe manner for one (#1) of one sampled resident who required the use of a mechanical lift for transfers; b. resident care equipment was sanitized in between residents for two (#5 and #10) of three sampled residents who required blood pressure monitoring; and c. catheter care was performed in a manner to prevent infection for one (#4) of one sampled resident who was observed during catheter care. The administrator identified three residents who utilized a mechanical lift for transfers, one resident who had an indwelling urinary catheter, and 20 residents who resided in the center.	C1505		

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C1505	Continued From page 4 Findings: The center's "Indwelling Catheter Care", dated 06/2020, read in parts, "...To keep perineal area clean and prevent infections...Perform catheter care. Females...Gently wash the juncture of the tubing from the urethra down the catheter...when handling catheter tubing, always hold in a manner that urine does not flow back into the bladder..." The center's "Mechanical Lift" policy, dated 04/2021, read in parts, "...Mechanical lifts may be utilized in various areas of the community and must be used in a dignified, respectful manner, and with discretion when transferring a resident. The use of mechanical lifts shall follow manufacturer instructions..." The center's "Infection Control" policy, dated 05/2023, read in parts, "...The community follows infection control practices for...prevention and control of disease and infection...employs the following procedures for preventing/controlling infection...The sanitation of equipment, including medical equipment that may be used on more than one resident..." 1. Resident #1 had diagnoses which included unspecified dementia and generalized osteoarthritis. A care plan, dated 04/19/23, documented Resident #1 required the use of a mechanical lift for transfers. On 10/06/23 at 5:18 a.m., CNA #1 and CNA #2 were observed providing care to Resident #1. They placed the mechanical lift sling under the resident, rolled the wheels of the mechanical lift	C1505		

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C1505	Continued From page 5	C1505		

over the fall mat under thebed, and then positioned the mechanical lift over the resident. They attached the sling to the lift, lifted Resident #1 off the bed, and then rolled the mechanical lift wheels across the fall mat. The mechanical lift became stuck on the fall mat while the resident was in the sling on the lift. The staff were able to roll the mechanical lift off of the fall mat and place the resident in their wheelchair.

On 10/06/23 at 5:54 a.m., CNA #1 stated they thought they had moved the fall mat under the bed far enough to use the mechanical lift without running the wheels over the fall mat. CNA #1 was asked if it was safe to roll the mechanical lift wheels over an unstable surface with the resident in the mechanical lift. They stated, "No."

On 10/06/23 at 11:07 a.m., the administrator stated the mechanical lift should be operated on a hard surface. The administrator stated it would not be safe to transport a resident in the mechanical lift running the wheels over the fall mat.

2. On 10/06/23 between 9:20 a.m., and 9:50 a.m., MAT #1 was observed administering medication. MAT #1 was observed obtaining Resident #9's blood pressure. MAT #1 completed the blood pressure and placed the wrist blood pressure cuff machine on the top of the medication cart. They did not disinfect the blood pressure cuff. MAT #1 obtained Resident #10's blood pressure with the same wrist blood pressure cuff machine without disinfecting the cuff prior to/or after obtaining Resident #10's blood pressure. MAT #1 placed the blood pressure cuff on top of the medication cart. MAT #1 obtained Resident #5's blood pressure with the blood pressure wrist cuff machine used on

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C1505	Continued From page 6	C1505		

Resident #9 and #10 without disinfecting the blood pressure cuff prior to or after obtaining Resident #5's blood pressure.

3. Resident #4 was admitted on 09/19/23 and had diagnoses which included stage III pressure ulcer and had a UTI on 09/21/23.

A 14-day assessment, dated 10/02/23, documented Resident #4 was alert and oriented to person, place, and time, required assistance of one for ADLs, had an indwelling urinary catheter, and was incontinent of bowel.

Resident #4 had a urinalysis obtained on 09/21/23. The urine culture, dated 09/23/23, documented the sample contained the following organism Proteus Mirabiles (bacteria).

