OKLAHOMA
State Department
of Health

Delivery via email to: Bhale4@brookdale.com

June 7, 2021

License Number: AL7207

Ms. Britani Chappell, Administrator
Brookdale Owasso
12807 East 86th Place North
Owasso, OK 74055

Survey Event ID: G74Z11

Dear Ms. Chappell:

On **May 20, 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.

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:

OKLAHOMA
State Department
of Health

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
LICENSURE

Facility: **Brookdale Owasso**
Address: **12807 East 86th Place North**
City, State, Zip: **Owasso Ok 74055**
Provider #: **AL7207**
Complaint #: **OK00056412**
Investigation Date(s): **05/18/21 through 05/20/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate care and services.	S

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

An unannounced on-site investigation was initiated on Tuesday, May 18, 2021 at 10:30 a.m.

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

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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. 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.

Thank you for bringing these concerns to our attention.

Billie Seeman

Billie Seeman, RN, Clinical Health Facility Surveyor III

Date report completed: 05/25/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Owasso**
Address: **12807 East 86th Place North**
City, State, Zip: **Owasso Ok 74055**
Provider #: **AL7207**
Complaint #: **OK00057050**
Investigation Date(s): **05/18/21 through 05/20/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide a safe environment.	**US**
2. The center failed to ensure the residents were assessed before allowing self-administration of medications.	**US**

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

An unannounced on-site investigation was initiated on Tuesday, May 18, 2021 at 10:30 a.m.

A sample of five 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 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 a safe environment and abuse was conducted.

The residents were observed interacting with the staff, other residents and visitors appropriately throughout the survey. The staff were observed providing care and interacting with the residents appropriately.

Residents were asked if they felt safe at the center. They stated yes. The staff was asked about abuse allegations. They stated the facts of each incident and the interventions put in place.

Resident clinical records, incident reports, in-services and policy and procedures revealed incidents of abuse were documented, reported and acted upon appropriately and the staff were trained on abuse and violence in the workplace.

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

An investigation specific to self-administration of medication was conducted.

Residents who self-administered their medication had their medications locked in their rooms. The medications were reconciled with the medication administration records on file.

Residents stated they knew how to take their medications and wanted to administer their own medications. The nurse was asked how the center ensured the residents were taking their medications correctly. She stated the residents were given an initial evaluation and then evaluated every quarter, a physician order was obtained and the medications were counted weekly.

Physician's orders, medication evaluations, assessments, medication administration records and policy and procedures were reviewed. The center followed their policy and procedure for self-administered medication.

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 state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Billie Seeman

Billie Seeman, RN Clinical Health Facility Surveyor III

Date report completed: 05/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7207	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE OWASSO	12807 EAST 86TH PLACE NORTH OWASSO, OK 74055

(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 05/18/21 through 05/20/21 to investigate complaints #OK00056412 and #OK00057050. Total Residents: 33	C 000		
C1505 SS=G	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		

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C1505	Continued From page 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the center failed to prevent the development and worsening of pressure ulcers for one (#1) of three sampled residents who required staff assistance for activities of daily living (ADL).

This resulted in actual harm to the resident. The resident developed a stage II pressure ulcer to her right buttock and stage III pressure ulcers to her coccyx and left inner buttock.

The licensed practical nurse (LPN) identified five residents who required total assistance with ADLs and one resident who currently had pressure ulcers.

Findings:

The center's policy, titled, 'How-to Promotion of Skin Integrity,' revised 11/2018, documented, "...It is the practice of Brookdale to promote skin integrity for residents and help to prevent pressure injuries by assisting residents in keeping skin clean and free of irritation and dryness..and minimize skin exposure to moisture due to incontinence or perspiration...Changes in skin integrity should be reported to the Health and Wellness Director (HWD)/designee, documented in the Resident Record and entered into the Skin Management System...The HWD/Nurse/ or designee should receive reports...of skin

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C1505	Continued From page 2 concerns, take appropriate action...HWD/Nurse or designee should contact the resident's physician...if skin integrity is compromised; i.e....opened or reddened..." The center's policy, titled 'Skin Breakdown,' revised 09/2018, documented, "...Manage in Community...Manage incontinence...barrier ointment to buttocks for heavy incontinence...Open area flow sheet...increased protein, Vitamin C, Zinc...Complete documentation in resident record and Skin Management..." Resident #1 was admitted to the center on 04/16/21 and had diagnoses which included post polio, poliomyelitis, coronary artery disease, stroke, and hypertension. A pre-admission assessment, dated 04/09/21, documented the resident was alert and oriented to person, place and time; and had fair judgment. The assessment documented the resident was non-ambulatory; required one person assistance for dressing, transferring, and toileting; and was incontinent of bladder at times. The assessment documented the resident's skin was pink and intact with redness to her buttocks. A nurse's progress note, dated 04/16/21, documented the resident's skin was warm, dry, and intact, and she required one person assist for ADL's. A physician's order, dated 04/16/21, documented to apply Calmoseptine Ointment (A medication used to treat minor skin irritations) to affected area topically as needed for redness/irritation three times a day.	C1505		

