OKLAHOMA
State Department
of Health

Delivery via email to: Arichards8@brookdale.com

April 20, 2022

License Number: AL6601

Ms. Alyssa Richards, Administrator
Brookdale Claremore
1605 North Highway 88
Claremore, OK 74017

Survey Event ID: 0P9B11

Dear Ms. Richards:

On **April 5, 2022,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

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

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

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

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

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

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

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

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

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 Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Brookdale Claremore**
Address: **1605 North Highway 88**
City, State, Zip: **Claremore, OK, 74017**
Provider #: **AL6601**
Complaint #: **OK00056411**
Investigation Dates: **04/01/22, 04/03/22, and 04/05/22.**

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate care to residents in the memory care unit, and failed to notify family about changes in condition.	**US**
2. The center failed to administer medications as prescribed.	**US**

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

An unannounced on-site investigation was initiated 04/01/2022 at 9:50 a.m.

A sample of four 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 Centers for Medicare and Medicaid Services (CMS) 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.

Upon entrance to the facility and throughout the survey resident were observed for appropriate hygiene. Staff were observed interacting with resident and providing assistance when appropriate. Resident were found to have been clean, groomed, and appropriately dressed throughout the survey.

Residents on the assisted living area of the facility were asked if there family members were notified of changes in their condition. Each stated they believed that did occur. They were asked if they received consistent and appropriate assistance with their personal hygiene needs from the staff. Each stated they did.

Attempts to question residents on the memory care unit were not productive because of the diminished cognition of the residents.

Staff were asked if they were aware of any resident not having received care related to hygiene and other activities of daily living. Each stated they were unaware of such an occurrence. Staff were asked if they were aware of resident families not being informed of changes in a resident's condition. Each stated they were unaware of such an occurrence.

Resident records were reviewed for documentation that would suggest a deficient practice related to resident hygiene. None was observed. A review of resident records did find consistent documentation of resident families and representative having been notified of changes.

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

Residents on the assisted living area of the facility were asked if they had experienced any instances where they did not receive their ordered medications. Each stated they were unaware of that having occurred.

Attempts to question residents on the memory care unit were not productive because of the diminished cognition of the residents.

Resident records were reviewed for documentation that prescribed medication had not been administered to residents. No such documentation was found.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Eric R. Ward, MPA BSN RN

Date report completed: 04/06/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Brookdale Claremore**
Address: **1605 North Highway 88**
City, State, Zip: **Claremore, OK, 74017**
Provider #: **AL6601**
Complaint #: **OK00058593**
Investigation Dates: **04/01/22, 04/03/22, and 04/05/22.**

ALLEGATION	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to protect residents from sexual abuse and failed to ensure residents were not involuntarily secluded.	**US**

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

An unannounced on-site investigation was initiated 04/01/2022 at 9:50 a.m.

A sample of four 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 Centers for Medicare and Medicaid Services (CMS) 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 was conducted specific to the allegations of abuse, neglect, and seclusion.

Upon entrance to the facility and throughout the survey the resident were observed for any signs that suggested abuse or neglect. As well they were observed for situations that would be considered seclusion or restraint. No such signs or situations were observed. Although the assisted living area was included in the survey the focus and majority of time was spent on the memory care unit.

Cognitively intact residents in the assisted living area of the facility were asked if they had experienced or were aware of any type of abuse or neglect having occurred at the facility. Each stated they were unaware of such an

occurrence. Each were asked if they had ever been made to remain in an area of the facility against their will. Each stated they had not. Each were asked if they had ever received medications that made it difficult for them to move around the facility because of sedation. Each stated they had not. Attempts to question residents on the memory care unit were not productive because of diminished cognition.

Two family members were interviewed related to abuse and neglect. Each stated an instance of inappropriate contact between two residents on the memory unit which included the touching on one's genitals. Interviews and documentation reviewed during the survey indicated a onetime occurrence for the individuals and appropriate interventions having been put in place by the facility staff to prevent reoccurrence.

Staff members on both units of the facility were asked if they were aware of any instances of abuse, neglect, or seclusion toward a resident while they had worked in the facility. Each stated they were unaware of such an occurrence.

Resident records were reviewed for documentation that suggested the existence of abuse, neglect, or residents having been secluded or restrained. No such evidence was observed.