On 10/06/23 at 5:07 a.m., CNA #1 and CNA #2 were observed providing incontinent care to Resident #4. Resident #4's pants were wet, and they were incontinent of bowel. CNA #1 cleaned Resident #4 and changed their pants. CNA #1 stated Resident #4's catheter was leaking. CNA #1 did not clean the catheter tubing. The staff had held the catheter tubing and bag up while changing Resident #4's pants allowing the urine to flow back into the bladder.

On 10/06/23 at 5:54 a.m., CNA #1 stated they performed catheter care when the resident had a bowel movement or when they provided incontinent care. They stated they had not performed catheter care because they were nervous.

10/06/23 at 11:07 a.m., the administrator/LPN stated the staff should perform catheter care every shift and with an incontinent episode. The

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C1505	Continued From page 7 administrator/LPN stated the staff should have performed catheter care after Resident #4 had a bowel movement. 10/06/23 at 11:10 a.m., the RN stated the staff should not have allowed the urine to flow back into the bladder and should have performed catheter care for Resident #4.	C1505		
C1916 SS=D	310:663-19-1(f) REPORTS TO THE DEPARTMENT (f) Each continuum of care facility and assisted living center shall report allegations and occurrences of resident abuse, neglect, or misappropriation of resident's property by a nurse aide to the Nurse Aide Registry by submitting a completed "Notification of Nurse Aide Abuse, Neglect, Mistreatment or Misappropriation of Property" form (ODH Form 718), which requires the following: (1) facility/center name, address and telephone; (2) facility type; (3) date; (4) reporting party name or administrator name; (5) employee name and address; (6) employee certification number; (7) employee social security number; (8) employee telephone number; (9) termination action and date (if applicable); (10) other contact person name and address; and (11) the details of the allegation or occurrence of abuse, neglect, or misappropriation of resident property.	C1916		

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C1916	Continued From page 8 This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to notify the nurse aide registry of an allegation of neglect involving CNA #4 for one of one allegation of neglect involving Resident #2. The administrator identified 20 residents who resided in the center. Findings: An OSDH combined initial and final incident report, dated 06/27/23, documented an allegation of neglect. The report documented Resident #2 was found laying in the bathroom floor during 6:00 a.m. rounds by the care staff. The report documented the resident had a camera in their room, which revealed Resident #2 had fallen at 7:55 p.m. on 06/26/23. The report documented the video recorded a staff member opening the resident's door and turning the light off at 10:00 p.m. during shift rounds without entering the resident's room and Resident #2 was not found until 6:00 a.m. rounds the next day. On 10/10/23 at 11:28 a.m., The Administrator stated they had done an investigation and terminated CNA #4. The administrator was asked if they had reported CNA #4 to the Nurse Aide registry. They stated they sent in an incident report but had not reported CNA #4 using the Notification of Nurse Aide form 718. The administrator stated they must have submitted the report incorrectly.	C1916		

OKLAHOMA
State Department
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Delivery via email to: arains1@brookdale.com

December 29, 2023

License Number: AL6001

Ms. Amanda Rains, Administrator
Brookdale Stillwater
1616 East McElroy Road
Stillwater, OK 74075

RE: Survey Event VOHF11

Dear Ms. Rains:

On **October 10, 2023,** agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1916:** The facility's plan of correction did not address the deficiency cited at C1916.

Please provide an AMENDED plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
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: 12/8/2023** **Facility Name:** Brookdale Stillwater **License Number:** AL6001 **Survey Event ID:** V0HF11 **Date Survey Completed: 10/10/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304SS=D310:663-13-1(d) RESIDENT SERVICE CONTRACT	Based on: interview and record review, the center failed to ensure night checks were completed for one (#2) of three sampled residents who were reviewed for falls.

