OKLAHOMA
State Department
of Health

Delivery via email to: leah@thebrentwoodseniorliving.com

May 7, 2025

License Number: AL1601

Ms. Leah Bell, Administrator
The Brentwood Senior Living
6920 West Lee
Lawton, OK 73505

Survey Event ID: UTJQ11

Dear Ms. Bell:

On **April 3, 2025,** 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 Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face to face, or a virtual 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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **The Brentwood Senior Living AL**
Address: **6920 W Lee**
City, State, Zip: **Lawton, OK.**
Provider #: **AL 1601**
Complaint #: **OK00067436**
Investigation Date: **04/01/25 through 04/03/25**

ALLEGATION(S)	
1. The facility failed to assess and monitor in a timely manner.	
2. The facility failed to ensure residents are free from physical, verbal, and psychosocial abuse.	
enter text	

An unannounced on-site investigation was initiated 04/01/2025 at 11:00 a.m.

A sample of eight participants, including any identified participants, was selected for the investigation based on the concerns relevant to the allegation(s).

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 Summary of Complaint Investigation A tour of the facility was conducted upon entrance into the facility. Residents were observed for abuse and neglect, and privacy concerns. Staff were observed interacting with residents, as well as during medication passes, and mealtimes.
Records reviewed included: Residents health records, facility reported incidents, grievances, and contracts.
Residents and staff were asked questions regarding abuse and abuse training, choices, and housekeeping.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 04/03/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: The Brentwood Senior Living AL
Address: 6920 W Lee
City, State, Zip: Lawton, OK.
Provider #: AL 1601
Complaint #: 67551
Investigation Date: 04/01/25 through 04/03/25

ALLEGATION(S)	
1. The facility failed to ensure the right to access medical care and treatment of choice.	
enter text	

An unannounced on-site investigation was initiated 04/01/2025 at 11:00 a.m.

A sample of eight participants, including any identified participants, was selected for the investigation based on the concerns relevant to the allegation(s).

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 Summary of Complaint Investigation A tour of the facility was conducted upon entrance into the facility. Residents were observed for abuse and neglect, and privacy concerns. Staff were observed interacting with residents, as well as during medication passes, and mealtimes.
Records reviewed included: Residents health records, facility reported incidents, grievances, and contracts. Residents and staff were asked questions regarding abuse and abuse training, choices, and housekeeping.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 04/03/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: The Brentwood Senior Living AL
Address: 6920 W Lee
City, State, Zip: Lawton, Ok
Provider #: AL 1601
Complaint #: OK00067551
Investigation Date(s): 04/01/25 through 04/03/25

ALLEGATION(S)
1. The facility failed to maintain safe, clean, comfortable, homelike environment.
2. The facility failed to ensure a variety of food was served according to resident preferences and standard of care.

An unannounced on-site investigation was initiated 04/01/2025 at 11:00 a.m.
A sample of eight residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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 Summary of Complaint Investigation: A tour of the facility was conducted upon entrance into the facility. Residents were observed for abuse and neglect, and privacy concerns. Staff were observed interacting with residents, as well as during medication passes, and mealtimes.
Records reviewed included: Residents health records, facility reported incidents, grievances, and contracts.
Residents and staff were asked questions regarding abuse and abuse training, choices, food, and housekeeping.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 04/03/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **The Brentwood Senior Living AL**
Address: **6920 W Lee**
City, State, Zip: **Lawton, OK.**
Provider #: **AL 1601**
Complaint #: **OK00078835**
Investigation Date: **04/01/25 through 04/03/25**

ALLEGATION(S)	
1. The facility failed to maintain a clean, safe, comfortable, homelike environment.	
2. The facility failed to protect residents' rights to privacy.	
enter text	

An unannounced on-site investigation was initiated 04/01/2025 at 11:00 a.m.

A sample of eight participants, including any identified participants, was selected for the investigation based on the concerns relevant to the allegation(s).

