OKLAHOMA
State Department
of Health

Delivery via email to: lwinkfein@brookdale.com

April 27, 2023

License Number: AL6201

Ms. Lisa Winkfein, Administrator
Brookdale Ada
801 Stadium Drive
Ada, OK 74820

RE: Survey Event ID: 9MV611

Dear Ms. Winkfein:

On **April 13, 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 April 13, 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.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Ada**
Address: **801 Stadium Drive**
City, State, Zip: **Ada, OK, 74820**
Provider #: **AL6201**
Complaint #: **OK00059096**
Investigation Date(s): **04/12/23 - 4/13/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to notify residents' legal surrogate of a COVID-19 outbreak.	**US**
2. The center failed to have adequate staffing to meet residents' needs.	**US**
3. The center failed to provide a clean environment that is free of offensive odors.	**US**

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

An unannounced on-site investigation was initiated on 04/12/2023 at 10:20 a.m.

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

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

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to notifying residents' legal surrogate of a COVID-19 outbreak was conducted.

Sampled clinical records were reviewed for progress notes, assessments, care plans, physician orders, and incident reports. The reviewed clinical records documented notifications were made to family/legal representative when the resident tested positive to COVID-19. Grievances and resident council meeting minutes

were reviewed and documented no concerns related to family/legal representative's being notified of COVID-19 outbreaks.

A tour of the facility was conducted upon entrance and throughout the survey. The facility had signage related to COVID-19 prevention posted at the front entrance and throughout the building. Residents were observed to be clean, well-groomed and free of signs or symptoms of COVID-19. Staff was observed to use proper infection control techniques.

Residents were interviewed and reported their family/legal representative had been notified if they tested positive for COVID-19 and during a COVID-19 outbreak in the facility. Residents reported their family/legal representatives were notified when they had a change in their medical condition. Staff was interviewed and reported phone calls were made to a resident's family/legal representative when the resident tested positive for COVID-19. Staff reported family/legal representatives for all residents residing in the facility were notified by phone of a COVID-19 outbreak in the facility.

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

An investigation specific to sufficient staffing to meet residents' needs was conducted.

Sampled clinical records were reviewed for progress notes, activities of daily living, care plans, physician orders, and assessments. Staffing schedules were reviewed and documented adequate staffing was scheduled for each shift. The facility's "Residency Agreement" was reviewed, and documented laundry and linen were laundered once weekly. Grievances and resident council meeting minutes documented no concerns with adequate staffing or laundry services.

Residents were observed during meals, during activities and in their rooms. Residents were observed to be well-groomed and wearing clean clothing. Staff was observed answering call lights and providing assistance to residents in a timely manner. Staff was observed in the laundry room conducting laundry services and delivering laundry to resident rooms.

Residents were interviewed and reported no concerns with staff answering call lights or providing personal care assistance. Residents reported their laundry was laundered once or twice a week. Some residents reported their family preferred launder their items. Staff was interviewed and reported no concerns with being adequately staffed and providing care to residents as needed. Staff reported that all staff was responsible to do residents laundry and had no issues providing laundry services for residents as stated in the resident agreement.

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

An investigation specific to a clean environment that is free of offensive odors was conducted.

Sampled clinical records were reviewed for progress notes, activities of daily living, care plans, physician orders, and assessments. Staffing schedules were reviewed and documented adequate staffing scheduled for each shift. The facility's "Residency Agreement" was reviewed and documented light housekeeping services would be provided weekly. The facility grievances were reviewed and documented no concerns with having a clean environment. The resident council meeting minutes were reviewed and documented the complaints with cleaning had been addressed and had improved.

The facility was observed to be clean and free of lingering odors throughout the survey. Residents were observed to be clean, well-groomed and free of strong odors. Staff was observed cleaning resident rooms, providing laundry services for residents, and providing assistance with personal care.

Residents were interviewed and reported staff cleaned their rooms at least once a week. Residents reported no concerns with strong odors in the facility or the cleanliness of their room. Staff was interviewed and reported being scheduled to clean resident rooms weekly, and resident's trash was taken out daily or more often as needed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1, #2, and #3. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Leah Mays

_____

Leah Mays, Clinical Health Facility Surveyor

Date report completed: 04/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6201	A. BUILDING: _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ADA	801 STADIUM DRIVE ADA, OK 74820

(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 was conducted from 04/12/23 through 04/13/23. A complaint investigation (#OK00059096) was conducted in conjunction with the survey.	C 000		
C 398 SS=E	310:663-3-8(e) FOOD STORAGE, PREPARATION AND SERVICE (e) All staff assisting in, or responsible for food preparation shall have attended a food service training program offered or approved by the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that two (#1 and #2) of three dietary staff responsible for food preparation had attended a food service training program approved by the Oklahoma State Department of Health. The Administrator identified 16 residents who resided in the facility. Findings: The facility's "ServSafe Certification" policy, dated 05/01/10, read in parts, "...ServSafe certification is a standard for dining services management in all communities ...There must be at least one "ServSafe" certified manager present on the premises when food is being prepared, handled, and/or served ...Newly hired dining services management must obtain their "ServSafe" certification within the first 90 days of	C 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6201	A. BUILDING: _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ADA	801 STADIUM DRIVE ADA, OK 74820

