Oklahoma State Department of Health
Creating a State of Health

March 18, 2020

License Number: AL5506

Ms. Lisa Dimonico, Administrator
Brookdale Edmond Danforth
116 West Danforth
Edmond, OK 73003

RE: Survey Event ID: E9X611

Dear Ms. Dimonico:

On **February 4, 2020**, agents from our office concluded a State Licensure survey with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on February 4, 2020.

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

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

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;

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

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Edmond Danforth**
Address: **116 West Danforth**
City, State, Zip: **Edmond, Okla. 73003**
Provider #: **AL5506**
Complaint #: **OK00054747**
Investigation Date(s): **02/03/2020 to 02/04/2020**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were properly administered.	**US**
2. The center failed to have an effective pest control program.	**US**

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

An unannounced on-site investigation was initiated on Monday, February 3, 2020 at 10:30 a.m.

A sample of 4 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.
Four residents were interviewed regarding medication administration practices and pest control. None of the four residents had any complaints about medication administration, pills left in resident rooms, or pills found on the floor. No evidence of pills left in the rooms or pills on the floor were observed during the survey process.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.
Two staff members were interviewed about seeing any cockroaches recently. One staff member said it had been months ago, the other staff member said it was about a month ago. Two residents did complain about seeing a bug in their room, but was unsure if it was a cockroach or not. On the day of survey the pest control company was in the center for monthly inspection and treatment. No evidence of cockroaches were observed during the survey process.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation OK00054747. 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

Mary Cooper RN

Date report completed: 02/06/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5506	A. BUILDING _____ B. WING _____	02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDMOND DANFORTH	116 WEST DANFORTH EDMOND, OK 73003

(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
N 000	Initial Comments A re-licensure survey was conducted 02/03/2020 and 02/04/2020. Resident census was 30. The following deficient practices were cited.	N 000		
N1437 SS=E	310:677-13-7 (b) (8) Skills And Functions Limitations. A certified medication aide shall not: (8) Administer medications or nutrition via nasogastric or gastrostomy tubes, or administer oral metered dose inhalers or nebulizers, unless the CMA has completed a Department-approved advanced training program and has demonstrated competency for such services; or This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure oral metered dose inhalers were administered by CMAs (certified medication aides) who had completed a Department approved advanced training program for 1 (#7) of 1 sampled resident who received a physician ordered inhaler. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #7 had a diagnosis of asthma and a physician's order, dated February 2020, for Advair Discus (a dry powder medication administered per inhalation). The order stated all medications to be administered by staff.	N1437		

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N1437	Continued From page 1 On 02/04/2020, the MAR (medication administration record) for resident #7 for December 2019, January 2020 and February 2020 were reviewed. The MARs documented CMA (certified medication aide)/employee #2 administered the Advair Discus inhaler to the resident 12 times in December 2019, 12 times in January 2020 and and once in February 2020. CMA #3/employee administered the Advair Discus inhaler to the resident once in December 2019. CMA #4/employee administered the Advair Discus inhaler to the resident five times in December 2019, three times in January 2020 and and once in February 2020. The employee records for CMA/employee #2, CMA/employee #3 and CMA/employee #4 did not include documentation any of them had completed Department approved training in respiratory medications. At 2:20 p.m., CMA/employee #2 stated she administered resident #7 her inhaler every day she was at work and she had no advanced training in respiratory medications. At 2:40 p.m., the RN stated CMA/employee #3, #4 and #5 had administered the inhaler to resident #7 and they did not have advanced training in respiratory medications.	N1437		

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A re-licensure survey was conducted 02/03/2020 and 02/04/2020. Resident census was 30. The following deficient practices were cited.	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 observation, interview and record review, it was determined the center failed to ensure registered nurse supervision for 2 (#1 and #8) of 2 sampled residents that self-administered medications. This had the potential for more than minimal harm at a pattern. Findings: Resident #1 Resident #1 had an order for Levemir (insulin), dated 09/12/19, 15 units at 8:00 a.m. and 20 units at 8:00 p.m. On 01/03/2020, the order was changed to Levemir twice daily at 8:00 a.m. and 5:00 p.m. For blood sugar results up to 239 dl/ml (deciliters per milliliter) the resident was to have 20 units of Levemir and for blood sugar results 240 dl/ml and above the resident was to have 25 units of	C 911		