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C1505	Continued From page 3 A skin assessment, dated 04/16/21, documented the resident's skin was intact with no open areas. An admission assessment, dated 04/20/21, documented the resident required one person assist for dressing, toileting, and transferring; was non-ambulatory; and was incontinent of bladder at times. The assessment documented the resident's skin was pink, warm, dry, and intact with no wounds. A personal service plan, dated 04/20/21, documented the resident was incontinent of bladder, needed assistance with toileting, and to apply Calmoseptine to the buttocks. The service plan documented to be alert to redness, irritation, and breakdown while providing bathroom assistance. A plan of accommodation, dated 04/22/21, documented, "...The Community (Brookdale) will continue to provide the following care...Maintain strict skin hygiene...Staff will notify HWD [health wellness director] of any areas of resident's skin that are opened or reddened...HWD and ED [executive director] will check frequently during scheduled working hours to ensure she is clean, dry receiving personalized care that she is being assessed for and or needs..." The medication administration record (MAR), dated 04/01/21 through 04/30/21, documented the Calmoseptine was not signed off as applied from 04/16/21 through 04/30/21. A third party provider collaboration note, dated 05/03/21, documented the resident was seen by a skilled nurse from hospice. The note documented the resident had a stage II pressure ulcer (Partial thickness loss of skin presenting as	C1505		

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C1505	Continued From page 4	C1505		

a shallow open ulcer) to the left buttock. The note documented to apply barrier cream daily and as needed.

A third party provider collaboration note, dated 05/07/21, documented the resident had two moisture incontinent open wounds on her right buttock, one measured "quarter size," and one "dime size." The note documented to apply barrier cream daily and as needed.

A nurse's progress note, dated 05/11/21, documented the resident complained her bottom was hurting. The note documented on assessment, the resident had a reddened area to her right buttock, close to the coccyx. The note documented barrier cream was applied.

A nurse's progress note, dated 05/12/21, documented the resident had a stage I pressure ulcer(Intact skin with a localized area of redness which remains red when pressed) to her left buttock area. The note documented the hospice nurse was contacted, and barrier cream was applied.

A skin management form, dated 05/14/21, documented the resident had:

~ a stage II pressure ulcer to her right buttock which measured 1.0 centimeters (cm) in length (L) x 3.0 cm in width (W) x 0.0 cm in depth (D), no drainage or odor, with a pink wound bed, and the surrounding tissue was dry and intact;

~ a stage III pressure ulcer (Full thickness loss of skin) to the coccyx which measured 1.0 cm in length x 1.0 cm in width x 0.0 cm in depth, with a small amount of serous drainage (Clear or slightly yellow liquid part of blood; it can be seen in

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C1505	Continued From page 5 partial thickness wounds), and a pink wound bed with surrounding tissue dry and intact; and ~ a stage III pressure ulcer to the left inner buttock which measured 5.0 cm in length x 2.0 cm in width x 0.0 cm in depth, with a scant amount of sanguineous drainage (bloody) with the surrounding tissue intact and blanchable. The MAR, dated 05/01/21 through 05/13/21, revealed the Calmoseptine had not been signed off as applied to the affected reddened areas as needed from 05/01/21 through 05/13/21. A physician's order, dated 05/14/21, documented to clean decubitus ulcers on bilateral glutes and coccyx with normal saline, then pat dry, apply medihoney, and cover with a dry dressing. On 05/18/21 at 1:56 p.m., the resident was asked if she had a pressure ulcer. She stated yes, she had bed sores. The resident had a low air loss mattress in place (A mattress which helps the patient in the prevention of ulcer and wounds caused by continuous pressure on certain body parts). The low air loss mattress control panel was not lit up, and the mattress was flat. The resident was asked if her bed was comfortable. She stated no. On 05/19/21 at 11:16 a.m., the resident's low air loss mattress was flat, and the control panel was not lit up. Certified nurse aide (CNA) #1 turned the switch on the side panel of the control box. The mattress setting was on firm, and a green light was flashing on the control panel. At 11:20 a.m., the LPN stated she did not know what the mattress was supposed to be set on. She stated she was not given instructions or the	C1505		

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C1505	Continued From page 6	C1505		

settings for the mattress when it was brought to the center. The documentation from hospice documented the electric bed and mattress were delivered on 05/13/21.

On 05/20/21 at 9:00 a.m., the LPN/HWD was asked what was meant by strict skin hygiene as documented on the plan of accommodation. She stated the staff would clean the resident after she went to the bathroom, apply barrier cream, encourage the resident to get up, and reposition the resident.

