OKLAHOMA
State Department
of Health

Delivery via email to: Jkreps@Brookdale.com

July 26, 2021

License Number: AL7206

Ms. Julie Foster, Administrator
Brookdale Tulsa 71st and Sheridan
6022 East 71st Street
Tulsa, OK 74136

Survey Event ID: LT8Y11

Dear Ms. Foster:

On **July 8, 2021,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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.

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of Health

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

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Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.07.26 15:49:05 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Tulsa 71st and Sheridan**
Address: **6022 East 71st Street**
City, State, Zip: **Tulsa 74136**
Provider #: **AL7206**
Complaint #: **#OK00056023**
Investigation Date(s): **June 27, 2021 and July 7, 8, 9/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. Failed to have adequate staff to ensure resident safety.	US

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

An unannounced on-site investigation was initiated on 06/27/2021 at 10:58 a.m.

A sample of 3 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

Allegation #1: Deficient practice was unsubstantiated related to this allegation.
An investigation specific to an allegation the facility failed to have adequate staff to ensure resident safety.

The incident of elopement was investigated and it was determined that a power outage had caused the locking mechanism to malfunction on the door. Staff were inserviced on door policy and security of staff. Staff check exit doors on assigned hallways at different times during shifts. Monthly elopement drills were completed. Monthly fire drills are completed, this opens all doors to the facility then staff ensure all doors are secure and functioning properly at the end of the drill. The administrator reports that there have been no elopements this year, and the resident has not eloped since the date of incident.

Determination Summary and Follow-Up Action:
Deficient practice was substantiated for allegation. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

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

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

Thank you for bringing these concerns to our attention.

Mary Cooper RN by Pamela Sewell RN

Mary Cooper RN

Date report completed: 07/12/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Tulsa 71st and Sheridan**
Address: **6022 East 71st Street**
City, State, Zip: **Tulsa 74136**
Provider #: **AL7206**
Complaint #: **#OK00057228**
Investigation Date(s): **June 27, 2021 and July 7, 8, 9/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. Ensure residents were free from abuse and neglect.	**US**
2. The center failed to provide adequate medical care.	**S**
3. Failed to provide care and services according to resident contracts.	**US**

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

An unannounced on-site investigation was initiated on 06/27/2021 at 10:58 a.m.

A sample of 6 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

Allegation #1: Deficient practice was unsubstantiated related to this allegation.
An investigation specific to an allegation the facility failed to ensure residents were free from alleged abuse was investigated.
Observations were made of residents in the common areas and in their rooms. Residents interacted with staff and visitors. Incident reports from 06/2020 were reviewed for any allegations of staff abuse and resident to resident abuse. Incidents were documented and investigated. Staff reported that if any abuse was observed they would report to the charge nurse or administrator. Two residents were interviewed regarding staff treatment and care, both residents did not report any concerns with staff treatment or care. In-services were reviewed for reportable events, and when to file incident reports, and behavior problem solving and workplace violence.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.
Observations were made of resident rooms and bathrooms. No soiled linens or towels were observed in resident bathrooms. Maintenance records were reviewed for complaints and repairs. Maintenance was interviewed regarding the notification process of needed repairs. Staff were observed transporting laundry to the laundry room.

Determination Summary and Follow-Up Action:
Deficient practice was substantiated for allegation #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #1 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.

Mary Cooper RN by Paula Terrell RN

Mary Cooper RN

Date report completed: 07/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7206	A. BUILDING: _____ B. WING _____	07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TULSA 71ST AND SHERIDAN	6022 EAST 71ST STREET TULSA, OK 74136

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An abbreviated survey was conducted on June 27, July 6, July7, and July 8 to investigate complaint #OK00057228 and #OK00056023. Census was 48.	C 000		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review, it was determined the registered nurse failed to ensure physician ordered weekly weights were obtained for three (#1, #2, and #5) of five residents sampled for weight loss. This had the potential for more than minimal harm at a pattern. Findings: 1. Resident #1 was admitted on 01/05/21. Diagnoses included, anxiety disorder,	C 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7206	A. BUILDING: _____ B. WING _____	07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TULSA 71ST AND SHERIDAN	6022 EAST 71ST STREET TULSA, OK 74136