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C 911	Continued From page 1 Levemir. The resident did not have a physician's order to self-administer his insulin, but did have a self-administration assessment completed by the RN (registered nurse) on 09/16/19. The self-administration assessment form stated residents who desire to self-administer will have a physician's order to do so. On 02/03/2020 at 3:30 p.m., resident #1 stated the center's staff administered his oral medications, but he performed his FSBS (finger stick blood sugar) testing and administered his own insulin. On 02/04/2020 at 10:50 a.m., resident #1 provided his FSBS log as requested. The log documented morning FSBS results as: 02/01/2020 = 125 02/02/2020 = 129 02/03/2020 = 159 02/04/2020 = 278 (The resident stated he forgot to do FSBS before breakfast) Resident #1 stated he did not document the amount of insulin he administered himself. He just documented the results of FSBS. He stated he administered himself 30 units of Levemir this morning, 20 units on 02/03/2020 and 15 units on both 02/02/2020 and 02/01/2020. He was asked if his dose of Levemir had changed and he stated no. Resident #1 also had a new bottle of Tramadol on his table beside his chair. He stated his son brought it to him last night. He also stated he had not yet let any of the center's staff know about the Tramadol.	C 911		

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C 911	Continued From page 2 At 11:00 a.m., the center's RN (registered nurse) stated he was unaware of the Tramadol bottle in the resident's room. He also stated he got an order to discontinue the resident's Tramadol yesterday. The RN was asked about the resident's insulin order. He was unaware of the insulin dose resident #4 was self-administering. Resident #8 Resident #8 had an order, dated 10/12/19, for staff to administer his medications. He also had a self-administration assessment completed 11/01/19 by the center's RN granting the resident approval to self-administer medications. The self-administration assessment form documented residents who desire to self-administer will have a physician's order to do so. On 02/03/2020 at 10:45 a.m., resident #8 was interviewed in his room. A partial bottle of aspirin 81 mg and a partial bottle of antacid tablets was observed on his table. The resident stated he had been taking the aspirin and antacid probably since he moved into the center in October, 2019. The resident's record was reviewed on 02/04/2020 and no physician's order was found for the aspirin or antacid. At 3:16 p.m., the RN was asked for the physician's order for the aspirin and antacid. He stated there was no order for either one and he was unaware the resident had the medications in his room. He also stated he never counted medications for residents that self-administer, he just checked orders with medications in resident rooms quarterly.	C 911		

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C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This Rule is not met as evidenced by: Based on record review and interview, it was determined the center failed to ensure the RN (registered nurse) reviewed resident's medications monthly for 8 (#1 through #8) of 8 sampled residents. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 02/04/19 at 11:30 a.m., the resident's medications were reviewed for residents #1 through #8. There was no documentation the RN reviewed the resident's medications monthly. Physician's orders were printed out and placed in the records quarterly and signed by the RN. The RN stated he only reviewed and signed all resident's medications quarterly because the thought it was supposed to be done quarterly.	C 921		
C1921 SS=E	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order	C1921		

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C1921	Continued From page 4 This Rule is not met as evidenced by: Based on observation, interview and record review, the center failed to have a physician's order for two medications found in a resident's room for 2 (#1 and #8) of 2 sampled residents that self-administered medications. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #1 On 02/04/2020 at 10:50 a.m., a new bottle of Tramadol 50 mg (milligrams) was observed on table beside the chair of resident #1. He stated his son brought it to him last night. He also stated he had not yet let any of the center's staff know about the Tramadol. At 11:00 a.m., the center's RN (registered nurse) stated he was unaware of the Tramadol bottle in the resident's room. He also stated he got an order to discontinue the resident's Tramadol yesterday. Resident #8 On 02/03/2020 at 10:45 a.m., resident #8 was interviewed in his room. A partial bottle of aspirin 81 mg and a partial bottle of antacid tablets was observed on his table. The resident stated he had been taking the aspirin and antacid probably since he moved into the center in October, 2019. The resident's record was reviewed on 02/04/2020 and no physician's order was found for the aspirin or antacid. At 3:16 p.m., the RN (registered nurse) was asked for the physician's order for the aspirin and antacid. He stated there was no order for either	C1921		

