OKLAHOMA
State Department
of Health

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

April 11, 2024

License Number: AL1604

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

RE: Survey Event ID: 4HVT11

Dear Mr. Ghosn:

On **March 22, 2024**, 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 **March 22, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 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 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 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 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 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: BROOKRIDGE RETIREMENT COMMUNITY
Address: 7802 QUANAH PARKER TRAILWAY
City, State, Zip: LAWTON, OK, 73505
Provider #: AL1604
Complaint #: OK00062057
Investigation Date(s): 03/20/24, 03/21/24 and 03/22/24

ALLEGATION(S)

The center failed to have and/or implement an effective pest control policy and procedure

An unannounced on-site investigation was initiated 03/20/2024 at 11:45 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 Summary of Complaint Investigation:

Observations were made of resident rooms, common areas, kitchen, and utility rooms and closest.

Residents were asked about pests in the facility.

Staff were asked about pest in the facility and their pest management program.

Resident council, grievances and policies were reviewed.

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: 03/25/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: BROOKRIDGE RETIREMENT COMMUNITY
Address: 7802 QUANAH PARKER TRAILWAY
City, State, Zip: LAWTON, OK, 73505
Provider #: AL1604
Complaint #: OK00062148
Investigation Date(s): 03/20/24, 03/21/24, and 03/22/24

ALLEGATION(S)

The center failed to ensure residents were not physically, verbally, or psychosocially abused.
The center failed to ensure treatment and care was provided for residents with wounds according to the standard of care.
The center failed to ensure residents and/or their representatives were involved in the plan of care.

An unannounced on-site investigation was initiated 03/20/2024 at 11:45 a.m.

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

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:

Observations were made of resident rooms, common areas, kitchen for staff and resident interactions. Medication administration was observed as well as meal service. Residents with wounds were observed for wound, treatment by outside providers.

Residents were asked about mistreatment and abuse, who to report it to and if they were afraid of any residents, or staff at the facility. Residents were asked about staff identified in the allegations. Residents were asked about wound treatments, pests, and family involvement in care.

Family was interviewed about abuse, wound treatments, notification of changes, and involvement in care planning.

Staff were asked about their knowledge of abuse and any mistreatment they have observed. The staff were asked about who to report an incident of abuse to and how the facility would address the report. The staff were asked about family involvement in care planning and wound treatments being provided.

Resident council, grievances and abuse policy, contracts, wound documentation, progress notes, abuse investigations and care plans were reviewed.

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: 03/25/2024

OKLAHOMA
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INVESTIGATIVE REPORT

Facility: BROOKRIDGE RETIREMENT COMMUNITY
Address: 7802 QUANAH PARKER TRAILWAY
City, State, Zip: LAWTON, OK, 73505
Provider #: AL1604
Complaint #: OK00063086
Investigation Date(s): 03/20/24, 03/21/24, and 03/22/24

ALLEGATION(S)

The center failed to ensure residents were not physically, verbally, or psychosocially abused.

An unannounced on-site investigation was initiated 03/20/2024 at 11:45 a.m.

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

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:

Observations were made of resident rooms, common areas, kitchen for staff and resident interactions. Medication administration was observed as well as meal service.

Residents were asked about mistreatment and abuse, who to report it to and if they were afraid of any residents, or staff at the facility. Residents were asked about staff identified in the allegations.

Staff were asked about their knowledge of abuse and any mistreatment they have observed. The staff were asked about who to report an incident of abuse to and how the facility would address the report.

Resident council, grievances and abuse policy, abuse investigations and clinical records were reviewed.

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: 03/25/2024

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 03/22/2024

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

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 03/20/24, 03/21/24, and 03/22/24. Complaint investigations (#OK00062057, #OK00062148 and #OK00063086) was conducted in conjunction with the survey.	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 observation, record review, and interview, the center failed to: a. ensure hair nets were worn in the kitchen, b. to maintain a clean and sanitary kitchen, c. to label food items in the refrigerator, and d. to thaw chicken and beef to prevent contamination in the refrigerator. The DON identified 63 Residents received nutrition form the kitchen. Findings: A "Employee hygiene", procedure document, undated, read in part, " ... Employees must keep hair from contacting exposed food, clean equipment, utensils, and linens. Exposed hair must be covered with hairnet, hat, etc ..." A "Cleaning", procedure document, updated, read in part, " ...The floor of the kitchen must be cleaned daily and after each spill or contamination ... Refrigerator units must be cleaned ...Wall surfaces that become splatter	C 391		