(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 911	Continued From page 1 hypertension and edema. The Physicians order summary, dated 05/01/21, documented. " ...weekly weights due to NAR [nutrition assessment risk] one time a day every Tue...order date 04/13/2021 ..." The Weights and Vitals Summary sheet, dated 07/01/21, did not have a weekly weight documented for 05/25/21. 2. Resident #2 was admitted to the facility on 08/19/20. Diagnoses included, Unspecified Dementia and Abnormal weight loss. The Physicians order summary, dated 06/01/21, documented, " ...Weekly weights on Tuesday afternoons one time a day ...every Tues related to abnormal weight loss with a start date of 2/23/2021 ..." The Weights and Vital summary, dated 07/07/21, documented weights were obtained only one time a month for 03/2021, 04/2021, 5/2021 and 6/2021. A Progress note, dated 03/26/21, documented, " ... weight has stabilized and improving, does fluctuate somewhat. No new orders received at this time ..." No orders were documented to discontinue monthly weights. 3. Resident #5 was admitted to the facility on 11/19/20, with diagnoses which included, Alzheimer's Disease, Hypertension, anxiety disorder, and abnormal weight loss. The Physicians order summary, dated, 07/08/21, documented " ...weekly weights on Tuesday d/t NAR one time a day every Tuesday ..." No	C 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7206	A. BUILDING: _____ B. WING _____	07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TULSA 71ST AND SHERIDAN	6022 EAST 71ST STREET TULSA, OK 74136

(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 911	Continued From page 2 weights were documented for the following days: 05/25, 06/01, 06/08, 06/15, 06/22, and 06/29/21. From 05/18/21 to 07/08/21, only two weights were obtained. On 07/08/21 at 08:19 a.m., the administrator was asked if there was any documentation for the missing weights for resident #5. She stated, "our old scale was broke, we were without one in June."	C 911		
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 understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7206	A. BUILDING: _____ B. WING _____	07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TULSA 71ST AND SHERIDAN	6022 EAST 71ST STREET TULSA, OK 74136

(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
C1505	Continued From page 3	C1505		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the center failed to ensure ADL's (activities of daily living) regarding grooming was completed for two (#6 and #7) of three residents sampled for assistance with ADL's. This had the potential for more than minimal harm at a pattern.

1. On 07/07/21 at 10:55 a.m., resident #6 was observed. He was unshaven, his hair was not combed and a brown substance was noted under his fingernails.

On 07/08/21 at 07:15 a.m., resident #6 was observed in the dining room for breakfast. He was unshaven and had a brown substance under his fingernails.

At 10:31 a.m., RN (registered nurse) #2 was asked to observe resident #6 appearance to include fingernails, whiskers and hair care. She acknowledged assistance was needed with grooming and requested staff assist with care as soon as possible.

At 12:42 p.m., RN #1 was asked what kind of assistance resident #6 needed with his ADL's.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7206	A. BUILDING: _____ B. WING _____	07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TULSA 71ST AND SHERIDAN	6022 EAST 71ST STREET TULSA, OK 74136

(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
C1505	Continued From page 4 She replied he needed assistance of one with everything, grooming and showering. 2. On 07/08/21 at 10:00 a.m., resident #7 was observed to have long fingernails with a brown substance under the nails. Whiskers were observed on her chin. At 10:35 a.m., resident #7 was observed with RN #2. RN #2 acknowledged grooming was needed for resident #7 for facial hair and finger nail care. At 12:42 p.m., RN #1 was asked what kind of assistance did resident #7 need with her ADL's. She replied assistance of one person for dressing and toileting.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: Kari.Willard@Brookdale.com

August 31, 2021

License Number: AL7206
Survey Event ID: LT8Y11

Ms. Kari Willard, Administrator
Brookdale Tulsa 71st And Sheridan
6022 East 71st Street
Tulsa, OK 74136

Dear Ms. Willard:

On **July 8, 2021,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 31, 2021**.

