OKLAHOMA
State Department of Health

Delivery via email to: sam.brookridge@gmail.com; lisa.brookridge@gmail.com

November 14, 2025

License Number: AL1604

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

RE: Survey Event ID: QQGJ11

Dear Mr. Ghosn:

On **November 3, 2025**, agents from our office concluded a State Licensure survey with complaint investigation 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 **November 3, 2025**.

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 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 OSDH.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 #: **OK00077565**
Investigation Date(s): **10/30/25 through 11/03/25**

ALLEGATION
The center failed to ensure medical information was confidential.

An unannounced on-site investigation was initiated 10/31/2025 at 8:50 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:

A tour of the facility was conducted upon entrance and throughout the survey. Residents' medical care was observed locked, computer screens were locked, and confidential information was kept in designated areas for privacy. Residents were observed during meals, in their rooms, while participating in activities, and during medication passes. Retirement Staff members were observed answering call lights, administering medication, serving meals, and providing assistance to residents.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Incident reports were reviewed. Facility policies and procedures were reviewed. Resident council minutes, grievances, and in-services were reviewed. Sampled employee files were reviewed.

Residents were interviewed regarding any concerns with privacy and safety of medical information. Staff members were interviewed regarding privacy of confidential information. Administrative staff were interviewed regarding medical record logins and passwords.

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

OKLAHOMA
State Department
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Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/03/2025

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 11/03/2025

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 A relicensure survey with complaint (#OK00077565) was conducted from 10/30/25 through 11/03/25. Deficiencies were cited as a result of the survey. Facility Census: 57	C 000		
C 391 SS=E	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 and interview, the facility failed to prevent cross contamination by ensuring scoops were not stored in food bins. The administrator identified 57 residents resided in the facility. Findings: The facility did not provide a policy related to kitchen storage. On 10/30/25 at 2:30 p.m., a tour of the kitchen was conducted. Storage bins for flour and bread crumbs were observed with scoops handles within these products inside the bins. On 10/30/25 at 2:35 p.m., the kitchen supervisor	C 391		

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 11/03/2025

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 391	Continued From page 1 stated scoops should not be stored inside the bins.	C 391		
C 952 SS=D	310:663-9-5(b) STAFF QUALIFICATIONS (b) Each assisted living center shall ensure that staff members providing socialization, activity, and exercise services are qualified by training. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the designated activities staff member had received qualified training to provide activities to residents. The DON reported 57 residents resided in the	C 952		

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 11/03/2025

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 952	Continued From page 2 facility. Findings: On 10/30/25 at 9:45 a.m., residents were observed participating in an activity conducted by the activities staff. An employee list for the facility, provided on 10/30/25, showed the activities staff member's hire date was 03/24/24. On 10/30/25 at 1:05 p.m., the activities staff member stated no training had been provided for activities. The staff member stated the administrator stated they would get a training program started. On 11/03/25 at 9:26 a.m., human resource staff stated no staff training policies were available.	C 952		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff had first aid	C 954		

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 11/03/2025

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 954	Continued From page 3 training for 1 (PCA #1) of 5 sampled staff files reviewed for first aid training. The DON identified 57 residents resided in the facility. Findings: On 10/30/25, PCA #1's employee file did not contain proof that the employee had completed first aid training. The employee file showed a hire date of 06/02/25. On 10/30/25 at 3:30 p.m., human resource staff stated PCA #1 had not received first aid training. On 11/03/25 at 9:26 a.m., human resource staff stated that no staff training policies were available.	C 954		

OKLAHOMA
State Department of Health

Delivery via email to: sam.brookridge@gmail.com; lisa.brookridge@gmail.com

December 3, 2025

License Number: AL1604

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

RE: Survey Event QQGJ11

Dear Mr. Ghosn:

On **November 3, 2025**, a Licensure inspection with complaint investigations 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 **December 3, 2025**.

