
Delivery via email to: jordan.brookridge@gmail.com; jordan.brookridge@gmail.com

December 28, 2022

License Number: AL1604

Mr. Sam Ghosn, Administrator
Brookridge Retirement Community
7802 Quanah Parker Trailway
Lawton, OK 73505

RE: Survey Event ID: TFR711

Dear Mr. Ghosn:

On **December 8, 2022**, 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 December 8, 2022.

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 ;
- (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) 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 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
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.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT LICENSURE

Facility: Brookridge Retirement Community
Address: 7802 Quanah Parker Trailway
City, State, Zip: Lawton, OK 73505
Provider #: AL1604
Complaint #: #OK00059632
Investigation Date(s): 12/01/22, 12/02/22, 12/07/22, and 12/08/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents' rights were not violated.	S
2. The center failed to ensure residents' rights to a grievance process were not violated.	S

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

An unannounced on-site investigation was initiated on 12/01/2022 at 8:15 a.m.

A sample of ten residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Julie Edmiaston, RN, BSN

Date report completed: 12/12/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/08/2022
NAME OF PROVIDER OR SUPPLIER BROOKRIDGE RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 7802 QUANAH PARKER TRAILWAY 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
N 000	Initial Comments A relicensure survey was conducted from 12/01/22, 12/02/22, and 12/07/22 through 12/08/22. A complaint investigation (#OK00059632) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. AMD- Antimicrobial Foam Dressing CNA's- Certified Nurse aides CPR- Cardiopulmonary Resuscitation CVA- Cerebrovascular Accident I.E.- For Example ER- Emergency Room ETC.- et cetera [not a complete list] HX- history MAR- Medication Administration Record MAT- Medication Administration Technician MINs- Minutes POA- Power of Attorney QA- Quality Assurance X- times	N 000		
N1105 SS=E	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services.	N1105		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N1105	Continued From page 1 (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to complete: a) a performance review for every nurse aide at least once every twelve months for two (#1 and #2) of two sampled CNAs employed by the center for at least 12 months and, b) failed to provide two (2) hours of in-service training specific to their job assignment each month. The Administrator reported 72 residents resided in the center. Findings: On 12/02/22 at 11:18 a.m., the house supervisor #3 was asked about the center's policy for performance reviews. They reported it was yearly for CNA's. They were asked to submit in-services for year 2022. They stated the only in-service they had was November, 2022. They were asked how often had the staff received in-service. They stated every two weeks, but they could not find them.	N1105		

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C 000	Continued From page 2	C 000		
C 000	INITIAL COMMENTS A relicensure survey was conducted from 12/01/22, 12/02/22, and 12/07/22 through 12/08/22. A complaint investigation (#OK00059632) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. AMD- Antimicrobial Foam Dressing CNA's- Certified Nurse aides CPR- Cardiopulmonary Resuscitation CVA- Cerebrovascular Accident I.E.- For Example ER- Emergency Room ETC.- et cetera [not a complete list] HX- history MAR- Medication Administration Record MAT- Medication Administration Technician MINs- Minutes POA- Power of Attorney QA- Quality Assurance X- times	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the center failed to maintain the kitchen in accordance with Chapter 257 Food Service Establishment Regulations to:	C 391		

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C 391	Continued From page 3 a) ensure cleaning and sanitation of the kitchen to prevent contamination of the kitchen. b) ensure the handwashing station was stocked with a functional soap dispenser. c) ensure staff wore a beard covering during food preparation. d) ensure utensils/scoops were not stored with the handles touching the contents in the flour and sugar bins. e) ensure food was covered, labeled, and dated. f) ensure the food was cooked to the desired time/temperature control. The Administrator reported 72 residents resided in the center and who receive nutrition from the kitchen. Findings: 1.) The "Cleaning" policy, not dated, read in parts, "...Surfaces must be cleaned with a sanitizing agent/solution. Chlorine, iodine or quaternary ammonium compounds are approved sanitizing agents...Refrigerators units must be cleaned monthly...Waste receptacles should be cleaned and disinfected weekly..." "...310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (a)...Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c)	C 391		