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C 391	Continued From page 1 during food preparation process must be cleaned daily ..." A "Thawing Food", procedure document, undated, read in part, "...Meats to be thawed must be placed on the lowest shelf in the refrigerator to prevent contamination of other foods with meat juices..." On 3/20/24 at 11:52 a.m. Dietary Aide #2 was observed preparing hamburger patties and was not wearing a hairnet. They were asked what the policy was for wearing hairnets. They stated I am not wearing a hairnet because I was not told I don't have to wear a hairnet if my hair is up. On 3/20/24 at 11:53 a.m., Cook #1 stated dietary aide #2 was not wearing a hairnet and they should wear a hairnet in the kitchen at all times. On 3/20/24 at 11:53 a.m., there was an observation of the hand sink soap dispenser had roach eggs and roach carcasses on the drip tray. On 3/20/24 at 11:58 a.m, the following observations were made: 1. food debris and grease on the floor behind the oven, 2. grease and food debris on top of the oven, 3. food debris and grease on the wall next to the fryer, 4. food debris where clean pans were stored under the food prep table on the bottom shelf, 5. a white powder substance on the floor next to the steam oven was observed on the baseboards and underneath the steam oven with food debris intermingled, 6. hamburger meat on the bottom shelf with blood dripping in the bottom of the refrigerator,	C 391		

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C 391	Continued From page 2 7. sausage patties wrapped in plastic and sausage links had no date or label, and 8. raw chicken thighs wrapped in plastic were not in a tray in the bottom of the refrigerator with blood leaking into the bottom of the unit. On 03/20/24 at 12:10 p.m., Dietary Manager was asked what kind of training she had had for her job. They replied, "sir, I just worked in the field. I've had no school or training." On 03/20/24 at 12:15 p.m., roach carcasses were observed on a sticky glue trap underneath the oven. On 03/20/24 at 12:27 p.m., There was an observation of the Dietary Manager in the kitchen not wearing a hairnet. They were asked what the policy was for wearing hairnets in the kitchen. They replied, "you just have to wear one and I did not put one on." On 20/24 at 12:31 p.m., the Dietary Manager stated they had worked at the facility for four years. They were shown the food debris underneath the cook and grease on the wall and front of the cooking equipment and the floor behind the oven, on the sidewall, and the front of the equipment. They were asked to identify the sustnace. They stated grease and stuff off the skillets. They were shown debris, white in color on the floor and wall by the steam oven and was asked what that was. They replied it was boric acid for roaches. They stated staff does not clean right. They stated they have a cleaning schedule but they don't follow it. They were asked about the meat stored in the refrigerator. They stated, the blood from the hamburger meat in the bottom of the refrigerator and the raw chicken should be in pans. They were asked about pest in	C 391		

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C 391	Continued From page 3 the kitchen. They stated, "the facility has a problem. It calmed down and they came back again." They were asked who treated pests at the center. They stated the facility treated it themselves.	C 391		
C1110 SS=F	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 ensure the quality assurance committee documented efforts and outcomes for issues identified in the meetings. The "Assisted Living Resident Condition and Care Overview" report, dated 03/20/24, documented 63 residents resided in the facility.	C1110		

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C1110	Continued From page 4 Findings: An undated, "Policy for Quality Assurance Committee", read in parts, "....Brookridge Retirement Community had established, and will maintain, an internal quality assurance committee...This committee shall...document quality assurance efforts and outcomes..." A review of the quality assurance meeting minutes for 04/06/23, 07/07/23, 10/30/23, and 01/15/24 contained no documentation the committee documented there efforts to address issues identifed through their process. On 03/21/24 at 3:37 p.m., the DON stated there was no documentation the quality assurance committee was addressing issues identified in their meetings.	C1110		
C1120 SS=E	310:663-11-2 QUALITY ASSURANCE REPRESENTATIVES The quality assurance committee shall include at least the following: (1) registered nurse or physician if a medical problem is to be monitored or investigated; (2) assisted living center administrator; (3) direct care staff person or a staff person who has responsibility for administration of medications; and (4) pharmacist consultant if a medication problem is to be monitored or investigated. This Rule is not met as evidenced by: Based on record review and interview, the facility	C1120		

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C1120	Continued From page 5 failed to ensure the Quality Assurance Committee had members that included a registered nurse and a pharmacist. The "Assisted Living Resident Condition and Care Overview" report, dated 03/20/24, documented 63 residents resided in the facility. Findings: An undated, "Policy for Quality Assurance Committee", read in parts, "....Brookridge Retirement Community had established, and will maintain, an internal quality assurance committee...This committee shall include...registered nurse... and may include...pharmacist consultant if a medical problem is to be investigated..." A review of the quality assurance meeting minutes for 04/06/23, 07/07/23, 10/30/23, and 01/15/24 contained no documentation and registered nurse and/or a pharmacist was involved in the quality assurance committee. On 03/21/24 at 3:37 p.m., the DON stated there is not a registered nurse or pharmacist on the committee and has not been over the past year. On 03/22/24 at 11:10 a.m., the DON stated if a registered nurse. doctor or pharmacist were on the quality assurance committee Resident #5 edema might have improved sooner.	C1120		
C1304 SS=F	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's	C1304		