We will conduct a revisit for 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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date:** 11-1-2025 **Facility Name:** Brookridge Retirement Community **License Number:** AL 1604 **Survey Event ID:** QQGJ11 **Date Survey Completed:11-3-2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C952 SS=D	Based On: Observation, record review, and interview, the facility failed to ensure the designated activities staff member had received qualified training to provide activities to residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Matter has already been corrected

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?	Policy in place for activities staff to do training through Relias all will have certificates of compilation.
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 activities staff will have training on activities through Relias and all will have a certificate of compilation.
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?	All activities staff will have yearly training on activities through Relias and certificates for each category 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.	Once Relias does training w/ DON - then DON will have activities staff do categories over activities on Relias and H.R. will ensure certificates of compilation are done and turned into H.R. There is a spread sheet with all certificates and training due monthly by HR to ensure all employees are in compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12-3-2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Erin Lhosn **Date** 11-18-2025

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		**Submitted by**	

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐Unacceptable Date: 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.

POLICY AREA	Employment
TITLE OF POLICY	3.65 New Hire Policy- Activities
REGULATORY REFERENCE (if any)	
EFFECTIVE/REVISED DATE	11/5/2025

POLICY: [Name of AL] will ensure in addition to procedure shown in policy 3.64, any new hire for position of Activities must also complete required training through RELIAS.

PROCEDURE:

1. Each employee must complete the following, through the RELIAS training program, before being released to position of hire:
    a. Activities: Best Practices for Activities Professionals
    b. Activities: Enhancing Your Program
    c. Implementing a Quality Activity Program
    d. Interdisciplinary Approach to Activities
    e. Encouraging Resident Participation in Activities
    f. Dementia Care: Activities for People with Memory Problems
    g. Dementia Care: Art and Music Interventions
    h. Alzheimer's disease and Related Disorders: Recreational Activities
2. From the date of hire all activities professionals will be required to complete all areas of training and obtain certifications through RELIAS within 30 days of hire.

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11-1-2025
Facility Name: Brookridge Retirement Community
License Number: AL 1604
Survey Event ID: QQGJ11
Date Survey Completed:11-3-2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 SS=E	Based on: Observation and interview, the facility failed to prevent cross contamination by ensuring scoops were not stored in food bins..

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Matter has already been corrected

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?	Policy update, Inservice done w/ kitchen staff, Dietary sup and assist sup daily checks of dry storage on check sheet and weekly inspection done by H.R. and check sheet in place. H.R. will supervise that all above.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Policy update, Inservice done w/ kitchen staff, Dietary sup and assist sup daily checks of dry storage on check sheet and weekly inspection done by H.R. and check sheet in place. H.R. will supervise that all above.
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?	Dietary sup and assist sup daily checks of dry storage on check sheet and weekly inspection done by H.R. and check sheet in place. H.R. will supervise that all above.
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.	Policy for dry storage has been updated Kitchen staff had had inservice on dry storage Dietary Sup and Assist Sup will do daily checks and H.R will do weekly checks There is a check sheet see attached daily for Dietary staff and weekly for H.R.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12-3-2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Sam Chosen **Date** 11-18-2025

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		Submitted by	

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐Unacceptable Date:. 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.

POLICY AREA	Food Service
TITLE OF POLICY	10.06 Dry Storage Policy
REGULATORY REFERENCE (if any)	
EFFECTIVE/REVISED DATE	11/5/2025

POLICY: [Name of AL] will ensure all employees meet all of the state guidelines for dry storage.

PROCEDURE:

1. 1 All items must be stored in a clean, dry location
    a. A place where it is not exposed to splash, dust or other contamination.
    b. Must be kept at least 15cm (6 inches) above the floor.
2. A clean scoop/utensil will be used each time. After a scoop/utensil is used it must be taken to the dirty side of the kitchen sink to be washed. Scoop/Utensils will NOT be left in dry storage bins/containers.
3. Dietary Supervisor/Assistant Dietary Supervisor will do daily checks to ensure no scoop/utensil is left in dry storage.
4. HR will do a weekly check to ensure no scoop/utensil is left in the dry storage bins/containers.