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C 391	Continued From page 4 Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris..." On 12/02/22 at 8:35 a.m., a tour of the kitchen was initiated with the dietary supervisor #4. They were asked about the microwave. They stated they saw it. They were asked if the microwave was dirty. They stated yes. On 12/02/22 at 09:10 a.m., the dietary supervisor #4 was asked if the inside of the refrigerator was dirty. She stated, yes, it is. On 12/02/22 at 8:35 a.m., during kitchen tour a large trash can was observed without a lid in the cooking area. The trash can have a thick black build up on the outside of the can and had dried food particles in the handle portion of the can. Cook #1 was asked about the lid for the trash can. They stated it was not in the kitchen. They were asked if the outside of the trash can have a thick black build-up. They stated yes. On 12/08/22 at 11:22 a.m., the dietary supervisor #4 was asked to submit cleaning logs. They stated, they did not know where they were. The only cleaning schedule submitted was for December, 2022. They were asked if that was the only cleaning schedule they had. They stated, yes. 2.) "...310:257-3-13. Where to wash...Food employees shall clean their hands in a handwashing lavatory or approved automatic handwashing facility and may not clean their hands in a sink used for food preparation or warewashing, or in a service sink or a curbed cleaning facility used for the disposal of mop water and similar liquid waste..."	C 391		

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C 391	Continued From page 5 On 12/02/22 at 08:35 a.m., a tour of the kitchen was conducted. The handwashing station located inside of the kitchen area was not stocked with a functional soap dispenser. The dietary supervisor was asked if the soap dispenser in the handwashing station was functional. She stated no and it had been reported to maintenance and they always have something else to do. 3.) "...310:257-3-20. Effectiveness (a) Except as provided in (b) of this Section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles..." On 12/07/22 at 4:53 p.m., dietary staff #5 was asked if they wore a beard covering when they served lunch on 12/02/22. They stated no. They were asked if chef #6 had a beard covering on while serving soup for dinner tonight. They stated no. On 12/08/22 at 11:20 a.m., chef #6 was asked about serving food without wearing a beard cover. They stated they were informed it could be two inches thick if it was neatly trimmed. 4.) "...310:257-5-31. In-use utensils, between-use storage During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: (1) Except as specified under (2) of this Section, in the food with their handles above the top of the food and the container;	C 391		

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C 391	Continued From page 6 (2) In food that is not Time/Temperature Control for Safety Food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon..." On 12/02/22 at 08:35 a.m., a tour of the kitchen was initiated. Dietary supervisor #4 was asked if there were scoops located in the flour and sugar bins. They stated, "Yes, it is in all of them." They were asked if the scoops should be located inside the container. They stated no it should not. 5) "...310:257-5-60. Ready-to-eat, Time/Temperature Control for Safety Food, date marking... (e) of this Section, refrigerated, ready-to-eat, Time/Temperature Control for Safety Food prepared and held in a food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of seven (7) days..." On 12/02/22 at 08:35 a.m., a tour of the kitchen was conducted. A plastic bag of turkey and gravy, green beans, carrots, diced tomatoes, and a large pan of cooked ground beef, and a large pan of cooked chili was observed in the refrigerator without dates. Several individual bowls of cranberry sauce was observed in the refrigerator uncovered and not dated. They were asked if it was the center's policy to cover and date food items. They stated yes, they were supposed to. They were asked if the cranberry sauce was covered and dated. They stated no. Two pieces of chicken was not dated. They stated the chicken was cooked yesterday and	C 391		

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C 391	Continued From page 7 they just did not date it. They were asked if they boiled eggs were dated. They stated no, they were done yesterday and was not dated. They were asked about the whipped topping. They stated no, it was not dated. On 12/02/22 at 09:10 a.m., the dietary supervisor #4 was asked if the above items were labeled or dated. They stated, no ma'am. 6) "...310:257-5-9. Temperature (d) Time/Temperature Control for Safety Food that is cooked to a temperature and for a time specified under OAC 310:257-5-46 through 310:257-5-48 and received hot shall be at a temperature of 57°C (135°F) or above..." "...310:257-7-56. Food temperature measuring devices...(a) Food temperature measuring devices shall be provided and readily accessible for use in ensuring attainment and maintenance of food temperatures as specified under Subchapter 5. (b) A temperature measuring device with a suitable small-diameter probe that is designed to measure the temperature of thin masses shall be provided and readily accessible to accurately measure the temperature in thin foods such as meat patties and fish filets..." On 12/02/22 at 9:20 a.m., the dietary supervisor #4 was asked to submit the temperature logs for the items cooked for breakfast this morning. They stated they had no thermometer or a place to document them. They stated they were supposed to be getting the logs ready. They were asked how they ensured the food was cooked to the desired temperature. They stated they could tell if it was hot and the residents had no complaints about cold food.	C 391		

