Oklahoma State Department of Health
Creating a State of Health

September 5, 2019

License Number: AL6201

Ms. Kimberly Cross, Administrator
Brookdale Ada
801 Stadium Drive
Ada, OK 74820

RE: Survey Event ID: JYF411

Dear Ms. Cross:

On **August 21, 2019**, agents from our office concluded a State Licensure survey 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 August 21, 2019.

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,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL6201	A. BUILDING _____ B. WING _____	08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ADA	801 STADIUM DRIVE ADA, OK 74820

(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 re-licensure survey was conducted on 08/19/19 through 08/21/19. Current census was 35. The following deficiencies were cited.	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the center failed to ensure:

a. Laboratory tests were obtained as ordered by the physician for 2 (#1 and #2) of three sampled residents who had orders for laboratory tests to be done; and

b. Finger stick blood sugars (FSBS) were obtained as ordered by the physician for 1 (#4) of 1 sampled resident who had an order for daily FSBS to be completed.

These failed practices had the potential for more than minimal harm at a pattern. Findings:

RESIDENT #1

Resident #1 had an order for a TSH (a blood test to determine thyroid stimulating hormone) level to be drawn every twelve months. No TSH test results were found in the resident's record.

A pharmacy consult report, dated 03/18/19, documented the resident did not have a TSH level in the chart and recommended a TSH level be drawn on the next lab day and every six months thereafter, due to the resident's heart medication.

RESIDENT #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6201	A. BUILDING: _____ B. WING _____	08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1505	Continued From page 2 Resident #2 had an order for a TSH level to be drawn every six months. No TSH test results were found in the resident's record. A pharmacy consult report, dated 06/18/19, documented the resident was receiving thyroid replacement medication, and a recent TSH level was not located in the resident's record. The pharmacist recommended a TSH level be drawn on the next lab day and at least annually. On 08/20/19 at 3:48 p.m., the registered nurse stated she could not find the TSH laboratory results for either resident. RESIDENT #4 Resident #4 had a diagnosis of diabetes and had an order dated 08/12/19 for daily finger stick blood sugars (FSBS) (blood glucose monitoring via sticking the finger). No FSBS readings/results were located in the resident's record. A home health record for resident #4, documented a FSBS was obtained on 08/15/19. No other FSBS had been done as ordered. On 08/20/19 at 2:30 p.m., the licensed practical nurse (LPN) stated she had not done daily FSBS on resident #4. At 2:38 p.m., the resident stated he had not been checking his glucose levels because he did not have his glucometer (device used to check blood sugar levels). He stated his FSBS had not been checked daily by the staff or home health.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C5010	Continued From page 3	C5010		
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 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 4	C5010		

This Rule is not met as evidenced by:
Based on observation, interview, and record review, it was determined the center failed to ensure blood glucose levels were obtained as ordered by the physician for 1 (#4) of 1 sampled resident who received home health services for blood glucose monitoring. Findings:

Resident #4 was admitted to the center on 07/26/19 with diagnosis of diabetes.

A physician's order, dated 08/12/19, documented the resident had an order for home health and daily finger stick blood sugars (FSBS) (blood glucose monitoring via sticking the finger). No FSBS readings were located in the residents record.

A home health plan of care for resident #4, dated 08/15/19, documented a skilled nurse would see the resident one time a week for nine weeks and the patient/caregiver was to perform blood glucose testing daily. The plan of care was sent by facsimile to the center on 08/21/19.

On 08/20/19 at 2:30 p.m., the licensed practical nurse (LPN) stated the resident's blood glucose levels were monitored by home health. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C5010	Continued From page 5 stated she had not done daily FSBS. At 2:38 p.m., resident #4 stated he had not checked his glucose levels because he did not have his glucometer (device use to check blood sugar levels). He stated his FSBS had not been checked daily by the staff or home health. He stated he thought the home health nurse planned to come once a week. On 08/21/19 at 10:57 a.m., the LPN stated the home health nurse did not inform her they would not be doing the resident's FSBS daily. A Coordination of Services policy, dated as revised 03/2019, documented, "...The agency should coordinate care with service providers involved in the care of a client, including...contracted health care professionals...and other agencies...Document coordination of care on the progress note..."	C5010		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL6201	BROOKDALE ADA

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)
1. BS 36191	08/19/2019	08/21/2019	1.00	0.00	17.50	0.00	8.75	4.00
2.								
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**

SEP 0 6 2019

Oklahoma State Department of Health
Creating a State of Health

October 2, 2019

License Number: AL6201
Survey Event JYF411

Ms. Kimberly Cross, Administrator
Brookdale Ada
801 Stadium Drive
Ada, OK 74820

Dear Ms. Cross:

On August 21, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. 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 **October 21, 2019**.

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) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/KS