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C1921	Continued From page 5 one and he was unaware the resident had the medications in his room.	C1921		
C1951 SS=D	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to ensure accurate documentation for 1 (#2) of 1 sampled resident for medication administration. This failed practice had the isolated potential for more than minimal harm. Findings: On 02/03/2020 at 12:06 p.m., during medication pass observation, resident #2 did not have polyethelene glycol powder give 17 (seventeen) grams by mouth two times a day for constipation available for administration. CMA (certified medication aide) #1 was unable to find the medication on the cart or in the medication room. CMA #1 documented the medication was not given at this time. On 02/04/2020 at 8:45 a.m., CMA #2 was asked if resident #2's medication was delivered. CMA #2 was unable to locate resident #2's medication on the cart or in the medication room.	C1951		

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C1951	Continued From page 6 At 10:50 a.m., resident #2's MAR (medication administration record) was reviewed with RN (registered nurse) #1. RN #1 was asked why on 02/03/2020 at 5:30 p.m., resident #2's polyethelene glycol powder was documented it was administered when the medication was not available in the center. RN #1 said he was unsure how it was given or why it was documented as given.	C1951		
C5010 SS=D	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may 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.	C5010		

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C5010	Continued From page 7	C5010		

This Rule is not met as evidenced by:
Based on interview and record review, it was determined the center failed to coordinate care with third party providers for 1 (#2) of 1 sampled resident who had an order for warfarin (blood thinner) and an order for a PT/INR laboratory blood test. This failed practice had the isolated potential for more than minimal harm. Findings:

On 02/04/2020, resident #2's record was reviewed. The resident had a home health certification for 12/02/19 through 01/30/2020. The home health nurse was to manage the resident's warfarin dose and PT/INR blood tests to ascertain the effectiveness of the resident's warfarin dose. The resident had a physician's order for 6 mg (milligram) of warfarin every Thursday and 4 mg all other days of the week.

On Monday, 01/20/2020 there was an home health order for the resident to take 6 mg of warfarin, instead of the usual 4 mg dose and for the resident to have a laboratory PT/INR blood test on 02/03/2020.

The resident's record was reviewed on 02/04/2020. There was no documentation in the resident's record the PT/INR blood test had been

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C5010	Continued From page 8 performed on 02/03/2020. The center's RN (registered nurse) stated he was not aware the resident had been discharged from home health on 01/30/2020 and he was also unaware the resident had an order for a PT/INR blood test to be done 02/03/2020.	C5010		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5506	BROOKDALE EDMOND DANFORTH

Type of Survey (select all that apply)

[2]

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

[A]

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 36967	02/03/2020	02/04/2020	0.25	0.00	10.00	0.00	4.50	5.00
2. 41872	02/03/2020	02/04/2020	0.25	0.00	3.25	0.00	0.50	1.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

MAR 19 2020

OKLAHOMA
State Department
of Health

Delivery Via Email: ldimonico@brookdale.com

September 3, 2020

License Number: AL5506

Ms. Lisa Dimonico, Administrator
Brookdale Edmond Danforth
116 West Danforth
Edmond, OK 73003

Survey Event ID: E9X611

Dear Ms. Dimonico:

On **February 4, 2020**, 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 **April 30.2020**.

If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State Department of Health, ou=Long Term Care, email=katies@health.ok.gov, c=US
Date: 2020.09.03 08:20:02 -05'00'

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/24/2020** **Facility Name:** Brookdale Edmond Danforth **License Number:** AL5506 **Survey Event ID:** E9X611 **Date Survey Completed: 2/4/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C911	Based on: observation, interview & record review, it was determined the center failed to ensure registered nurse supervision for 2 (#1 and #8) of 2 sampled residents that self administered medications. This had the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the plan of correction for Brookdale Edmond Danforth regarding the statement of deficiencies dated 2/4/2020. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. We remain committed to the delivery of quality healthcare services & will continue to make changes and improvements to satisfy that objective.