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C 397 SS=E	310:663-3-8(d)(4) FOOD STORAGE, PREPARATION AND SERVICE (4) Only clean, whole eggs with shell intact, pasteurized liquid, frozen, dry eggs, egg products and commercially prepared and packaged hard boiled eggs may be used. All eggs shall be thoroughly cooked except pasteurized egg products or pasteurized in-shell eggs may be used in place of pooled eggs or raw or undercooked eggs. This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure only pasteurized eggs were thoroughly cook and served when requested. The Administrator reported 72 residents resided in the center and had the ability to request their choice of eggs for breakfast. Findings: "...310:257-5-12. Eggs and milk products, pasteurized P (a) Egg products shall be obtained pasteurized..." On 12/02/22 at 08:35 a.m., the breakfast plates on the table were observed with leftover eggs and liquid yolks. On 12/02/22 at 09:10 a.m., the dietary supervisor #4 was asked about the eggs served for breakfast. They stated they were shell eggs. They were asked how the eggs were prepared.	C 397		

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C 397	Continued From page 9 They stated over easy, and fried hard and sunny side up and boiled. They were asked if the eggs were pasteurized. They stated no they were just eggs. The box was not marked pasteurized and the eggs in the holder used to prepare the breakfast meal were not stamped to indicate they were pasteurized and the large box of eggs were not stamped to indicate they were pasteurized. On 12/07/22 at 10:00 a.m., the Administrator was interviewed and was asked about the pasteurized eggs. The Administrator stated the kitchen was supposed to use pasteurized eggs.	C 397		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on record review, observation, and interview the center failed to monitor and maintain hot water for bathing to not exceed 115 degrees Fahrenheit for three (#2, 7, and #8) of four sampled resident apartments. The Administrator reported 72 residents resided in the center.	C 701		

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C 701	Continued From page 10 Findings: The "Appendix A Hot Water Use" policy, read in parts, "...Resident Use Bathing Temperature 115 [degrees Fahrenheit] ..." 1.) On 12/07/22 at 12:30 p.m., the temperature of the water was checked in resident #2's kitchen faucet. The temperature of the water was 121.4 degrees Fahrenheit. 2.) On 12/02/22 at 2:45 p.m., the temperature of the water was checked in resident #7's kitchen faucet. The temperature of the water was 133.7 degrees Fahrenheit. Resident #7 reported staff provided assistance with bathing. 3.) On 12/02/22 at 3:30 p.m., the temperature of the water was checked in resident #8's kitchen faucet. The temperature of the water was 140.9 degrees Fahrenheit. Notified the bookkeeper and they read the thermometer at 140.5 degrees Fahrenheit. They notified maintenance to return to the center to make adjustments to the hot water tank. Resident #8 stated the water was "very hot." Resident #8 reported they would turn the hot and cold water on at the same time and then made adjustments. At 5:00 p.m., the Administrator reported the hot water tank was new and adjustments were made by maintenance to turn it down and they would continue to monitor for changes.	C 701		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary	C 911		

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C 911	Continued From page 11 to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to provide RN supervision to ensure one (#7) of one sampled resident received wound care treatments and did not self-administer medications per physician's orders. The Administrator reported 72 residents resided in the center. Findings: The "Policy and Procedure documentation for Self-Administration of Medication" not dated, read in parts, "...I agree to provide documentation from my personal physician that I am capable and competent of self-administration of medication..." The "History and Physical/Medication List" dated 11/11/22, read in parts, "...How long has this patient been with you? 7 yrs... hx of	C 911		