The LPN stated the resident had stress incontinence and did not always make it to the toilet in time. She was asked for the documentation the staff repositioned and provided incontinent care to the resident. The LPN stated they did not have ADL records.

She was asked if she was aware of the resident's skin breakdown as documented by the hospice staff on 05/03/21 and 05/07/21. She stated yes, but she did not know the pressure ulcers were open. The LPN was asked if she measured and documented the pressure ulcers on 05/03/21 or 05/07/21. She stated no, she did not document it in the computer.

The LPN stated she did not have documentation of the frequent checks for resident #1 made by the HWD and or the executive director as stated in the plan of accommodation.

At 9:25 a.m., certified nurse aide (CNA) #2 was asked how she knew what care to provide to each resident. She stated she was given a paper with a brief description of the residents' needs upon hire. She was asked if resident #1 was on the paper. She stated no. She produced another

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C1505	Continued From page 7 sheet of paper with resident information. It did not document to reposition or provide incontinent care to resident #1. The document stated the resident required assist of one for ADLs. The CNA was asked what care she provided for the resident. She stated the resident needed to be turned every two hours. The CNA stated the resident had not needed to be turned prior to last week. At 11:45 a.m., the LPN performed wound care to the resident's pressure ulcers. The right upper buttock pressure ulcer measured 1 cm in length x 1.3 cm in width x 0 cm in depth, with a darkened area to the wound bed and bloody drainage. The surrounding tissue was red and had adhesive related skin injury. The coccyx pressure ulcer measured 1.9 cm in length x 1.3 cm in width x 0.4 cm in depth. The wound bed was white. The surrounding tissue was macerated (Skin lighter in color; it occurs when skin is in contact with moisture). The left buttock pressure ulcer measured 0.5 cm in length x 1.2 cm in width x 0 cm in depth. The wound bed was red with small amount of serosanguinous drainage. The surrounding tissue was red and had adhesive related skin injury. The LPN stated she was attempting to get new orders for the dressing change due to the damage the tape had done to resident's wounds.	C1505		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may	C5010		

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C5010	Continued From page 8 receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to coordinate care with a third party provider for one (#1) of one sampled resident who was receiving hospice services. The center identified six residents who received	C5010		

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BROOKDALE OWASSO	12807 EAST 86TH PLACE NORTH OWASSO, OK 74055

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C5010	Continued From page 9 services from third party providers. Findings: The Hospice plan of care documented resident #1 was placed on hospice services on 03/11/21. Resident #1 was admitted to the center on 04/16/21 and had diagnoses which included post polio, poliomyelitis, coronary artery disease, stroke and hypertension. A third party provider collaboration note, dated 04/30/21, documented the resident became dizzy while she was showered by a hospice aide. The collaboration note revealed it was not communicated with a provider at the center. A third party provider collaboration note, dated 05/04/21, documented, "...barrier applied to bottom, starting to open..." The note was signed by a hospice aide. The collaboration note revealed it was not communicated with a provider at the center. A third party provider collaboration note, dated 05/07/21, documented the resident had two moisture incontinent wounds on right buttock. The note was signed by a hospice nurse. The collaboration note revealed it was not communicated with a provider at the center. It was documented to be communicated to the family, the physician and a hospice nurse. A third party provider collaboration note, dated 05/13/21, documented, "...bottom sores..." The note was signed by the hospice aide. The collaboration note revealed it was not communicated with a provider at the center.	C5010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7207	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE OWASSO	12807 EAST 86TH PLACE NORTH OWASSO, OK 74055

(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
C5010	Continued From page 10 A third party provider collaboration note, dated 05/13/21, documented the resident was declining and new orders were to be faxed to the physician. The note was signed by a hospice nurse. The collaboration note revealed it was not communicated with a provider at the center. It was documented to be communicated with a hospice nurse. Third party provider collaboration notes for the resident were reviewed and revealed the resident was seen by a hospice nurse nine times and seen by a hospice aide eight times from 04/19/21 through 05/17/21. The collaboration notes revealed none of the notes had been signed off as reviewed by the community nurse. On 05/18/21 and 05/19/21, the resident's low air loss mattress was observed to be turned off. On 05/19/21 at 11:20 a.m., the licensed practical nurse (LPN) was asked who provided the low air loss mattress. She stated hospice. The LPN was asked what the settings were for the mattress. She stated she did not know. The LPN stated she was not given instructions or the settings for the mattress when it was brought to the center. On 05/20/21 at 9:00 a.m., the LPN was asked how often the hospice nurse came to the center to provide care for the resident. She stated she did not know. The LPN was asked how she ensured hospice provided the care as ordered. She stated if the nurse did not show up before the end of her shift, she would change the resident's dressing. She then stated some days she would do the dressing change and then the hospice nurse would come in and change it again.	C5010		