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?	The resident now has an order for home health to check FSBS & administer insulin per physicians orders. The facility will also go over our self administration policy with all families. The famiies will be reminded not to leave any medication with residents unless they have an order for it.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All family members will sign a copy of our self administration policy so they are aware of our policy.
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?	Health & Wellness Director or designee will do random room checks of residents who self administer their medications. The medications in the apartment will be matched to the physician orders. All findings will be dated & noted.
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.	By random reviews & documentation of findings completed by Health & Wellness Director or designee. The person checking the medications will have a copy of the physician orders to make sure only medications that have an order are in the apartment. All findings will be reviewed during QA for 3 months. The Executive Director will follow up weekly to make sure the checks were made & documented.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Lisa DiMonico** OAC 310:663-25-4(F)			**Date 3/27/2020**
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: 3/24/2020** **Facility Name:** Brookdale Edmond Danforth **License Number:** AL5506 **Survey Event ID:** E9X611 **Date Survey Completed: 2/4/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921	Based on: Record review & interview, it was determined the center failed to ensure the RN (registered nurse) reviewed resident's medications monthly for 8 (#1 through #8) of 8 sampled residents. This failed practice had the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the plan of correction for Brookdale Edmond Danforth regarding the statement of deficiencies dated 2/4/2020. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. We remain committed to the delivery of quality healthcare services & will continue to make changes and improvements to satisfy that objective.

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?	The RN (registered Nurse) will run/print the EMAR on the last business day of the month to review residents monthly medication orders.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	By checking monthly we will catch any potential medications errors.
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?	The Executive Director will follow up monthly to verify the Registered Nurse has made the review & has documented it.
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.	The ED & RN will discuss the findings monthly. We will make sure all protocols are being followed. We will track the orders & note anything that is incorrect. We will track & discuss monthly in QA for three months. The records from the audit will be kept in a notebook to track our progress.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Lisa DiMonico OAC 310:663-25-4(F)	**Date 3/27/2020**

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

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/24/2020** **Facility Name:** Brookdale Edmond Danforth **License Number:** AL5506 **Survey Event ID:** E9X611 **Date Survey Completed: 2/4/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1921	Based on: Observation, interview & record review, the center failed to have a physician's order for two medications found in a residents roomfor 2 (#1 & #8) of 2 sampled residentsthat self administer medications. This failed practice had the potential for more than minimal harmat a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the plan of correction for Brookdale Edmond Danforth regarding the statement of deficiencies dated 2/4/2020. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. We remain committed to the delivery of quality healthcare services & will continue to make changes and improvements to satisfy that objective.

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?	The Executive Director will go over our medication policy with all families. The families will be directed to give the medication to the person on the medication cart & not leave it in the residents apartment.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	By going over our policy with all families & having them sign that they are aware this should keep them from bringing in medicine & leaving it in their family members room.
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?	The Health & Wellness director or designee will randomly make room checks & look for meds that do not belong.
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.	If any meds are found they will be picked up & logged. The Health & Wellness Director or Executive Director will call the families to make them aware of our findings. By making random rounds on various days of the week & different shifts we hope to discourage & educate families & residents about the storage of medications. All findings will be recorded & discussed for three months during QA. All findings will be noted & kept together,
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Lisa DiMonico** OAC 310:663-25-4(F)			**Date 3/27/2020**
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.			
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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: 3/24/2020** **Facility Name:** Brookdale Edmond Danforth **License Number:** AL5506 **Survey Event ID:** E9X611 **Date Survey Completed: 2/4/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1951	Based on: Observation, interview & record review, it was determined the center failed to ensure accurate documentation for 1 (#2) of 1 sampled residnets for medication administration. The failed practice had the isolated potential for for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the plan of correction for Brookdale Edmond Danforth regarding the statement of deficiencies dated 2/4/2020. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. We remain committed to the delivery of quality healthcare services & will continue to make changes and improvements to satisfy that objective.