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C 911	Continued From page 12 CVA...Surgical History: Amputation ...Are there any concerns or limitations Brookridge should be aware of? Need assistance...Resident is capable of administering own medications. No..." The physician's admission orders did not determine resident #7 capable to self-administer medications. Resident #7's "Care Plan for Medication Administration" dated 11/2022, read in parts, "...Independent resident in medication administration..." On 12/02/22 at 12:25 p.m., resident #7 was asked about wound care. They stated, they put the dressing on yesterday [12/01/22] at wound care. They were asked how often it needed to be changed. They stated, "every other day." They were asked if the center knew about the wound. They stated, "I can tell them." They reported they were going back to wound care next week. Resident #7 was asked about medications. They stated they did their own medications. Wound care supplies were observed on resident #7's kitchen table. On 12/02/22 at 2:00 p.m., LPN #13 was asked about resident #7's current 14-day assessment. They reported it was due today. They were asked about the resident's wound. They reported the resident returned from the wound care center last week and stated, "no more wound care." They were asked if the center received wound care orders. They were going to put the resident on home health, but the resident had no wound care orders. The "Physician Order Details" dated 12/01/22, faxed on 12/02/22, read in parts, "...Wound Treatment..." The wound care orders did not	C 911		

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C 911	Continued From page 13 contain instructions for wound care treatments. The "Physician Order Details" dated [incorrectly], faxed on 12/05/22, read in parts, "...Wound treatment...Cleanser: Vashe...Every Other Day/30 Days...Discharge Instructions: soak 3-5 min's...Primary Dressing: Curity AMD Gauze Sponge...Every Other Day/30 Days...Discharge Instructions: Apply to wound as directed. Do not cut...Secondary Dressing: Xtrasorb Medium...Every Other Day...Discharge Instructions: Apply to wound as directed. Do not cut...Secured with: cling, tape..." On 12/07/22 at 2:42 p.m., LPN #13 notified the wound care center on Monday [12/05/22] and reported "yes [resident #7] did have wound orders" and they were faxed on 12/05/22 after it was discovered the wound care treatments were missing from the physician's orders faxed on 12/02/22. LPN #13 was asked about the order for resident #7 to not self-administer medications. LPN #13 stated, "No, I did not see it." On 12/02/22 at 2:45 p.m., resident #7 provided a list of the medications and a pill planner was observed in the apartment and contained the morning and evening pills. Resident #7 was asked about the pill planner. Resident #7 reported name-deleted family member set up the pill planner.	C 911		
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant	C 921		

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STATE FORM

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C 954	Continued From page 15 This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide evidence of first aid training for three (#10, 11, and #12) of eighteen sampled direct care staff employees. The bookkeeper reported eighteen direct care staff were employed by the center. Findings: On 12/02/22 at 9:55 a.m., the bookkeeper was asked to submit evidence of first aid training for #10, 11, and #12. They reported they did not have first aid, they only had CPR training.	C 954		
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.	C1110		

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C1110	Continued From page 16 This Rule is not met as evidenced by: Based on record review and interview, the center failed to establish and maintain quality assurance committee at least quarterly for 2022. The Administrator reported 72 residents resided in the center. Findings: On 12/07/22 at 10:00 a.m., the Administrator was asked to submit the yearly QA for 2022. The Administrator stated yes, they were supposed to, and the last licensed practical nurse was no longer employed at the center and "I could not find it."	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.	C1304		

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C1304	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to allow a choice of home health services for one (#3) and failed to follow the grievance procedure as outlined in the center's service contract for two (#3 and #8) of ten sampled service contracts reviewed. The Administrator reported 72 residents resided in the center. Findings: The "[Name deleted-Home Health] List" dated 12/01/22, documented, thirty-two (32) current resident names on the center's home health agency list. The "Policy Investigating Grievances and Complaints" not dated, read in parts, "...Brookridge Retirement Community will investigate all grievances and complaints filed with the facility... Responsibility of Investigation...The administrator may assign the responsibility of investigating grievances and complaints to the appropriate department ..." The "Grievances" policy, not dated, read in parts, "...Residents have the right to express their complaints and dissatisfactions without fear of reprisal. They also have the right to ask the Manager, the Resident Council, and/or Board of Directors/Owner to assist in resolving a problem..." The "Grievance Resolution" procedure, not dated, read in parts, "...If the Manager is unable to effect the desired change or resolve the matter to the resident's satisfaction, the resident may direct	C1304		

