

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Brentwood Extended Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 841 North 38th Street Muskogee, OK 74401	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on record review and interview, the facility failed to ensure the facility administrator was aware of the provisions and responsibilities of the facility abuse policy which resulted in a substandard investigation of an abuse allegation for 1 (#59) of 15 sampled residents reviewed for abuse. The administrator reported 55 residents resided in the facility. Findings: An undated policy titled Management of Suspected Abuse/Neglect, read in part, The facility staff, during employee orientation and through an ongoing training program, provides all employees with information regarding abuse and related reporting requirements, including prevention, intervention, and detection. A quarterly MDS assessment, dated 02/03/25, showed Res #59 had a BIMS score of 15 which indicated the resident's cognition was intact at the time of the assessment. An OOSDH incident form, incident date 05/07/25, showed the form was the initial report regarding an allegation of physical abuse that had been made regarding Res #59. The corresponding fax receipt showed OSDH had received the incident report on 05/08/25 at 8:59 a.m. Investigation documentation for the allegation of abuse toward Res #59 on 05/07/25, that was provided by the facility administrator on 07/31/25 was reviewed. The documents did not show interviews of staff or residents regarding the alleged abuse. On 07/31/25 at 12:26 p. m., the administrator was asked who conducted abuse investigations at the facility. They stated they did. They were asked if they had conducted the investigation regarding Res #59 that occurred on 05/07/25. They stated they had conducted that investigation. They were asked to provide all their documentation related to that investigation. On 07/31/25 at 2:23 p.m., the administrator was asked to describe the investigation they had conducted regarding the alleged abuse of Res #59 on 05/07/25. The administrator stated at the time of the investigation they were unaware of all the requirements of conducting an abuse investigation as they were new to the organization and had not been trained in the process at that time. They stated they had not conducted interviews with other residents or staff members to determine if they had information regarding that or other incidents. They stated they had not suspended or took other actions to prevent the accused perpetrator from contacting the resident during the investigation. They had not contacted OSDH in the required time frame and had not contacted the local law enforcement agency of the allegation. They stated they have since been trained and were aware of the process.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on record review and interview, the facility failed to ensure the OSDH was informed of an allegation of physical abuse by a staff member in the mandated time frame and the facility failed to contact the local law enforcement agency of an allegation of physical abuse by a staff member for 1 (#59) of 15 sampled resident reviewed for abuse. The administrator reported 55 residents resided in the facility. Findings: An undated policy titled Management of Suspected Abuse/Neglect, read in part, It is the policy of this facility, under the guidance of applicable laws, that any person having reasonable cause to believe that any person in a state of abuse, exploitation or neglect shall report the information to the Oklahoma State Department of Health and any additional regulatory agencies required by the allegation. A quarterly MDS assessment, dated 02/03/25, showed Res #59 had a BIMS score of 15 which indicated the resident's cognition was intact at the time of the assessment. An OSDH incident form, incident date 05/07/25, showed the form was the initial report regarding an allegation of abuse that had been made regarding Res #59. The corresponding fax receipt showed the OSDH had received the incident report on 05/08/25 at 8:59 a.m. The incident report showed on 05/07/25 the activities director was informed by Res #59 a staff member had slapped them, but did not provide a date of the alleged assault. The section of the incident form that indicated if law enforcement had been contacted and when, was blank. On 07/31/25 at 2:23 p.m., the administrator was asked regarding the allegation of physical abuse toward Res #59 if they had reported the allegations of abuse to the OSDH within the required two hours. They stated they had not because at the time of the report they had not yet been trained on conducting abuse investigations at the facility. They were asked if they had contacted any law enforcement agency regarding the allegation of abuse. They stated they had not because they were unaware of that requirement at that time.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on record review and interview, the facility failed to conduct a thorough investigation of an allegation of physical abuse for 1 (#59) of 15 sampled residents reviewed for abuse. The administrator reported 55 residents resided in the facility. Findings: An undated policy titled Management of Suspected Abuse/Neglect, read in part, The facility shall ensure, in a timely and thorough manner, objective investigation of all allegations of abuse, neglect and mistreatment. A quarterly MDS assessment, dated 02/03/25, showed Res #59 had a BIMS score of 15 which indicated the resident's cognition was intact at the time of the assessment. An OSDH incident form, incident date 05/07/25, showed the form was the initial report regarding an allegation of abuse that had been made regarding Res #59. The corresponding fax receipt showed the OSDH had received the incident report on 05/08/25 at 8:59 a.m. The incident report showed on 05/07/25 the activities director was informed by Res #59 a staff member had slapped them, but did not provide a date of the alleged assault. Investigation documentation for the allegation of abuse toward Res #59 on 05/07/25, that was provided by the facility administrator on 07/31/25 was reviewed. The documents did not show interviews with staff or residents regarding the alleged abuse around the time of the allegation. There were interviews regarding the incident dated 07/25/25 included in the packet of investigation material the administrator had provided. On 07/31/25 at 2:23 p.m., the administrator was asked to describe the investigation they had conducted regarding the alleged abuse of Res #59 on 05/07/25. The administrator stated at the time of the investigation they were unaware of all the requirements of conducting an abuse investigation. They stated they were new to the organization and had not been trained in the abuse investigation process at that time. They stated their investigation of the incident did not include interviews with residents and staff members regarding the incident with Res #59 or possible concerns regarding the alleged perpetrator. They stated they have since been trained and were aware of the process.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>Based on record review and interview, the facility failed to ensure the required PBJ staffing data was submitted to CMS for the second quarter of FY 2025. The administrator identified 55 residents resided in the facility. Findings: A PBJ Staffing Data Report, dated 01/01/25 through 03/31/25 (second quarter of FY 2025), showed the facility had not provided staffing data to CMS for the PBJ staffing data report for the quarter. On 07/31/25 at 11:00 a.m., the office manager stated the employee that handled submitting the PBJ staffing data to CMS no longer worked at the facility and that at the time they did not have anyone that was able to send the data. They stated they now have multiple employees can submit the staffing data.</p>