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C1304	Continued From page 6 current service contract. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain a pest free environment. The "Assisted Living Resident Condition and Care Overview" report, dated 03/20/24, documented 63 residents resided in the facility. Findings: On 3/20/24 at 11:53 a.m., the hand sink soap dispenser observed with roach eggs and roach carcasses on the drip tray. On 03/20/24 at 12:15 p.m., roach carcasses were observed on a sticky glue trap underneath the oven. On 3/21/24 at 9:10 a.m., rodent droppings were observed on the floor in the hall outside resident room 51. The media room closet was observed with large amounts of rodent droppings around	C1304		

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C1304	Continued From page 7 the furnace. On 3/21/24 at 9:18 a.m., CMA #2 was asked about the pest at the facility. They stated, I think they are up in the attic, you can hear them. I think it's raccoon or rats. Last month, I saw one in the medication room. A couple residents said they had a rat in their room. CMA #2 further stated they have seen roaches in the kitchen recently. On 3/21/24 at 9:21 a.m., Maintenance #1 was shown rat droppings outside room 51 in the hall. They stated it could be mouse droppings. The maintenance confirmed when looking closer and stated it is mouse droppings. The maintenance was shown the closet in the media room. He was asked what you see. He states I see mouse droppings. Mouse droppings were observed in the closet around the air handler in the media room. On 3/21/24 at 9:31 a.m., Maintenance #1 was shown where mouse droppings were observed on the floor in the kitchen behind the oven and asked to identify what was observed. They stated mouse droppings. Maintenance #1 was asked to describe any pest control the facilty used. They stated I'm putting out traps and sticky pads for roaches or mice. They were asked is it effective. They replied somewhat, obviously they are not all gone. On 3/21/24 at 10:40 a.m., the Administrator was asked what pest remediation services they had in the facility. The administrator stated they use a program called roach hotel brand with stick food traps. The administrator than stated the pest control was very effective. The administrator was shown the observations in the kitchen, media room and hallway. The Administrator than stated	C1304		

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C1304	Continued From page 8 the pest management was not effective and the facility needed to do better. The administrator was asked for a policy on pest control and they stated there were no policies.	C1304		
C1327 SS=E	310:663-13-2(7) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (7) a provision that the written contract constitutes the entire agreement between the resident and the assisted living center not excluding the marketing materials and the requirements of this Chapter; This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide the assurance of the contract in it's entirety for ten (#1 through #10) of ten sampled residents. The "Assisted Living Resident Condition and Care Overview" report, dated 03/20/24, documented 63 residents resided in the facility. Findings: The service contracts for residents #1 through #10 did not contain documentation that the contract constituted the entire agreement between the resident and the assisted living center. On 03/21/24 at 9:57 a.m., the marketing director was asked where the contract constituted the	C1327		

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BROOKRIDGE RETIREMENT COMMUNITY	7802 QUANAH PARKER TRAILWAY LAWTON, OK 73505

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C1327	Continued From page 9 entire agreement between the resident and the assisted living center. After looking through the contract the marketing director there was nothing in the contract that would indicate the contract constituted the entire agreement.	C1327		

OKLAHOMA
State Department
of Health

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

April 26, 2024

License Number: AL1604

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

RE: Survey Event 4HVT11

Dear Mr. Ghosn:

On **March 22, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 14, 2024**.

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 4/21/2024
	Facility Name: Brookridge Retirment Community
	License Number: AL1604
	Survey Event ID: 4HVT11
	Date Survey Completed: 3/22/2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: the center failed to: a) ensure hair nets were worn in the kitchen b) to maintain a clean and sanitary kitchen c) to label food items in the refrigerator d) to thaw chicken and beef to prevent contamination in the refrigerator.

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?	Dietary in-service on 4/8/24 and 4/20/24 on wearing hair nets in the kitchen, maintaining a clean and sanitary kitchen, always covering, dating and labeling all food in refrigerators, proper way to thaw meats in refrigerator and cold running water.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Maintaining regular in-service with dietary staff and ensure proper documentation of training is complete. Policies and procedures updated and signed by all dietary staff.
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?	New cleaning logs and schedules were created and will be monitored by kitchen staff daily, weekly and monthly. Dietary supervisor will monitor that all policy and procedures are being implemented, and all logs are being completed.
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.	Kitchen staff will hold each other accountable on maintaining and implementing policies in accordance with CH257 relating to food service. Dietary supervisor and Human resources will monitor all dietary staff to make sure all logs are being completed. A copy of the logs will be provided and reviewed at Q&A quarterly meetings. Q&A notes will be maintained by Human Resources to ensure they are being addressed.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/14/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Sam Ghosn	**Date 4/21/2024**
OAC 310:663-25-4(F)	

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.			