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

Sincerely,

Tempal Killman Digitally signed by Tempal Killman
Date: 2021.08.31 09:30:52 -05'00'

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

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/16/2021** **Facility Name:** Brookdale Tulsa 71st and Sheridan **License Number:** AL7206 **Survey Event ID:** LT8Y11 **Date Survey Completed: 7/8/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505	Based on: interview, and record review, it was determined the center failed to ensure ADL's (activities of daily living) regarding grooming was completed for two (#6 and #7) of three residents sampled for assistance with ADL's. This had the potential for more thanminimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Staff will be inserviced and checked off on dressing and grooming tasks. Assignment plans will be in place for staff to ensure that staff is aware of the care needed each resident. Care plans will be accessable for information and care plans will be updated per policy.

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?	Staff inserviced on care and services provided to residents as well as dressing and grooming .Nurse will complete random spot checks on residents visually. This will be added to QA as well. Care plan will be updated accordingly. Assignment sheets will be reviewed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Staff inserviced on care and services provided to residents as well as dressing and grooming .Nurse will complete random spot checks on residents visually. This will be added to QA as well. Care plan will be updated accordingly. Assignment sheets will be reviewed.
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?	Random resident checks visually by nurse or executive director, and assignment sheet review. Will complete ongoing training with staff.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	This deficient practice will be discussed in QA and documented. RN as well as LPNS will participate and sign off. Random checks in place by community nurse for accuracy of assessments and accountability. Walk throughs and resident interaction as well as engagement. Review and training of the assignment plans which is directly from the care plan. Training This will be discussed in each QA for the next three QA's. Assigment sheets will be reviewed and kept for monitoing for care and services. These will be signed off on by a nurse and caregiver and kept in a POC binder for the next 2 months.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/31/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Kari Willard OAC 310:663-25-4(F)			**Date 8/16/2021**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/16/2021** **Facility Name:** Brookdale Tulsa 71st and Sheridan **License Number:** AL7206 **Survey Event ID:** LT8Y11 **Date Survey Completed: 7/8/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 911	Based on: interview and record review, it was determined the registered nurse failed to ensure physician ordered weekly weights were obtained for three (#1, #2, and #5) of five residents sampled for weight loss. This had the potential formore than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: New weight scale in place and physican orders are being followed for weights. Nutrition Tracker updated monthly with accurate weights and NAR information. NAR will be reviewed with dietician when she visits quarterly. Community nurse will review weights and vitals at least monthly for accuracy.

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?	Physican orders in place and audit being done by community nurse to ensure that weights are being entered and completed per the physicians order. NAR program in place for the residents and orders followed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Auditing an Nutrition at Risk program in place. Colloboraitve Care meeting occur every other week and residents nutrition stutus will be discussed as well as dietician reviews quarterly.
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?	Monthly Audits for Weights and Witals. Colloborative Care review will occur every other week and discussion will occur as well as documented in the CCR system.
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.	This deficient practice will be discussed in QA and RN as well as LPNS will participate and sign off. Monthly Audits in place by community nurse for accuracy an accountability. Audits will be printed and documented and signed off on by the nurse for the next three months. This will be discussed in each QA for the next three QA's. Reported will bPrinted and stored in the POC binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/31/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Kari Willard** OAC 310:663-25-4(F)	**Date 8/16/2021**

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

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

Items Below Are For OSDH Use Only

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

OKLAHOMA
State Department
of Health

Delivery via email to: trichards3@brookdale.com

December 19, 2022

License Number: AL7206

Ms. Tammy Richards, Administrator
Brookdale Tulsa 71st And Sheridan
6022 East 71st Street
Tulsa, OK 74136

Survey Event ID: LT8Y12

Dear Ms. Richards:

On **December 16, 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 **July 8, 2021,** have now been corrected effective **November 1, 2021.**

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
	AL7206	A. BUILDING: _____ B. WING _____	R 12/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TULSA 71ST AND SHERIDAN	6022 EAST 71ST STREET TULSA, OK 74136

(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 completed on 12/16/22. Credible evidence of correction was submitted for all deficiencies.	{C 000}		

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

Oklahoma State Department of Health

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