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?	On 6/27/23 resident fell at the center and should have been checked on per night check policy. Center was found to be out of compliance per center policy. An investigation was conducted, associate was placed on administrative leave and terminated. In-services will be complete with clinical staff on policy of night time/safety checks.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents in the community have the potential to be affected but none were identified as being affected
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?	HWD/ED and staff will be re-in serviced on Following policy for night time checks as per resident needs. Continued compliance will be monitored through random review of assessment and care plan needs to determine resident needs for safety checks by the ED, HWD and/or designee
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.	Continued compliance will be monitored during morning stand Up meetings, quarterly and annual QA process by the ED, HWD, department managers and/or designees. Enter methods to evaluate for effectiveness:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

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

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ **Acceptable** ☐ **Unacceptable** **Date:** Click here to enter a date. **Surveyor:** Surveyor
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. **Facility in Compliance by:** Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/8/2023** **Facility Name:** Brookdale Stillwater **License Number:** AL6001 **Survey Event ID:** VOHF11 **Date Survey Completed: 10/10/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505 SS=E 310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENTRIGHTS - Medical Care	Based on: Based on observation, record review, and interview, the center failed to ensure: a.) a mechanical lift was used in a safe manner forone (#1) of one sampled resident who requiredthe use of a mechanical lift for transfers; b.) resident care equipment was sanitized in between residents for two (#5 and #10) of threesampled residents who required blood pressuremonitoring; and c.) catheter care was performed in a manner toprevent infection for one (#4) of one sampledresident who was observed during catheter care.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not To be construed as an admission Of or agreement with the finding And conclusions of the Statement Of Deficiencies, or (if applicable,), The administrative sanctions imposedon the community. Rather, it isSubmitted as confirmation of ourOngoing efforts to comply with as Statutory and regulatory requirements In this document, we have outlined Specifications in response to eachallegation or finding. We have notpresented all contrary, factual or legal arguments, nor have we identified all mitigating factors.

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?	Center staff failed to provide safe care while using a mechanical lift, provide adequate foley cath care and provide infection control reduction after the use of blood pressure equipment. Random skill competency check offs along with return demonstration to be shown to HWD or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents in the community have the potential to be affected but none were identified as being affected.
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?	HWD/ED and staff will be re-in serviced on proper cleaning of equipment, foley catheter care, and safe use of mechanical device by the ED, HWD and/or designee.
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.	Continued compliance will be monitored during initial, annually and prn skill competency, quarterly and annual QA process by the ED, HWD, department managers and/or designees. 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?	1/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 12/8/2023**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/8/2023** **Facility Name:** Brookdale Stillwater **License Number:** AL6001 **Survey Event ID:** V0HF11 **Date Survey Completed: 10/10/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: 310:663-15-1 & 63 OS 1-1918(B)(5)	Based on: observation, record review, andinterview, the center failed to ensure: a mechanical lift was used in a safe manner forone (#1) of one sampled resident who requiredthe use of a mechanical lift for transfers;b. resident care equipment was sanitized inbetween residents for two (#5 and #10) of threesampled residents who required blood pressure monitoring; andc. catheter care was performed in a manner toprevent infection for one (#4) of one sampledresident who was observed during catheter care

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?	Center staff failed to provide safe care while using a mechanical lift, provide adequate foley cath care and provide infection control reduction after the use of blood pressure equipment. Random skills competency check offs will be completed along with return demonstration to be shown to HWD or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents in the community have the potential to be affected but none were identified as being affected
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?	Associates will be re-in serviced on proper cleaning of equipment, following infection control protocol and procedures,Foley catheter care and safe use of mechanical device by the ED, HWD and/or designee.
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.	Continued compliance will be evaluated through skill competency initial, annually and prn along with return demonstration of compliance Demonstration of infection control process Continued process will be evaluated through the QA process by the ED, HWD and/or designee
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

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

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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Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor
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OKLAHOMA
State Department
of Health

Delivery via email to: arains1@brookdale.com

January 12, 2024

License Number: AL6001

Ms. Amanda Rains, Administrator
Brookdale Stillwater
1616 East McElroy Road
Stillwater, OK 74075

RE: Survey Event VOHF11

Dear Ms. Rains:

On **October 10, 2023**, a Relicensure with complaint inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your amended 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 **October 10, 2023**.

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.

Respectfully,

Clorissa Nubine

Clorissa Nubine, 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: 12/8/2023

Facility Name: Brookdale Stillwater

License Number: AL6001

Survey Event ID: V0HF11

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1916 SS=D310:663-19-1(f) REPORTS TO THE DEPARTMENT	Based on: interview and record review, it wasdetermined the center failed to notify the nurseaide registry of an allegation of neglect involvingCNA #4 for one of one allegation of neglectinvolving Resident #2.