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 4/21/2024
	Facility Name: Brookridge Retirement Community
	License Number: AL1604
	Survey Event ID: 4HVT11
	Date Survey Completed: 3/22/2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1110	Based on: record review and interview, the facility failed to ensure the quality assurance committee documented efforts and outcomes for issues identified in the meetings.

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?	Q&A meeting was held on 4/18/2024 and documented efforts and outcomes for issues identified in the meeting.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Human resources will monitor for customer satisifaction and document in quality assurance notes all efforts and outcomes of trends and incidents.
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?	Q&A meetings will be held quaretly to ensure efforts and outcomes are identified in a timely manner and have all proper documentation attached to Q&A notes.
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.	Human Resources and LPN/DON will monitor that all Q&A meetings are up to date and will provide changes as needed. Q&A meeting dates have been set for July and October. Human resources will communicate to all required attendees for all future meetings. Human Resources and LPN/DON will monitor all efforts and outcomes for issues identified in quarterly Q&A meetings. Q&A notes maintain by Human Resources to ensure they are managed properly, and will bring documented information to Q&A meeting.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/14/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. SAM KHOSN	**Date 4/21/2024**

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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OKLAHOMA State Department of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/21/2024

Facility Name: Brookridge Retirement Community

License Number: AL1604

Survey Event ID: 4HVT11

Date Survey Completed: 3/22/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1120	Based on: record and interview, the facility failed to ensure the Quality Assurance Committee had members that included a registered nurse and a pharmacist.

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?	Q&A meeting was held on 4/18/2024, all were present to include the RN.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The committee shall include a RN at all Q&A meetings.
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?	Updated Policy for Q&A Meetings to include the RN shall be part of the committee.
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.	Human Resources will hold all required committee personal accountable to be present at all meetings and will send out reminders to all committee personal of dates and times when meeting will be held to ensure they are present. Human resources will hold all required committee personal accountable to be present. Human Resources will bring all documented information needed for Q&A quarterly meetings. Q&A notes will be maintained by Human resources to ensure all preventive measures are effective.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/14/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. SAM GHOSH OAC 310:663-25-4(F)	**Date 4/21/2024**

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.

OKLAHOMA State Department of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/21/2024

Facility Name: Brookridge Retirement Community

License Number: AL1604

Survey Event ID: 4HVT11

Date Survey Completed: 3/22/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304	Based on: record review and interview, the facility failed to maintain a pest free environment.

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?	Created a policy and procedure on pest control, and educated maintance and dietary supervisor both on 4/16/2024.
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 staff was educated on monitoring and reporting all pest sightings to Human Resources so the issue can be addressed immeditaly.
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?	New logs created to show the building is being treated for pest and rodent control. Weekly treatments done and logged by maintenance and reported to Human Resources. Rodent treatments have been effiective and successful as of 4/8/2024. Roach treatments are in effect and maintained as of 4/16/2024.
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.	Human Resources will superviser and maintain dates and logs for all pest and rodent treatment. Human resources will monitor to stay in compliance with pest control policy. Human resources will address and identifiy any issues, efforts and outcomes that occur in Q&A quarterly meetings. Human Resources will maintain all documentation that the facility and residents are in a pest free enviorment.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/14/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) SAM GHOSN	**Date 4/21/2024**

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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OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 4/21/2024
	Facility Name: Brookridge Retirement Community
	License Number: AL1604
	Survey Event ID: 4HVT11
	Date Survey Completed: 3/22/2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1327	Based on: record review and interview, the center failed to provide the assurance of the contract in it's entirety for ten (#1 through #10) of ten sampled residents.

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?	Administration has reviewed and updated resident contract to include in the contract "in it's entirety" on 3/29/2024.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The contract has been updated, for all furture residents, to ensure the contract states "in it's entirenty." Marketing will continue to review and update the contract as needed.
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?	Marketing Director will ensure that all new residents coming into the facility will have the updated contract.
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.	Marketing Director and Administration will review and monitor all new contracts and maintain that they are up to date. Marketing Director will ensure all new residents have the updated contract. Marketing Director will maintain and review up to date contract for all new residents coming into the facility and documention provided for Q&A quarterly meetings. Human Resources will ensure Marketing Director provides all proper documentation for Q&A quarterly meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/14/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 4/21/2024**

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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

OKLAHOMA
State Department
of Health

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

May 22, 2024

License Number: AL1604

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

RE: Survey Event 4HVT12

Dear Mr. Ghosn:

On **May 21, 2024,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your re-licensure survey with complaint investigation on **March 22, 2024,** have now been corrected effective **May 14, 2024.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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 05/21/2024

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 An offsite/paper revisit was conducted on 05/21/24. 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