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C1304	Continued From page 18 his/her grievance to the Resident Council and/or Broad of Directors/Owner. A prompt response to the resident's grievance or concern will be given to the resident verbally and, if desired, in writing. Whatever the case, residents will be given a reasonable explanation for the action taken on their behalf... If resident is not satisfied with explanation, they may contact the Ombudsman for further intervention..." The "Residents Rights and Responsibilities" not dated, read in parts, "...Every resident's civil and religious liberties, including the right to independent personal decisions and knowledge of available choices, shall not be infringed upon and the facility shall encourage and assist in the exercise of these rights...Every resident shall have the right to prompt efforts by the facility to resolve grievances the resident may have..." 1.) Resident #3's "Residency Agreement" dated 09/03/18, read in parts, "...Licensed home health, hospice and other medical support services as required by your care provider are welcome at BrookRidge. All outside providers are to remain in regular communication with the facility nurse regarding patient care...Dispute Resolution and Grievance Procedures...Upon the receipt of a Dispute and Grievance Report, the director will begin an investigation into the allegations. The department director will be notified of the nature of the problem and that an investigation is necessary. The investigation and report will include, as each may apply: a. The date and time the incident took place. b. The circumstances surrounding the incident. c. Where the incident took place. d. The names of any witness and their account of the incident.	C1304		

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C1304	Continued From page 19 e. The Resident's account of the incident. f. The employee's account of the incident. g. Accounts of any other individuals involved (i.e., employee's supervisors, etc.) h. Recommendations for corrective action. Administrator's Review...The Dispute and Grievance Investigation Report must be filed with the administrator within five (5) days of the receipt of the Dispute and Grievance Report. Informing Complaint[ant] of Investigation Results...The resident or person acting on behalf of the resident will be informed of the findings of the investigation, as well as any corrective actions recommended, within ten (10) working days of the filing of the dispute or grievance...A copy of the Dispute/Grievance Resolution Report must be attached to the Dispute and Grievance Report and filed in the business office...Availability of reports...copies of all reports must be signed and are property of BrookRidge and are not available to the Resident or persons acting on behalf of the Resident..." Resident #3's "Home Health Certification and Plan of Care" read in parts, " ...Start of Care Date: 10/20/22...Certification Period: From: 10/20/2022 To: 12/18/2022...Primary Diagnosis Essential (primary) hypertension..." Resident #3's "Resident Assessment Form" dated 11/21/22, read in parts, " ...Alert x 4 ...Judgment: Good...Special Treatments and Procedures...HH [Home Health]..." Resident #3 was alert to person, place, time, and situation. Resident #3's "Plan of Care" dated 11/30/22, read in parts, "...Independent resident in medication administration..."	C1304		

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C1304	Continued From page 20 On 12/01/22 at 9:45 a.m., the house supervisor #3 was asked if all of the center's residents received services from the center's own home health care agency. The house supervisor #3 stated, "Yes, they are." On 12/01/22 at 12:55 p.m., residents' POA was contacted and reported the only home health agency allowed in the center was the center's home health agency and just wanted the resident to have an option. The POA reported they had discussed their concerns with the center's Ombudsman. On 12/08/22 at 11:49 a.m., the Administrator was asked to tell me about the incident when resident #3's POA requested another home health agency. The Administrator stated yes she did. They wanted to put her [the resident] on services once a week or twice week and the agency was from out of town. The Administrator explained the center was responsible for that and the patient has rights; however, they were in charge of the residents if the care was not provided. The Administrator was asked if the center notified the POA in writing of the findings or any corrective actions. The Administrator stated nothing was given to her in writing about her concern. They stated they were trying to consider other agencies; however, some are not available on the weekends, therefore what would the center do. The Administrator was asked if the resident was allowed to use the resident's choice of home health services. The Administrator stated, "No, because I did not know them." The Administrator reported he had spoken with the resident and the POA and they had no concerns with the center's home health agency. 2.) Resident #8's "Residency Agreement" dated	C1304		