(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 398	Continued From page 1 employment...Contact your local, city, county or state departments of health for additional requirements...". The policy did not address certification for non-management staff. Dietary cook #1 had a hire date of 11/26/21. Dietary cook #2 had a hire date of 11/03/20. On 04/13/23 at 09:00 a.m., dietary staff files were reviewed for required training. Dietary cook #1 and #2 did not have documentation for completing an approved food service training program. On 04/13/23 at 10:15 a.m., the Associate Director of Dining Services reported the facility required all dietary staff to obtain their "ServSafe" certification within 90 days of employment. The Associate Director of Dining Services reported dietary staff #1 and #2 had not completed a "Food Handlers" class or obtained a "ServSafe" certificate.	C 398		

OKLAHOMA
State Department
of Health

Delivery via email to: lwinkfein@brookdale.com

May 16, 2023

License Number: AL6201

Ms. Lisa Winkfein, Executive Director
Brookdale Ada
801 Stadium Drive
Ada, OK 74820
Survey Event ID: 9MV611

Dear Ms. Winkfein:

On **April 13, 2023,** a licensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 30, 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,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2023.05.16 13:55:41 -05'00'

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/9/2023** **Facility Name:** Brookdale ADA **License Number:** AL6201 **Survey Event ID:** 9MV611 **Date Survey Completed: 4/12/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 398SS=E310:663-3-8(e) FOOD STORAGE,PREPARATION AND SERVICE	Based on: The plan of correction is not To be constructed as admission Of or agreement with the findingsAnd conclusions of the statementOf deficiencies, or (if applicable),The administrative sanctions imposedOn the community. Rather, it is Submitted as confirmation of our Ongoing efforts to comply with asStatutory and regulatory requirementsIn this document, we have outlinedSpecifications in response to each Allegation or finding. We have not Presented all contrary, factual orLegal arguments, nor have weIdentified all mitigating factors.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: CENTER FAILED TO HAVE DINING ASSOCIATES COMPLETE THE SAFE SERV CERTIFICATION WITHIN 90 DAYS OF HIRE

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?	ASSOCIATE #1 AND ASSOCIATE #2 WERE IDENTIFIED NOT TO HAVE THEIR SERV SAFE CERTIFICATES WITHIN 90 DAYS OF HIRE. CENTER SHALL HAVE AT LEAST ONE CERTIFIED MANAGER ON SITE WHILE FOOD IS HANDLED, PREPARED AND OR SERVED. ED, DSC AND OR DESIGNEE WILL COMPLETE RANDOM AUDIT OF NEW DINING CARE MANAGERS TO ENSURE THEY HAVE COMPLETED THE REQUIRED TRAINING AND TESTING REQUIRED TO SERVE, HANDLE OR PREPARE MEALS
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	1. OTHER RESIDENTS COULD HAVE BEEN EFFECTED BUT NONE WERE 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?	CENTER WILL HAVE MEASURES IN PLACE UPON HIRE TO ENSURE DINING MANAGER WILL TRAIN AND TEST WITHIN THE 90 DAYS OF HIRE BY REVIEWING NEW HIRES DURING WEEKLY MANGER MEETING AND ATTENDING RANDOM MEAL TIMES TO ENSURE CERTIFIED DINING STAFF ARE PRESENT. INSERVICE WILL BE COMPLETED WITH DINING SERVICE COORDINATOR ON THE CORRECT PROCEDURE OF ORGANIZING TRAIING AND TESTING OF NEW DINING MANGERS.
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;	ED, DSC AND OR DESIGNEE WILL MONITOR COMPLIANCE DURING WEEKLY MANAGERS MEETING TO REVIEW NEW HIRES IN DINING DEPARTMENT TO CREATE A TIMELINE FOR TRAINING/TESTING OF NEW HIRES TO ENSURE SERV SAFE TESTING AND COMPLETION IS COMPLETED WITHIN

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.	90 DAYS OF HIRE. CONTINUED COMPLIANCE WILL BE DURING QUARTERLY ASSURANCE MEETINGS. CONTINUED COMPLIANCE WILL BE DURING QUARTERLY ASSURANCE MEETINGS. Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature LISA WINKFEIN OAC 310:663-25-4(F)	**Date 5/9/2023**

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

Delivery via email to: lwinkfein@brookdale.com

July 13, 2023

License Number: AL6201

Ms. Lisa Winkfein, Administrator
Brookdale Ada
801 Stadium Drive
Ada, OK 74820

RE: Survey Event 9MV612

Dear Ms. Winkfein:

On **July 10, 2023,** 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 on **April 13, 2023,** have now been corrected effective **June 30, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6201	A. BUILDING: _____ B. WING _____	R-C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ADA	801 STADIUM DRIVE ADA, OK 74820

(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 07/10/23. 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