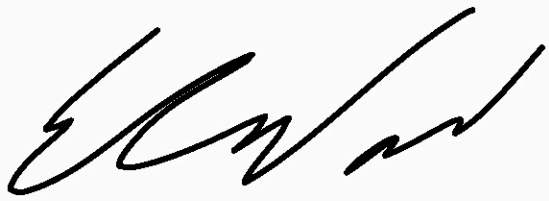
Facility records were reviewed for documentation that suggested abuse, neglect, or seclusion had occurred at the facility. No such documentation was observed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

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

Thank you for bringing these concerns to our attention.



Eric R. Ward, MPA BSN RN

Date report completed: 04/06/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6601	A. BUILDING: _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CLAREMORE	1605 NORTH HIGHWAY 88 CLAREMORE, OK 74017

(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 Complaint investigations (#OK00056411 and OK00058593) were conducted on 04/01/22, 04/03/22, and 04/05/22.	C 000		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement.	C1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6601	A. BUILDING: _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
C1912	Continued From page 1	C1912		

This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to notify the department of an allegation of abuse for one (#1) of four sampled residents reviewed for abuse.

The Executive Director identified 22 residents with diminished cognition that lived on the memory care unit.

Findings:

Resident #1 had diagnoses which included Alzheimer's disease.

The "Abuse, Neglect, & Exploitation" policy, revised 05/2021, read in parts...The Executive Director or designee should report allegation of abuse to the Department of Health...

A progress note, dated 03/26/22 at 10:44 p.m., documented a male resident had been found the resident's room. A family member had informed the staff the male had been seen via a camera located in #1's room to have exposed his penis and had #1 touch it.

An incident investigation report, dated 03/26/22, document the executive director had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6601	A. BUILDING: _____ B. WING _____	C 04/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CLAREMORE	1605 NORTH HIGHWAY 88 CLAREMORE, OK 74017

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C1912	Continued From page 2 informed of the incident between resident #1 and the male resident on that date. On 04/03/22 at 11:20 a.m., the executive director was asked if she was aware of the incident that occurred on 03/26/22 between resident #1 and a male resident who had entered her room. She stated she was aware. She was asked when she became aware. She stated on 03/26/22 at approximately 4:50 p.m. She was asked if she had contacted the Oklahoma State Department of Health of the alleged abuse. She stated after investigating the allegation she felt it had not been necessary to file an incident report with the department of health.	C1912		

OKLAHOMA
State Department
of Health

Delivery via email to: Arichards8@brookdale.com

May 9, 2022

License Number: AL6601

Ms. Alyssa Richards, Executive Director
Brookdale Claremore
1605 North Highway 88
Claremore, OK 74017

Survey Event ID: 0P9B11

Dear Ms. Richards:

On **April 5, 2022,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 18, 2022**.

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: 2022.05.09 09:01:36 -05'00'

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/2/2022** **Facility Name:** Brookdale Claremore **License Number:** AL 6601 **Survey Event ID:** 0P9B11 **Date Survey Completed: 4/5/2022**

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construced as an admission of or agreement with the finding and conclusions of the statement of deficiencies or if applicable the administrative sanctions imposed on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with as statutory and regulatory requirements in this document, we have outlined specifications in response to each allegation or finding. We have not presented 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?	State Reportable form observed to be out of Compliance with the OSHD regulation of the 24H reporting for a male resident that was showing inappropriate sexual behavior. Resident was re-directed out of the apartment, incident reported to management along with an incident report completed at the community level but was not reported to OSHD. In-services will be completed with clinical staff for time line of reporting state reportable
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 reportable/incident reporting form completion of the required follow-up documentation.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:	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:

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.	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?	5/18/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Alyssa Richards Executive Director OAC 310:663-25-4(F)	**Date 5/2/2022**

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: Arichards8@brookdale.com

December 29, 2022

License Number: AL6601

Ms. Alyssa Richards, Administrator
Brookdale Claremore
1605 North Highway 88
Claremore, OK 74017

Survey Event ID: 0P9B12

Dear Ms. Richards:

On **December 29, 2022,** an offsite/paper complaint revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 5, 2022,** have now been corrected effective **May 18, 2022.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6601	A. BUILDING: _____ B. WING _____	R-C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE CLAREMORE	1605 NORTH HIGHWAY 88 CLAREMORE, OK 74017

(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 12/29/22. 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