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 Summary of Complaint Investigation A tour of the facility was conducted upon entrance into the facility. Residents were observed for abuse and neglect, and privacy concerns. Staff were observed interacting with residents, as well as during medication passes, and mealtimes.
Records reviewed included: Residents health records, facility reported incidents, grievances, and contracts. Residents and staff were asked questions regarding abuse and abuse training, choices, and housekeeping.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 04/03/2025

OKLAHOMA
State Department
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INVESTIGATIVE REPORT

Facility: The Brentwood Senior Living AL
Address: 6920 W Lee
City, State, Zip: Lawton, OK
Provider #: AL 1601
Complaint #: OK00079642
Investigation Date(s): 04/01/25 through 04/02/25

ALLEGATION(S)	
Allegations: Pharmaceutical Services Other State Licensure	
The facility failed to follow policy and procedure for safe medication administration.	
The facility failed to ensure activities were provided to meet the needs and interests of residents, stated in resident contracts.	
The facility failed to report falls to state agency as required.	

An unannounced on-site investigation was initiated 04/01/2025 at 11:00 a.m.

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

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 Summary of Complaint Investigation: A tour of the facility was conducted upon entrance into the center. Residents were observed for abuse and neglect concerns. Staff were observed interacting with residents, as well as during medication passes, and mealtimes.
Records reviewed included: Residents health records, facility reported incidents, grievances, and contracts. Residents and staff were asked questions regarding abuse and abuse training.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 04/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1601	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRENTWOOD SENIOR LIVING	6920 WEST LEE LAWTON, OK 73505

(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 Complaint investigations (#OK00067436, OK00067551, OK00073965, OK00078835, and #OK00079642) were conducted on 04/01/25 through 04/03/25. Facility Census: 30 Listed below are abbreviations that will be used throughout this document. QA - quality assurance GERD - gastroesophageal reflux disease COPD - chronic obstructive pulmonary disease.	C 000		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete an admission assessment within 30 days before or at the time of admission for 1 (#1) of 8 sampled residents reviewed for admission assessments. The administrator reported the facility census was	C 521		

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	AL1601	A. BUILDING: _____ B. WING _____	C 04/03/2025

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THE BRENTWOOD SENIOR LIVING	6920 WEST LEE LAWTON, OK 73505

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C 521	Continued From page 1 30. Findings: Resident #1's service contract, dated 03/31/25, showed they were admitted to facility on 03/31/25, with diagnoses which included acute kidney failure, anxiety, congestive heart failure, hypertension, COPD, history of falling, and diabetes mellitus. There was no documentation in Resident #1's medical record of an admission assessment completed 30 days before or at the time of admission. On 04/01/25 at 3:05 p.m., the administrator was asked to if Resident #1 had a completed admission assessment. The administrator stated no.	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	C 522		

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C 522	Continued From page 2 failed to ensure comprehensive assessments were completed every 12 months for 3 (#4, 5, and #8) of eight sampled residents reviewed for annual comprehensive assessments. The administrator reported a resident census of 30. Findings: 1) Resident #4's physician order, dated 12/02/24, showed Resident #4 was admitted to the facility on 01/29/19 with diagnoses which included hypertension, anxiety, depression, falls, degenerative joint disease, and GERD. Annual assessments in resident's medical record were dated for 2022 and 2023. There was no documentation in Resident #4's medical record for an annual assessment in 2024. 2) Resident #5's physician order, dated 02/03/25, showed Resident #5 was admitted to the facility on 03/01/18 with diagnoses which included anemia, anxiety, depression, and osteoarthritis. Annual assessments in the medical record were dated for 2022 and 2023. There was no documention in Resident #5's medical record for an annual assessment in 2024. 3) Resident #8's physician order, dated 02/03/25, showed Resident #8 was admitted to the facility on 07/19/22 with diagnoses which included anxiety, dementia, hypertension, GERD, restless leg syndrome, and hypoxia. An annual assessment in Resident #8's medical record was dated 08/29/23. There was no documentation of an annual assessment	C 522		

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	AL1601	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 522	Continued From page 3 completed in 2024. On 04/01/25 at 3:00 p.m., the administrator was asked to provide the 2024 annual assessments for Residents #4,5 and #8. The administrator stated the annual assessments were not completed for 2024.	C 522		
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to maintain an internal quality assurance committee that met at least quarterly. The administrator reported the facility census was 30.	C1110		

