OKLAHOMA
State Department
of Health

**Delivery via email to:** samghosn@gmail.com; gisela10.brookridge@gmail.com

November 1, 2023

License Number: AL1604

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

**Survey Event ID: CPE411**

Dear Mr. Ghosn:

On **October 26, 2023,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

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

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

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

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

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

Respectfully,

Lisa Calvin

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

Enclosure

# INVESTIGATIVE REPORT

**Facility:** **Brookridge Retirement Community**
**Address:** **7802 Quanah Parker Trailway**
**City, State, Zip:** **Lawton, OK 73505**
**Provider #:** **AL1604**
**Complaint #:** **OK00061665**
**Investigation Date(s):** **10/26/23**

## ALLEGATION(S)

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|---|
| The center failed to ensure equipment was maintained in safe working order, failed to ensure interventions were completed according to the fire marshal and failed to ensure interventions were in place for a resident at high risk for falls. |
| The center failed to ensure a working communication system for residents to call the nursing staff for assistance and failed to have and/or implement an effective pest control program. |
| The center failed to ensure a fire was reported to the Oklahoma State Department of Health according to State Law. |

An unannounced on-site investigation was initiated 10/26/2023 at 11:55 a.m.

A sample of three 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 Summary of Complaint Investigation:**

A tour of the facility was conducted upon entrance and throughout the investigation. The facility was observed for cleanliness and evidence of pests. Residents were observed during the noon meal in the main dining room and in their individual apartments. Equipment, including the emergency call light system, was observed and manually checked for working order. Staff were observed for response to call light alerts.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Resident contracts and marketing materials were reviewed. Incident reports, including reports to the Oklahoma State Department of Health, were reviewed for thorough investigations and interventions implemented. Invoices related to equipment repairs were reviewed. Fire drill records were reviewed. Staff in-services, including fire and safety training, were reviewed.

Numerous residents, including sampled residents, were interviewed regarding the facility call light system. Residents were interviewed related to emergency response and safety. Residents were interviewed related to cleanliness of the facility and concerns related to pests of any kind. Staff members were interviewed regarding the facility's call light system and response to resident needs. Staff members were interviewed related to frequency of resident checks and routine rounding. Administrative staff were interviewed related to equipment repairs and appropriate response and action taken related to an inspector's recommendations.

The attached Statement of Deficiencies, Form 2567 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: 10/27/2023

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL1604 | A. BUILDING: _____ B. WING _____ | C 10/26/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKRIDGE RETIREMENT COMMUNITY | 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 |
|---|---|---|---|---|
| C 000 | INITIAL COMMENTS<br><br>A complaint investigation (#OK00061665) was conducted on 10/26/23.<br><br>The following are abbreviations which will be used in this document:<br><br>CNA - Certified Nurse Aide<br>DON - Director of Nursing<br>PCA - Patient Care Assistant | C 000 | | |
| C1302 SS=E | 310:663-13-1(b) RESIDENT SERVICE CONTRACT<br><br>(b) All rights, privileges and assurances guaranteed to residents under these rules or marketing materials are deemed incorporated in any contract between an assisted living center and a resident.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the center failed to provide a 24-hour emergency call system, as stated in the residency agreement and marketing materials, for two (#1 and #3) of three residents reviewed for emergency call lights.<br><br>The Director of Nursing reported 54 residents resided at the center.<br><br>Findings: | C1302 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| C1302 | Continued From page 1<br><br>Marketing materials for the facility, "Independent Living With Added Peace of Mind," documented residents would have a 24 hour emergency call system.<br><br>A facility "Residency Agreement," documented standard quality services and amenities would include an emergency response system in every apartment.<br><br>1. An annual assessment for resident #1, dated 03/13/23, documented the resident was alert and oriented. The assessment documented the resident had diagnoses which included hemiplegia, hemiparesis, and polyosteoarthritis.<br><br>On 10/26/23 at 1:10 p.m., resident #1 reported they had a call pendant which they wore around their neck and they used this pendant to alert staff when they needed assistance. The resident reported they weren't sure if the call lights in their apartment worked. The resident stated staff checked on them frequently, including through the nighttime hours.<br><br>Resident #1's call lights in the living area and bathroom were checked and neither call light was found to be in working order.<br><br>2. An annual assessment for resident #3, dated 04/28/23, documented the resident was alert and oriented. The assessment documented the resident had diagnoses which included osteoarthritis, hypertension, polyneuropathy, muscle spasms, anxiety, and depression.<br><br>On 10/26/23 at 12:35 p.m., resident #3 reported they had a call pendant which they wore around their wrist as a bracelet. The resident reported | C1302 | | |

