OKLAHOMA
State Department
of Health

Delivery Via Email: jbraun1@brookdale.com

August 14, 2020

License Number: AL7216

Ms. Jennifer Braun, Administrator
Brookdale Tulsa Midtown
5211 South Lewis Avenue
Tulsa, OK 74105

Survey Event ID: V6ZP11

Dear Ms. Braun:

On **January 29, 2020**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

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

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

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

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

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

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: 2020.08.14 09:50:12 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Midtown Tulsa**
Address: **5211 South Lewis Ave.**
City, State, Zip: **Tulsa, OK, 74105**
Provider #: **AL7216**
Complaint #: **OK #54944**
Investigation Date(s): **01/28/20 and 01/29/20**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure a resident met the admission criteria/was assessed for appropriate placement.	US

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

An unannounced on-site investigation was initiated on 01/28/2020 at 09:30.

A sample of 8 residents including any identified resident, 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 unsubstantiated related to this allegation.

An investigation specific to the center's admission criteria and appropriate placement and admission of residents to the center, was conducted. On a progress note, dated 9/13/19, the physician recommended "SNF placement" for the resident named in the allegation. The resident was assessed by the assisted living center prior to admission and again 14 days after admission. The resident was assessed to be independent with activities of daily living, requiring only minimal assistance. The resident was admitted with other comorbidities that could/would impact future care needs, including receiving chemotherapy for metastatic cancer. The resident was identified with a "port" and treatment was also to include radiation. Included on a document, titled "Order Summary Report," dated 9/27/19, "the person's needs can be met in the Assisted Living setting." There was no physician's signature.

The resident had chronic pain which required the long term use of narcotics for pain control. The resident was hospitalized on 10/30/19 and the history and physical documented the resident was "feeling lightheaded after standing" and was agitated and delusional on 11/04/19 with "pain uncontrolled." According to hospice notes, the resident had complaints of increased weakness on 11/15/19, observed to be hallucinating on 11/18/19, and was agitated on 11/19/19. A Hospice social worker documented "possible placement options" were discussed with the granddaughter on 11/21/19. The resident was noted as "screaming all night in pain" on 11/21/19. The center initiated a Plan of Accommodation on 11/21/19, approximately 2 months and 1 week after the resident's admission to the center, so the resident could "age in place" in her home. There was no physician signature, resident signature or resident's designated representative's signature on the Plan of Accommodation.

The resident fell into her furniture in her private room on 11/22/19 and it was documented the family "revoked hospice services" to have the resident evaluated at the hospital. The resident started hospice services again on 11/25/19 and the family chose to readmit the resident back to the assisted living on 11/26/19, where she remained until 12/10/19. The resident was transferred out to a free standing hospice, where she expired.

A review of the center's level of care and admission criteria was conducted. Documentation including hospice records and the "Plan of Accommodation" (POA) developed for the resident identified in the complaint to "Age in Place." The resident's hospitalizations were documented and reviewed, and interviews were conducted with staff, residents, and family members of residents currently in the center. Medical records documented hospice supplied a hospital bed, which was placed in a low position to decrease injury from falling out of bed, along with other measures by the center i.e.; fall mats, positioning walkers/wheelchairs to reduce fall risks etc.

Incident reports, both in-house and state required reportable incidents were reviewed. Only one fall was documented and the fall resulted in a head injury. The resident was hospitalized for the head injury on 11/22/19 and returned to the center on 11/26/19. The other hospital visits documented the resident wanting/needing more pain medication, episode of vaginal/rectal bleeding and hallucinating and increased weakness related to resident's diagnosis of metastatic cervical cancer. Hospice made visits to the resident 2 to 3 times a week.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.

Justina Leach

Date report completed: 01/31/2020

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
	AL7216	A. BUILDING: _____ B. WING _____	01/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE TULSA MIDTOWN	5211 SOUTH LEWIS AVENUE TULSA, OK 74105

(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 01/28/20 and 01/29/20 to investigate complaint #OK54944. The census was 98. The following deficient practice was cited.	C 000		
C5015 SS=E	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident;	C5015		

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C5015	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the Center failed to develop a complete Plan of Accommodation, identifying services specific to 1 (resident #5) of 1 residents, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident. The only signatures on the Plan of Accommodation were the Administrator and the registered nurse (RN). Resident #5 was admitted to the Center on 9/13/19. The resident had a "port" or device to be utilized during chemotherapy provided every 21 days. The plan of accommodation did not address who was responsible for providing ongoing assessment and care for this device. The plan did not address post chemotherapy needs nor did it address ongoing complaints of pain, delirium, hallucinations and increased weakness. The resident only resided in the center for 9 weeks.	C5015		

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Delivery Via Email: jbraun1@brookdale.com

August 24, 2020

Fac ID: AL7216
Survey Event ID: V6ZP11

Ms. Jennifer Braun, Administrator
Brookdale Tulsa Midtown
5211 South Lewis Avenue
Tulsa, OK 74105

Dear Ms. Braun:

On **January 29, 2020**, agents from our office concluded an investigation at your facility. You were advised of the findings of that investigation in our notice of **August 14, 2020**.

The original statement of deficiencies report has been revised during administrative review of this case. A copy of the corrected statement of deficienciest is included. Deficiencies identified during the investigation have been affected but do not require a new plan of correction. The corrected investigation report is being provided for your records and no additional action on your part is required at this time.

If we can be of any further assistance, please contact us 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: 2020.08.24 16:18:12 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 000	INITIAL COMMENTS An abbreviated survey was conducted on 01/28/20 and 01/29/20 to investigate complaint #OK54944. The census was 98. No deficient practice was cited. This survey was amended after an Administrative Review. Lisa McAlister, BSN, RN Manager of Survey & Compliance	C 000		

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