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C1110	Continued From page 4 On 04/03/25 at 12:05 p.m., the administrator was asked how often QA meetings were held and who were the attendees. The administrator stated they have not had QA meetings since there was not a nursing director. The administrator was unable to provide any QA minutes or signatures and was unable to state when the last meeting was held.	C1110		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure activities were provided to meet the needs and interests of the resident outlined in the facility's service agreement for 1 (#8) 1 sampled resident reviewed for an activity service agreement. Findings:	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1601	A. BUILDING: _____ B. WING _____	C 04/03/2025

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C1304	Continued From page 5 On 04/02/25 at 1:15 p.m., Resident #8 was observed leaning on an overbed table placed in front of recliner with lunch meal on top and was sleeping. At 2:20 p.m., Resident #8 remained asleep in the chair with the lunch meal on the table, untouched. At 2:30 p.m., a staff member entered Resident #8's room, asked if the resident wanted anything to eat. The resident stated they were not hungry. The staff member picked up the lunch tray and removed it from the room. Resident #8 went back to sleep. On 04/02/25 at 3:45 p.m., a "Church" activity was observed to be in progress, but Resident #8 was not in attendence. The resident was observed in her room setting in her recliner. A "Resident Handbook," as part of the service contract, not dated, read in part, "services included in your monthly lease fee." ACTIVITIES "This community offers customized social, recreational, educational, spiritual, cultural programs, directed by an activities director who coordinates a great variety of activities for participating Residents. A "Personal Preference and Social Factors" questionnaire to complete upon admission. Activities will be planned to meet the preference of the Residents of The Brentwood" Each day's planned activities are listed on the bulletin board and in the monthly calendar." An April 2025 "Event Calendar" showed: 9:30 a.m. workout and 2 p.m. Bingo every Monday. Ice cream was documented for every Tuesday at	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1304	Continued From page 6 2 p.m. Every Wednesday had a workout scheduled at 9:30 a.m. and 3:30 church. Every Thursday, was a movie at 1:30 p.m. scheduled. On Thursday, April 24, "paint and sip" was scheduled at 10:30 p.m., and 1:30 p.m. movie. On Friday, 9:30 a.m. workout and 2 p.m. Bingo, was documented on calendar. "Family Day" scheduled on Friday, April 18, 2025. No activities were documented on the Event calendar on Saturdays for April, 2025. On Sundays, the event calendar reads "Church up front" and "Easter Day" on April 20, 2025. Resident #8's physician order, dated 02/03/25, showed resident was admitted to the facility on 07/19/22 with diagnoses which included anxiety, dementia, hypertension, GERD, restless leg syndrome, and hypoxia. Resident #8 activity/life enrichment care plan, dated 10/03/23, showed Resident #8 required assistance of staff to attend activities of preference which was Bingo, pet therapy, and Bible study. On 04/02/25 at 3:10 p.m., the assistant administrator of facility was asked if activities were provided every day for the residents, which they stated, "we try to have activities every day". When asked if there was an activity director, the assistant administrator stated no.	C1304		
C2123 SS=D	310:663-21-2(b)(3) DEADLINES FOR FILING (b) The license application shall be	C2123		

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C2123	Continued From page 7 filed in accordance with the following deadlines: (3) The application for renewal of the license of an existing continuum of care facility or assisted living center, with no transfer of ownership or operation, shall be filed by the renewal date specified on the existing license. Each initial license shall be effective for one hundred eighty (180) days from the issue date. The renewal license shall be issued for a period of twelve (12) months from the date of issue. Provided that licenses may be issued for a period of more than twelve (12) months, but not more than twenty-four (24) months, for the license period immediately following the effective date of this provision in order to permit an equitable distribution of license expiration dates to all months of the year. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to file for a renewal of license by the renewal date specified on existing license. The administrator reported the facility census was 30. Findings: The Oklahoma State Department of Health "Assisted Living Center License" documented was effective beginning 02/20/22. The expiration date documented, "expiring on or before" 02/19/25. On 04/01/25 at 11:30 a.m., the administrator reported the owner was working on the license renewal.	C2123		

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C2123	Continued From page 8 On 04/03/25 at 10:43 a.m., OSDH verified the licence had expired. No current license was available.	C2123		

OKLAHOMA
State Department
of Health

Delivery via email to: leah@thebrentwoodseniorliving.com

May 21, 2025

License Number: AL1601

Ms. Leah Bell, Administrator
The Brentwood Senior Living
6920 West Lee
Lawton, OK 73505