OKLAHOMA
State Department
of Health

Delivery via email to: bhale4@brookdale.com

June 30, 2021

License Number: AL7207

Ms. Britani Chappell, Administrator
Brookdale Owasso
12807 East 86th Place North
Owasso, OK 74055

Survey Event ID: G74Z11

Dear Ms. Chappell:

On **May 20, 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 **July 21, 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: 2021.06.30 10:05:29 -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: 6/18/2021** **Facility Name:** Brookdale Owasso **License Number:** AL7207 **Survey Event ID:** G74Z11 **Date Survey Completed: 5/20/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C5010SS=E63 O.S. 1-890.8(A-D) Care and Services -Coordination of Care	Based on: interview and record review, it wasdetermined the center failed to coordinate carewith a third party provider for one (#1) of onesampled resident who was receiving hospiceservices.The center identified six residents who received services from third party providers.

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?	Facility failed to provide appropriate coordination of care. Resident has now been transferred to a new hospice service. HWD to coordinate care with hospice associates and residents provider on any new changes in condition. HWD will review skin weekly with hospice nurse and document accordingly, If HWD unavailable then a review of coordination notes daily for any changes in care or new orders. Care plan updated as needed for compliance.
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 will monitor open skin weekly with 3rd party provider and document findings in Point Click Care. HWD will notify PCP of any changes after review of skin and/or coordination notes. RNCM will In-service HWD on coordination of care with 3rd party providers and PCPs. RNCM will review charting and coordination of care notes bi-weekly during visits and document findings.
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.	HWD to review coordination care notes during daily during stand up. RNCM to review skin during bi-weekly visits and chart on any changes and coordinate with physican and 3rd party as needed for order changes. Continued compliance will be monitored during morning stand up meetings, quarterly and annual QA process by the ED, HWD, RNCM, and/or designees. HWD/ED/RNCM and or designee will review compliance bi-weekly through leadership meeting.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?	7/21/2021
OSDH Response: Element accepted Yes ☐ No ☑	
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Janene Lindsey	**Date** Enter a date of signature. 06/18/2021
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: 6/18/2021** **Facility Name:** Brookdale Owasso **License Number:** AL7207 **Survey Event ID:** G74Z11 **Date Survey Completed: 5/20/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505SS=G310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENTRIGHTS - Medical Care	Based on: observation, interview, and recordreview, it was determined the center failed toprevent the development and worsening ofpressure ulcers for one (#1) of three sampledresidents who required staff assistance foractivities of daily living (ADL).This resulted in actual harm to the resident. Theresident developed a stage II pressure ulcer toher right buttock and stage III pressure ulcers toher coccyx and left inner buttock.The licensed practical nurse (LPN) identified fiveresidents who required total assistance with ADLsand one resident who currently had pressureulcers.

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?	HWD/RNCM and or designee will follow Brookdale policy and procedures for skin integrity through documentation, skin monitoring, coordination of care with physican and 3rd party and following and updating care plan.
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 will monitor open skin weekly and document findings in Point Click Care. Quarterly skin monitoring of other residents in community as per policies. Phyisican orders will be followed and document in PCC. In-service will be completed with floor associates on using approved assignment plans for providing care and reporting changes to residents skin and comfort. HWD in-serviced by RNCM on appropriate reporting of skin integrity changes and appropriate documentation and interventions for optimal skin integrity. Interventions will be added to care plan such as repositioning, skin barrier, wound treatments, low-air loss mattress, incontinence care, pain and medication management and reviewed for compliance by HWD/RNCM/ED 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	HWD to review usage of assignment plans with associates during daily stand up and daily rounds. RNCM to review charting and review skin integrity bi-weekly during visits. RNCM to review skin during bi-weekly visits and chart on any changes and coordinate with physican and 3rd party as needed for order changes.

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, RNCM, and/or designees. HWD/ED/RNCM and or designee will review compliance bi-weekly through leadership meeting.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/21/2021
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Janene Lindsey	**Date** Enter a date of signature. 06/18/2021
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: bhale4@brookdale.com

FINAL DETERMINATION

September 30, 2021

License Number: AL7207

Ms. Brittani Chappell, Administrator
Brookdale Owasso
12807 East 86th Place North
Owasso, OK 74055

Survey Event ID: G74Z12

Dear Ms. Chappell:

A paper revisit conducted **September 8, 2021**, revealed that your facility corrected deficiencies effective **July 21, 2021**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me 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

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
	AL7207	A. BUILDING: _____ B. WING _____	R 09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE OWASSO	**12807 EAST 86TH PLACE NORTH OWASSO, OK 74055**

(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 paper revisit was conducted n 09-08-21. All deficiencies were cleared from the survey completed on 05-20-21.	C 000		

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