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C1304	Continued From page 21 06/10/21, read in parts, "...Dispute Resolution and Grievance Procedures...Upon the receipt of a Dispute and Grievance Report, the director will begin an investigation into the allegations. The department director will be notified of the nature of the problem and that an investigation is necessary. The investigation and report will include, as each may apply: a. The date and time the incident took place. b. The circumstances surrounding the incident. c. Where the incident took place. d. The names of any witness and their account of the incident. e. The Resident's account of the incident. f. The employee's account of the incident. g. Accounts of any other individuals involved (i.e., employee's supervisors, etc.) h. Recommendations for corrective action. Administrator's Review...The Dispute and Grievance Investigation Report must be filed with the administrator within five (5) days of the receipt of the Dispute and Grievance Report. Informing Complaint[ant] of Investigation Results...The resident or person acting on behalf of the resident will be informed of the findings of the investigation, as well as any corrective actions recommended, within ten (10) working days of the filing of the dispute or grievance...A copy of the Dispute/Grievance Resolution Report must be attached to the Dispute and Grievance Report and filed in the business office...Availability of reports...copies of all reports must be signed and are property of BrookRidge and are not available to the Resident or persons acting on behalf of the Resident..." On 12/02/22 at 3:30 p.m., resident #8 reported she had spoken with the house supervisor and	C1304		

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C1304	Continued From page 22 the Administrator for over an hour in regards to missing medications on November 25, 26, and 27th of 2022. Resident #8 was asked if she put the grievance in writing. Resident #8 stated, "no, I did not." On 12/08/22 at 11:49 a.m., the Administrator was asked about an incident when resident #8's medications were not available. The Administrator explained residents' medications come through the mail and they arrived at the front desk and then delivered to the resident's apartment and remained there for a day or two. The Administrator reported they needed to implement a system to sign off for the medications and they were not going to let that happen again. The Administrator was asked what was done about the grievance. The Administrator reported, "I got involved myself and was concerned about that." The Administrator did not understand why the medication staff did not report they were out of medications. The Administrator was asked if the grievance policy in the contract was followed in regards to resident #3 or #8. The Administrator stated, "I did not write it up, I should have."	C1304		
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.	C1505		

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C1505	Continued From page 23 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. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to follow physician's orders and ensure medication availability for two (#2 and #8) of ten sampled residents charged for monthly medication administration assistance. The Administrator reported 72 residents resided in the center. Findings: The "Policy for Medication Administration and	C1505		

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C1505	Continued From page 24 Medication Administration Record" not dated, read in parts, "...Medication will be administered only with a physician order...Only a licensed nurse, physician, or pharmacist may note medication orders on the M.A.R..." 1) Resident #2's "Residency Agreement" lease signing date 03/01/22, read in parts, "...Monthly charges...\$550.00 medication administration..." Resident #2's "Physician's Order" dated 11/01/22, read in parts, "...Lidoderm 5%...Patch...1 patch externally daily..." Resident #2's "MAR" dated November, 2022, read in parts, "...Lidocaine External Patch 5%...Topical...Place patch to left hip QHS, wear for 12 hours, then remove..." The medication was documented as "not available" for resident #2 for the month of November, 2022. On 12/07/22 at 12:30 p.m., the LPN #13 reported resident #2 did not have lidocaine patches on the cart. On 12/07/22 at 3:50 p.m., house supervisor #3 was asked why the lidocaine patch was not the medication cart. They stated it was ordered and needed a prior authorization from her insurance. On 12/07/22 at 4:20 p.m., resident #2 reported pain in the lower part of the back all across there and in my hip, but had already received a pain pill and could not have anything for six hours. On 12/07/22 at 4:25 p.m., LPN #13 reported they were trying to get resident #2's pain under control and resident #2 was sent to the ER, but was sent back. They reported there was a scheduled pain management appointment for December 14,	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/08/2022
NAME OF PROVIDER OR SUPPLIER BROOKRIDGE RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 7802 QUANAH PARKER TRAILWAY 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
C1505	Continued From page 25 2022. On 12/08/22 at 12:00 p.m., the Administrator was asked to review the missing lidocaine patch on the November, 2022 MAR. The Administrator reported we should have pursued it and found out why it was not here. On 12/08/22 at 12:20 p.m., the RN #9 was asked why resident #2's lidocaine patch did not get ordered. They stated, "No, I do not." On 12/08/22 at 2:22 p.m., the house supervisor #3 was asked why the resident's lidocaine patch had not been followed up on. They stated the medication aides had reported it to them throughout the month and the previous LPN had not followed up on it. 2) Resident #8's "Residency Agreement" lease signing date 06/09/21, read in parts, "...Monthly charges...\$550.00 medication administration..." Resident #8's "Resident Assessment Form" dated 11/30/22, read in parts, Alert x 4 [Oriented to person, place, time, and situation], judgment: G [good] ..." Resident #8's "Physician's Order" dated 11/22/22, read in parts, "...Magnesium Oxide 400 mg tab... take 2 tablets by mouth once daily...Quetiapine Fumarate [medication used to treat mood disorders] 50 mg tab ...take 2 tablets by mouth daily at bedtime...Vit D3 1000-unit soft gel...take 1 tablet by mouth twice daily..." On 12/02/22 at 3:30 p.m., resident #8 reported trouble with their medications about a week ago today. The girl brought the medications in and there were only five medications and there should	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/08/2022
NAME OF PROVIDER OR SUPPLIER BROOKRIDGE RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 7802 QUANAH PARKER TRAILWAY 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
C1505	Continued From page 26 have been seven medications in the cup. Resident #8 reported without these medications you begin to feel the effects. On 12/07/22 at 11:00 a.m., LPN #13 was asked to review resident #8's MAR for November, 2022. She was asked on how many occasions was resident #8's medication not available on the MAR for November, 2022. They stated, "A lot. They need to figure out why the medication is not here, there should never be a repeat." LPN #13 identified Magnesium Oxide was missed seven times, Quetiapine Fumarate was missed ten times, and Vitamin D3 was missed 13 times during the month of November 2022. LPN #13 was asked if Quetiapine Fumarate was missed about a week ago on November 25th, 26th, and 27th of 2022. They stated, yes.	C1505		