Survey Event ID: UTJQ11

Dear Ms. Bell:

On **April 3, 2025,** 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 **June 2, 2025**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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
	AL1601	A. BUILDING: _____ B. WING _____	C 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRENTWOOD SENIOR LIVING	6920 WEST LEE LAWTON, OK 73505

(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 Complaint investigations (#OK00067436, OK00067551, OK00073965, OK00078835, and #OK00079642) were conducted on 04/01/25 through 04/03/25. Facility Census: 30 Listed below are abbreviations that will be used throughout this document. QA - quality assurance GERD - gastroesophageal reflux disease COPD - chronic obstructive pulmonary disease.	C 000		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete an admission assessment within 30 days before or at the time of admission for 1 (#1) of 8 sampled residents reviewed for admission assessments. The administrator reported the facility census was	C 521		

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C 521	Continued From page 1 30. Findings: Resident #1's service contract, dated 03/31/25, showed they were admitted to facility on 03/31/25, with diagnoses which included acute kidney failure, anxiety, congestive heart failure, hypertension, COPD, history of falling, and diabetes mellitus. There was no documentation in Resident #1's medical record of an admission assessment completed 30 days before or at the time of admission. On 04/01/25 at 3:05 p.m., the administrator was asked to if Resident #1 had a completed admission assessment. The administrator stated no.	C 521	All prospective residents will have a pre admission assessment completed by RN prior to move in effective Immediately. At this time we do not have a RN on staff to complete this task , so we can not admit at this time. Will be completed by 6-2-2025	
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	C 522	Annual assessments and any change of condition will be done by RN within state guideline timeframe. At this time we have no nurse. Two applicants have been interviewed by ED. Owner wants to make final decision on who gets offered RN position. To be completed by 6-2-2025	

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C 522	Continued From page 2 failed to ensure comprehensive assessments were completed every 12 months for 3 (#4, 5, and #8) of eight sampled residents reviewed for annual comprehensive assessments. The administrator reported a resident census of 30. Findings: 1) Resident #4's physician order, dated 12/02/24, showed Resident #4 was admitted to the facility on 01/29/19 with diagnoses which included hypertension, anxiety, depression, falls, degenerative joint disease, and GERD. Annual assessments in resident's medical record were dated for 2022 and 2023. There was no documentation in Resident #4's medical record for an annual assessment in 2024. 2) Resident #5's physician order, dated 02/03/25, showed Resident #5 was admitted to the facility on 03/01/18 with diagnoses which included anemia, anxiety, depression, and osteoarthritis. Annual assessments in the medical record were dated for 2022 and 2023. There was no documention in Resident #5's medical record for an annual assessment in 2024. 3) Resident #8's physician order, dated 02/03/25, showed Resident #8 was admitted to the facility on 07/19/22 with diagnoses which included anxiety, dementia, hypertension, GERD, restless leg syndrome, and hypoxia. An annual assessment in Resident #8's medical record was dated 08/29/23. There was no documentation of an annual assessment	C 522		

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C 522	Continued From page 3 completed in 2024. On 04/01/25 at 3:00 p.m., the administrator was asked to provide the 2024 annual assessments for Residents #4,5 and #8. The administrator stated the annual assessments were not completed for 2024.	C 522		
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to maintain an internal quality assurance committee that met at least quarterly. The administrator reported the facility census was 30.	C1110	QA meeting will be conducted by any member of management to be done the first Monday of every month starting in May 2025. These meetings will be documented and kept in ED office. Will be completed ongoing each month effective 6-2-2025	

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C1110	Continued From page 4 On 04/03/25 at 12:05 p.m., the administrator was asked how often QA meetings were held and who were the attendees. The administrator stated they have not had QA meetings since there was not a nursing director. The administrator was unable to provide any QA minutes or signatures and was unable to state when the last meeting was held.	C1110		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure activities were provided to meet the needs and interests of the resident outlined in the facility's service agreement for 1 (#8) 1 sampled resident reviewed for an activity service agreement. Findings:	C1304	We do not have a dedicated activity director and have not had one since 8/2024. Owner stated not hire an activity person at this time. Daily activities will be scheduled and implemented by 6-2-2025	