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?	The Health & Wellness Director will inservice all associates who pass meds on the procedure for ordering medicine. They we also be reminded that if something is out you can't mark it as given or use someone elses.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	By going over our policy with all med passers they will all be aware of their responsibility to not let medicine run out.
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?	The Health & Wellness director or designee will randomly make checks & look for meds that are low & verify if they have been ordered.
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.	If any med are low The Health & Wellness Director or designee will see if they have been ordered. If they have not been ordered they will get with the associate who passed the last dose & find out why they were not ordered. The meds will also be ordered. By making random rounds on various days of the week & different shifts we hope to vary the associates are ordering medicines when needed. All findings will be recorded & discussed for three months during QA. All findings will be noted & kept together,

OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Lisa DiMonico OAC 310:663-25-4(F)	**Date 3/27/2020**

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

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

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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: 3/24/2020** **Facility Name:** Brookdale Edmond Danforth **License Number:** AL5506 **Survey Event ID:** E9X611 **Date Survey Completed: 2/4/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C5010	Based on: interview and record review it was determined the center failed to coordinate care with third party providers for 1 (#2) of 1 sampled resident who had an order for warfarin(blood thinner)and an order for PT/INR laboratoryblood test.This failed practice had the isolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the plan of correction for Brookdale Edmond Danforth regarding the statement of deficiencies dated 2/4/2020. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. We remain committed to the delivery of quality healthcare services & will continue to make changes and improvements to satisfy that objective.

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?	The Health & Wellness Director will contact all third party providers & notify them he must have a copy of the discharge order when residents come off service that list any ongoing need.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	By having a copy of the discharge order our community can schedule any labs that need to be taken care of at future dates.
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?	The Health & Wellness Director will make the necessary requests with the people who come out to draw labs.
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.	The Health & Wellness Director will complete the lab requisitions for the appropriate date to be drawn. The lab requisitions copies are kept in the book under completed lab. All findings will be recorded & discussed for three months during QA. All findings will be noted & kept together.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Lisa DiMonico** OAC 310:663-25-4(F)			**Date 3/27/2020**
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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: 3/24/2020** **Facility Name:** Brookdale Edmond Danforth **License Number:** AL5506 **Survey Event ID:** E9X611 **Date Survey Completed: 2/4/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1437	Based on: Interview & record review , it was determined the center failed to ensure oral metered dose inhalers were administered by CMA's (certified medication aides) who had completed a Department approved advanced training program for 1 (#7) of 1 sampled residentwho received a physician ordered inhaler. This failed practice had the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the plan of correction for Brookdale Edmond Danforth regarding the statement of deficiencies dated 2/4/2020. This plan of correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. We remain committed to the delivery of quality healthcare services & will continue to make changes and improvements to satisfy that objective.

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?	Resident #7 is able to self administer her inhaler. We will have an order to self administer.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	If a resident is not able to self administer inhalers or nebulizers they will be given by a RN, LPN or ACMA.
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?	The Health & Wellness Director or designee will check the EMAR weekly for 8 weeks to ensure the proper person is administering inhalers & nebulizers and chart the 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.	Weekly audits will be made & charted to ensure the proper associates are administering the inhalers or nebulizers. The EMAR will be checked to see who has been administering the nebulizers or inhalers. Each month for three months we add this to QA & chart our findings. We will keep the findings together in a notebook for review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Lisa DiMonico OAC 310:663-25-4(F)	**Date 3/27/2020**

OKLAHOMA
State Department
of Health

Delivery via email to: ldimonico@brookdale.com

November 16, 2020

License Number: AL5506

Ms. Lisa Dimonico, Administrator
Brookdale Edmond Danforth
116 West Danforth
Edmond, OK 73003

RE: Survey Event E9X612

Dear Ms. Dimonico:

On **November 12, 2020,** an offsite/paper revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **February 4, 2020,** have now been corrected effective **April 30, 2020.**

If you have any questions concerning the information in this letter, please contact us in Enforcement at (405) 21-6868.

Sincerely,

Users, Lisa D Calvin
Digitally signed by Users, Lisa D Calvin
Date: 2020.11.16 14:51:32 -06'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5506	A. BUILDING: _____ B. WING _____	R-C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDMOND DANFORTH	116 WEST DANFORTH EDMOND, OK 73003

(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
{N 000}	Initial Comments An Offsite/Paper Revisit was completed on 11/12/20. Credible evidence of correction was submitted for all deficiencies.	{N 000}		
{C 000}	INITIAL COMMENTS An Offsite/Paper Revisit was completed on 11/12/20. 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

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.			
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