Delivery via email to: jordan.brookridge@gmail.com; samghosn@gmail.com

January 17, 2023

License Number: AL1604

Mr. Sam Ghosn, Administrator
Brookridge Retirement Community
7802 Quanah Parker Trailway
Lawton, OK 73505

RE: Survey Event TFR711

Dear Mr. Ghosn:

On **December 8, 2022**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C0911:** The proposed action for C-911 did not include self-administration of medications for Resident #7.
- **C0921:** The proposed action for C-921 did not outline the procedures for future RN monthly medication reviews to include where the procedure will be documented.
- **C1304:** The proposed action for C-1304 did not identify how the corrective action would be accomplished for Resident #3 and Resident #8, and failed to ensure how future grievance procedures would be conducted.
- **C1505:** The proposed action for C-1505 did not outline the procedures to follow to ensure medication availability and measures put into place to prevent recurrence must include the date the staff was in-serviced (educated) and include the dates of any audits conducted for the medication administration records to ensure medications were available as ordered.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/5/2023

Facility Name: Brookridge Retirement Community

License Number: AL1604-1604

Survey Event ID: TFR711

Date Survey Completed: 12/8/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1105

Based on: 310: 677-11-1(a)(1)(2)(3) Based on our record and review the center failed to complete (a) a performance review for every nurse aide at least every 12 months for two (#1 and #2) of two sampled CNA employee by the center for at least 12 months and (b) failed to provide two (2) hours of in-service training specific to their job assignment each month.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

a- Yearly performance review for CMA and CNA are now completed.
b- Mandatory inservice was conducted on 12/16/22 and 12/30/22. All inservices for nursing staff are conducted biweekly according by our LPN, and signed out by RN.

Clinical reports Lead is instructed to follow up with the documents pertaining to skill check off yearly for nursing assistant staff. Bookkeeping additionally, follow up with the spreadsheet created for staff compliance.

A spreadsheet is in place and is monitored closer by bookkeeping to inform our clinical lead/staff if documents are to be updated.

We have bi-weekly inservices scheduled every pay day-Friday to ensure all trainings are held.

The sign in sheet for inservices, will be taken and placed in the (In-service note book) after signed by RN.

Records maintained by our Clinicals records lead on skills check off, and mandatory in-services will be included in the Q&A.

All direct care staff records are kept safe by bookkeeping and each one is updated/renewed as needed.

Administrator's Signature Administrator signature required.