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C1304	Continued From page 5 On 04/02/25 at 1:15 p.m., Resident #8 was observed leaning on an overbed table placed in front of recliner with lunch meal on top and was sleeping. At 2:20 p.m., Resident #8 remained asleep in the chair with the lunch meal on the table, untouched. At 2:30 p.m., a staff member entered Resident #8's room, asked if the resident wanted anything to eat. The resident stated they were not hungry. The staff member picked up the lunch tray and removed it from the room. Resident #8 went back to sleep. On 04/02/25 at 3:45 p.m., a "Church" activity was observed to be in progress, but Resident #8 was not in attendence. The resident was observed in her room setting in her recliner. A "Resident Handbook," as part of the service contract, not dated, read in part, "services included in your monthly lease fee." ACTIVITIES "This community offers customized social, recreational, educational, spiritual, cultural programs, directed by an activities director who coordinates a great variety of activities for participating Residents. A "Personal Preference and Social Factors" questionnaire to complete upon admission. Activities will be planned to meet the preference of the Residents of The Brentwood" Each day's planned activities are listed on the bulletin board and in the monthly calendar." An April 2025 "Event Calendar" showed: 9:30 a.m. workout and 2 p.m. Bingo every Monday. Ice cream was documented for every Tuesday at	C1304		

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C1304	Continued From page 6 2 p.m. Every Wednesday had a workout scheduled at 9:30 a.m. and 3:30 church. Every Thursday, was a movie at 1:30 p.m. scheduled. On Thursday, April 24, "paint and sip" was scheduled at 10:30 p.m., and 1:30 p.m. movie. On Friday, 9:30 a.m. workout and 2 p.m. Bingo, was documented on calendar. "Family Day" scheduled on Friday, April 18, 2025. No activities were documented on the Event calendar on Saturdays for April, 2025. On Sundays, the event calendar reads "Church up front" and "Easter Day" on April 20, 2025. Resident #8's physician order, dated 02/03/25, showed resident was admitted to the facility on 07/19/22 with diagnoses which included anxiety, dementia, hypertension, GERD, restless leg syndrome, and hypoxia. Resident #8 activity/life enrichment care plan, dated 10/03/23, showed Resident #8 required assistance of staff to attend activities of preference which was Bingo, pet therapy, and Bible study. On 04/02/25 at 3:10 p.m., the assistant administrator of facility was asked if activities were provided every day for the residents, which they stated, "we try to have activities every day". When asked if there was an activity director, the assistant administrator stated no. 310:663-21-2(b)(3) DEADLINES FOR	C1304		
C2123 SS=D	FILING (b) The license application shall be	C2123		

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C2123	Continued From page 7 filed in accordance with the following deadlines: (3) The application for renewal of the license of an existing continuum of care facility or assisted living center, with no transfer of ownership or operation, shall be filed by the renewal date specified on the existing license. Each initial license shall be effective for one hundred eighty (180) days from the issue date. The renewal license shall be issued for a period of twelve (12) months from the date of issue. Provided that licenses may be issued for a period of more than twelve (12) months, but not more than twenty-four (24) months, for the license period immediately following the effective date of this provision in order to permit an equitable distribution of license expiration dates to all months of the year. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to file for a renewal of license by the renewal date specified on existing license. The administrator reported the facility census was 30. Findings: The Oklahoma State Department of Health "Assisted Living Center License" documented was effective beginning 02/20/22. The expiration date documented, "expiring on or before" 02/19/25. On 04/01/25 at 11:30 a.m., the administrator reported the owner was working on the license renewal.	C2123	The facility license is valid and was issued effective 4-16-2025	

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C2123	Continued From page 8 On 04/03/25 at 10:43 a.m., OSDH verified the licence had expired. No current license was available.	C2123		

OKLAHOMA
State Department of Health

Delivery via email to: leah@thebrentwoodseniorliving.com

June 6, 2025

License Number: AL1601

Ms. Leah Bell, Administrator
The Brentwood Senior Living
6920 West Lee
Lawton, OK 73505

RE: Survey Event UTJQ12

Dear Ms. Bell:

On **June 5, 2025,** an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your Complaint survey on **April 3, 2025,** have now been corrected effective **June 2, 2025.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 06/05/25. The facility was in substantial compliance.	{C 000}		

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