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| C1302 | Continued From page 2<br>they used the call pendant every night at bedtime to call staff for assistance. The resident reported they didn't think the call lights in their apartment worked but staff checked on them frequently.<br><br>Resident #3's call lights in the living area and bathroom were checked and neither call light was found to be in working order.<br><br>On 10/26/23 at 12:43 p.m., PCA #1 reported she was carrying a pager and covering for one of the CNAs while they were at lunch. The PCA demonstrated how the pager worked when activated by a resident's call pendant. When the pager was tested using a regular call light in a resident's apartment, the PCA required assistance from the DON to find where the alert was showing on the pager. The PCA reported residents were checked every two hours or at every shift change. The PCA stated the aides kept a rounding list of residents who required more frequent checks.<br><br>On 10/26/23 at 1:20 p.m., the administrator reported call lights in all occupied rooms were checked once a month. The administrator stated they did not have documentation to show the call lights had been checked.<br><br>On 10/26/23 at 2:04 p.m., the marketing consultant reported not all residents chose to have a call pendant. They stated when a resident requested a pendant, this service was added to their contract and the resident was charged $29.00 a month.<br><br>On 10/26/23 at 3:18 p.m., the administrator reported the regular apartment call lights, as well as the pendant alerts, should activate the pagers which the CNAs carried at all times. | C1302 | | |

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|---|---|---|---|---|
| C1302 | Continued From page 3<br><br>On 10/26/23 at 4:30 p.m., the DON stated staff had checked the call lights in all occupied apartments. The DON reported of the 54 residents, 28 residents did not have working call lights in their apartment. The DON reported of the 28 residents without working call lights, 16 did not have a call alert pendant. The DON stated she would be taking over the responsibility of checking call lights and ensuring all residents had a functioning emergency call system. | C1302 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to:** samghosn@gmail.com; angela1.chateau@gmail.com

November 13, 2023

License Number: AL1604

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

**Survey Event ID: CPE411**

Dear Mr. Ghosn:

On **October 26, 2023,** 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 **December 1, 2023**.

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,

Tempal Killman

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

**OPTIONAL PLAN OF CORRECTION TEMPLATE**

**Current Date: 11/7/2023**

**Facility Name:** Brookridge Retirement Community

**License Number:** AL 1604

**Survey Event ID:** CPE411

**Date Survey Completed: 10/26/2023**

**SUMMARY OF DEFICIENCY CITED BY OSDH**

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|---|---|
| ID Prefix Tag: C1302 | Based on: The center failed to provide a 24 –hour emergency call system, as stated in the residency agreement and marketing materials, for two (#1 and #3) of three residents reviewed for emergency call lights. |

**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 | ASSISTED LIVING CENTER'S PLAN ELEMENTS |
|---|---|
| 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? | On 10/26/2023 LPN and Community Relations Coordinator went and checked all call lights in building, they understand and acknowledge the importance of montoring call lights and solving issues that may arise immeditaley. |
| **OSDH Response: Element accepted Yes ☐ No ☐** | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | All resident's apartments will have a Pull Function test and Fall Risk Pendant Test completed monthly and as needed to verify proper working order. |
| **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? | Spread sheets were created on a Fall Risk Pendant Test and Pull Cord Function Test this will be conducted monthly and as needed and turned into LPN. |
| **OSDH Response: Element accepted Yes ☐ No ☐** | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | LPN and Community Relations Coordinator will monitor and identify any problems that occur and fix immediately.<br><br>Monthly checks on all apartments will be conducted logged on spread sheets ,Fall Risk Pendant test and Pull cord function test will be turned in to LPN.<br><br>RN and LPN will review log sheets Quarterly at Q & A meeting.<br><br>Binder has been created for log sheets and kept in LPN office. |
| **OSDH Response: Element accepted Yes ☐ No ☐** | |
| 5. On what date will corrective action be completed? | 12/1/2023 |
| **OSDH Response: Element accepted Yes ☐ No ☐** | |

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|---|---|
| **Administrator's Signature** Administrator signature required.<br>OAC 310:663-25-4(F) | **Date** Enter a date of signature.<br>10-6-2023 |

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.<br>**Facility in Compliance by:** Click here to enter a date. |

OKLAHOMA
State Department
of Health

**Delivery via email to:** samghosn@gmail.com; angela1.chateau@gmail.com

January 17, 2024

License Number: AL1604

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

**Survey Event ID: CPE412**

Dear Mr. Ghosn:

On **January 11, 2024,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 26, 2023,** have now been corrected effective **December 1, 2023.**

If you have any questions concerning the information in this letter, please contact me 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 |
|---|---|---|---|
| | AL1604 | A. BUILDING: _____ B. WING _____ | R-C 01/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BROOKRIDGE RETIREMENT COMMUNITY | 7802 QUANAH PARKER TRAILWAY LAWTON, OK 73505 |

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|---|---|---|---|---|
| {C 000} | INITIAL COMMENTS<br><br>An offsite/paper revisit was conducted on 01/11/23. All tags have been cleared for this survey. | {C 000} | | |

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