OAC 310:663-25-4(F)

Sam Chosr

Date Enter a date of signature.

1-8-2023

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/5/2023

Facility Name: Brookridge Retirement Community

License Number: AL1604-1604

Survey Event ID: TFR711

Date Survey Completed: 12/8/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: 310-663-3-8(a) Based on record review, observation and interview the center failed to maintain the kitchen in accordance with chapter 257 food service establishment regulations to: a) ensure cleaning and sanitation of the kitchen to prevent contamination of the kitchen b) ensure the hand washing station was stocked with a functional soap dispenser. c) ensure staff wore a beard covering during food preparation d) ensure utensils/scoops were not stored with the handles touching the contents in the flour and sugar bins. e)ensure food was covered, labeled and dated. f) ensure the food was cooked to the desired time/temperature control.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

a) a new daily cleaning & sanitizing chart was created to be filled out dated & signed by the kitchen and dietary staff.
b) hand washing station is stocked now with a functional soap dispenser.
c) facility chef and staff was explained the importance to cover his beard while inside the kitchen cooking, serving or while handling food. Beard hair nets are available now.
d)all utensils or scoops are now inside individual zip lock bags.
e)staff was inserviced on the importance of covering the food, dating the food inside the fridge and all dry goods.
f) more thermometers were purchased and staff was inserviced as of how to use for time/temperature control/ and chart on our logs.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

A spreadsheet is now in place and to be monitored by our front desk staff to verify the job is completed, dated and signed by the assigned staff member.

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

The daily cleaning list I now monitored closer by dietary supervisor to ensure is completed, and turned into front desk for additional review.

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

After reviewing the daily cleaning log, facility lead will tour the kitchen to confirm the job is completed then take action if not satisfactory.

a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	By conducting a monthly documented meeting with dietary staff and cooks for any problems to be solved. The daily report will be include on our Quarterly Q&A for additional feed back and updates. All kitchen logs are kept with the bookkeeping office in a binder as evidence.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	1/26/2023	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Administrator signature required.	Date Enter a date of signature.	
OAC 310:663-25-4(F)	<i>SAM ZHOSN</i> 1-8-2023	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.		
Addendum Date	Enter a date of addendum.	Submitted by Enter name of person submitting addendum.
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Facility in Compliance by: Click here to enter a date.		



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/5/2023

Facility Name: Brookridge Retirement Community

License Number: AL1604-1604

Survey Event ID: TFR711

Date Survey Completed: 12/8/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 397

Based on: 310.663-3-8(d)(4) Record review observation, and interview, the center failed to ensure only pasteurized eggs were thoroughly cook and served when requested.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- a. How the correction will be evaluated for effectiveness;
- b. How the correction will be incorporated into the center's quality assurance system; and
- c. How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The center in-serviced all cooks on the importance of pasteurized eggs, proper temperature and cooking.

The center put into place, thermometers to record food temperature daily to ensure proper procedure and safety-are being follow up by the cook and chef.

Pasteurized eggs are the only shell eggs being purchased by the facility, and Dietary supervisor and Chef will monitor to ensure nothing else is serve in place of.

Logs with documentation are inspected daily and staff is now re-trained to ensure this procedure works.

When food orders is ready to be placed online, the list is reviewed for accuracy and compliance before is placed.

On 12/14/2022 the facility have a Q&A meeting to discuss all the findings. All corrections will be reviewed on our next Q&A meeting scheduled for March 2023.

Monitoring is now done daily by our cooks and temperatures are recorded on our logs and reviewed by administration leads.

Administrator's Signature Administrator signature required.

OAC 310:663-25-4(F)

Sam Zosn

Date Enter a date of signature.

1-8-2023

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

Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

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Facility in Compliance by: Click here to enter a date.



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/5/2023

Facility Name: Brookridge Retirement Community

License Number: AL1604-1604

Survey Event ID: TFR711

Date Survey Completed: 12/8/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 701

Based on: Record review observation and interview center failed to monitor and maintain hot water for bathing to not exceed 115 degrees Fahrenheit for three (#2, #7, and #8) of four sampled residents apartments

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Administrator signature required.

OAC 310:663-25-4(F)

SAB Chosen

Date Enter a date of signature.

1-8-2023

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Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

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