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/17/2019** **Facility Name:** Brookdale Ada **License Number:** AL6201 **Survey Event ID:** JYF411 **Date Survey Completed: 8/21/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505SS=E310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENTRIGHTS - Medical Care	Based on: interview and record review, it was determined the center failed to ensure:a. Laboratory tests were obtained as ordered by the physician for 2 (#1 and #2) of three sampled residents who had orders for laboratory tests to be done; and b. Finger stick blood sugars (FSBS) were obtained as ordered by the physician for 1 (#4) of 1 sampled resident who had an order for daily FSBS to be completed.These failed practices had the potential for more than minimal harm at a pattern. Findings:RESIDENT #1 Resident #1 had an order for a TSH (a blood testto determine thyroid stimulating hormone) level tobe drawn every twelve months. No TSH testresults were found in the resident's record.A pharmacy consult report, dated 03/18/19,documented the resident did not have a TSHlevel in the chart and recommended a TSH levelbe drawn on the next lab day and every sixmonths thereafter, due to the resident's heartmedication.RESIDENT #2Resident #2 had an order for a TSH level to bedrawn every six months. No TSH test resultswere found in the resident's record.A pharmacy consult report, dated 06/18/19,documented the resident was receiving thyroidreplacement medication, and a recent TSH levelwas not located in the resident's record. Thepharmacist recommended a TSH level be drawnon the next lab day and at least annually.On 08/20/19 at 3:48 p.m., the registered nursestated she could not find the TSH laboratory results for either resident.RESIDENT #4Resident #4 had a diagnosis of diabetes and hadan order dated 08/12/19 for daily finger stickblood sugars (FSBS) (blood glucose monitoringvia sticking the finger). No FSBS readings/resultswere located in the resident's record.A home health record for resident #4,documented a FSBS was obtained on 08/15/19.No other FSBS had been done as ordered.On 08/20/19 at 2:30 p.m., the licensed practicalnurse (LPN) stated she had not done daily FSBSon resident #4.At 2:38 p.m., the resident stated he had not beenchecking his glucose levels because he did nothave his glucometer (device used to check bloodsugar levels). He stated his FSBS had not beenchecked daily by the staff or home health.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not To be construed as an admission Of or agreement with the finding And conclusions of the Statement Of Deficiencies, or (if applicable,), The administrative sanctions imposed on the community. Rather, it is Submitted as confirmation of our Ongoing efforts to comply with as Statutory and regulatory requirements In this document, we have outlined Specifications in response to each allegation or finding. We have not presented all contrary, factual or legal arguments, nor have we identified all mitigating factors

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #1 and #2 have received lab draws for TSH levels. Results have been sent to the physicians. Resident #4 Home Health will perform daily blood sugars and train patient to obtain daily Blood sugar and log daily blood sugars. Physican has ordered a talking glucometer for resident. Community has also purchased a glucometer. HWD/HWC or designee will monitor and send blood sugar results to physician weekly. HWD/HWC or designee will sign off on tickler form That results were verified and sent to physician weekly.
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other resident labs have been reviewed and no other residents were identified as being affected.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The physician and family were notified of the missed labs/FSBS and clarifications have been requested for the labs and FSBS. The labs have been re-drawn and orders received to continue Q-6months lab draws. The residents have not experienced any adverse effects. Resident #4 will continue being monitored during Q-6mo HbGA1c lab draw and daily blood sugars. Compliance will be monitored by the HWD, nurse and/or designee during a daily review of new physician orders and monthly summaries reports. RN will review lab orders during chart audits during site visits.
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.	Continued compliance will be monitored by the ED, HWD, RN and/or designee during the quarterly quality assurance meetings. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records;
5. On what date will corrective action be completed?	10/21/2019

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Kimberly Cross Executive Director	**Date** Enter a date of signature. 9/30/19

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.

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.

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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** ON THIS DATE Long Term Care
	Current Date: 9/17/2019
	Facility Name: Brookdale Ada
	License Number: AL6201
	Survey Event ID: JYF411
	Date Survey Completed: 8/21/2019

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: observation, interview, and recordreview, it was determined the center failed to ensure blood glucose levels were obtained as ordered by the physician for 1 (#4) of 1 sampledresident who received home health services for blood glucose monitoring. Findings:Resident #4 was admitted to the center on07/26/19 with diagnosis of diabetes.A physician's order, dated 08/12/19, documentedthe resident had an order for home health and daily finger stick blood sugars (FSBS) (bloodglucose monitoring via sticking the finger). NoFSBS readings were located in the residentsrecord.A home health plan of care for resident #4, dated08/15/19, documented a skilled nurse would see the resident one time a week for nine weeks and the patient/caregiver was to perform bloodglucose testing daily. The plan of care was sentby facsimile to the center on 08/21/19.On 08/20/19 at 2:30 p.m., the licensed practicalnurse (LPN) stated the resident's blood glucoselevels were monitored by home health. Shestated she had not done daily FSBS.At 2:38 p.m., resident #4 stated he had notchecked his glucose levels because he did nothave his glucometer (device use to check bloodsugar levels). He stated his FSBS had not beenchecked daily by the staff or home health. Hestated he thought the home health nurse plannedto come once a week.On 08/21/19 at 10:57 a.m., the LPN stated thehome health nurse did not inform her they wouldnot be doing the resident's FSBS daily.A Coordination of Services policy, dated as revised 03/2019, documented, "...The agencyshould coordinate care with service providersinvolved in the care of a client,including...contracted health careprofessionals...and other agencies...Documentcoordination of care on the progress note..."

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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/RN and or designee have audited the physician orders and matched them to current home health orders for the residents.
[redacted]	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No other residents were identified as being affected by this deficiency
[redacted]	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The RN/HWD and/or designee will coordinate care with the Home Health representative during scheduled visits to review physician orders and/or results of lab work. Home Health will be complete a coordination of care form during their scheduled

Received Time Sep. 30. 2019 4:55PM No. 2650

	visits. New orders will be added to Point Click Care and audited during site visits for accuracy.
[redacted]	
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 RN/HWD, and/or designee will review physician orders weekly to observe for accuracy and compliance with standards of practice. Continued compliance will be monitored by the ED, HWD, and or designee during the quarterly QA process. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
[redacted]	
5. On what date will corrective action be completed?	10/21/2019

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Kimberly Cross, Executive Director	**Date** Enter a date of signature. 9/30/19

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.

[redacted]

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.

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ON THIS DATE
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