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?	On 6/27/23 a state Reportable form was faxed to OSHD of a combined initial and final report but center failed to turn a report into the nurse aide registry. Center was out of compliance of the 24hr reporting timeline. An investigation was conducted, associate was placed on administrative leave and terminated. In-services will be completed with clinical staff for time line of reporting to appropriate parties.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents in the community have the potential to be affected but none were identified as being affected
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?	HWD/ED and staff will be re-in serviced on reporting to appropriate parties and completing the appropriate incident reporting form that are defined as requiring documentation by the state regulation and/or internal policies. Continued compliance will be monitored through a daily review by the ED, HWD and/or designee of any outstanding state agencies of the required Nurse aide 718 form documentation.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Continued compliance will be monitored during morning stand Up meetings, quarterly and annual QA process by the ED, HWD, department managers and/or designees. Enter methods to evaluate for effectiveness:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. **Date** Enter a date of signature.

OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health
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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/8/2023

Facility Name: Brookdale Stillwater

License Number: AL6001

Survey Event ID: V0HF11

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: 310:663-15-1 & 63 OS 1-1918(B)(5)	Based on: observation, record review, andinterview, the center failed to ensure: a mechanical lift was used in a safe manner forone (#1) of one sampled resident who requiredthe use of a mechanical lift for transfers;b. resident care equipment was sanitized inbetween residents for two (#5 and #10) of threesampled residents who required blood pressure monitoring; andc. catheter care was performed in a manner toprevent infection for one (#4) of one sampledresident who was observed during catheter care

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?	Center staff failed to provide safe care while using a mechanical lift, provide adequate foley cath care and provide infection control reduction after the use of blood pressure equipment. Random skills competency check offs will be completed along with return demonstration to be shown to HWD or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents in the community have the potential to be affected but none were identified as being affected
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?	Associates will be re-in serviced on proper cleaning of equipment, following infection control protocol and procedures,Foley catheter care and safe use of mechanical device by the ED, HWD and/or designee.
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.	Continued compliance will be evaluated through skill competency initial, annually and prn along with return demonstration of compliance Demonstration of infection control process Continued process will be evaluated through the QA process by the ED, HWD and/or designee
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

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

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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Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/8/2023

Facility Name: Brookdale Stillwater

License Number: AL6001

Survey Event ID: V0HF11

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304SS=D310:663-13-1(d) RESIDENT SERVICE CONTRACT	Based on: interview and record review, the center failed to ensure night checks were completed for one (#2) of three sampled residents who were reviewed for falls.

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?	On 6/27/23 resident fell at the center and should have been checked on per night check policy. Center was found to be out of compliance per center policy. An investigation was conducted, associate was placed on administrative leave and terminated. In-services will be complete with clinical staff on policy of night time/safety checks.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents in the community have the potential to be affected but none were identified as being affected
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?	HWD/ED and staff will be re-in serviced on Following policy for night time checks as per resident needs. Continued compliance will be monitored through random review of assessment and care plan needs to determine resident needs for safety checks by the ED, HWD and/or designee
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.	Continued compliance will be monitored during morning stand Up meetings, quarterly and annual QA process by the ED, HWD, department managers and/or designees. Enter methods to evaluate for effectiveness:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

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

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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: kari.willard@brookdale.com

January 25, 2024

License Number: AL6001

Ms. Kari Willard, Administrator/Executive Director II
Brookdale Stillwater
1616 East McElroy Road
Stillwater, OK 74075

RE: Survey Event VOHF12

Dear Ms. Willard:

On **January 23, 2024,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey with complaint investigations on **October 10, 2023,** have now been corrected effective **January 8, 2024.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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
	AL6001	A. BUILDING: _____ B. WING _____	R-C 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE STILLWATER	1616 EAST MCELROY ROAD STILLWATER, OK 74075

(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 offsite/paper revisit was conducted on 01/23/24. The facility was in substantial compliance.	{C 000}		

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