All dietary/kitchen personal must follow this policy.

Dietary Supervisor/ Assistant Dietary Supervisor

Daily Dry Storage scoop/utensil check

Date/ Year	Dry Storage Check	S=scoop found NS= no scoop found	If scoop found what corrective action was taken	Name of doing inspection

H.R Weekly Dry Storage scoop/utensil check

Date/ Year	Dry Storage Check	S=scoop found NS= no scoop found	If scoop found what corrective action was taken	Name of doing inspection

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11-1-2025
Facility Name: Brookridge Retirement Community
License Number: AL 1604
Survey Event ID: QQGJ11
Date Survey Completed:11-3-2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C ~~952~~ 954 SS=D	Based On: Record review and interview, the facility failed to ensure direct care staff had first aid training for 1 (PCA #1) of 5 sampled staff files reviewed for first aid training

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Matter has already been corrected

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?	New Hire Policy in place for all new employees w/ training and certificates required before being put on schedule. See attached
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	H.R. will ensure all training and certificates are in before being put on schedule and if any employee does not get certificates or training done that is due yearly in at expiration date they will be removed from schedule until completed.
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?	H.R. will ensure all training and certificates are in before being put on schedule and if any employee does not get certificates or training done that is due yearly in at expiration date they will be removed from schedule until 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.	H.R. has a spread sheet of when all employees training and certificates are due monthly. H.R. prints and gets w/ each employee with what is due and if not completed by expiration date H.R. will remove employees from schedule until they are in compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12-3-2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Sam Chosn **Date** 11-18-2025

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		**Submitted by**	

~~Items Below Are For OSDH Use Only~~

Plan of Correction: ☐ Acceptable ☐Unacceptable	Date:.	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.		

POLICY AREA	Employment
TITLE OF POLICY	3.64 New Hire Policy
REGULATORY REFERENCE (if any)	
EFFECTIVE/REVISED DATE	11/5/2025

POLICY: [Name of AL] will ensure qualified employees will be required to complete a new hire packet with required information before being allowed to begin working.

PROCEDURE:

1. Application to be completed with copy of driver's license and social security card to be included.
2. Background check needs to be completed on new hire though OKScreen.
    a. If fingerprinting is determined necessary for an employee to continue the background check, an employee must complete IdentoGO fingerprinting services, off site, prior to start date.
3. Employee packet includes the following:
    a. W-4
    b. State withholding
    c. Direct deposit authorization
    d. Oklahoma new hire reporting form
    e. Brookridge new hire information form
    f. Employment eligibility verification form (I-9)
    g. Resident abuse/ neglect policy and procedure
    h. Resident rights sheet
    i. Hepatitis b exposure sheet
    j. Employee policy sheet
    k. Compensation form
    l. Call-in policy
    m. HIPPA information and testing packet
    n. Bloodborne pathogens and test packet
4. Each employee should also complete testing of:
    a. TB test- preformed on job site by director of nursing
    b. CPR/ First Aid certification- completed by nationalcprfoundation.com
    c. Food handler's license- completed by efoodtrainer.com
        i. Excluding housekeeping and maintenance positions.
5. A monthly employee audit will be performed by HR.
    a. HR will keep an up to date spreadsheet showing compliance.
    b. If an employee is shown not to be in compliance, they will be taken off the schedule until all items are up to date.

Each employee must complete the following before being released to position of hire.

OKLAHOMA
State Department of Health

Delivery via email to: sam.brookridge@gmail.com; lisa.brookridge@gmail.com

December 8, 2025

License Number: AL1604

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

RE: Survey Event QQGJ12

Dear Mr. Ghosn:

On **December 5, 2025,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey with complaints on **November 3, 2025,** have now been corrected effective **December 3, 2025.**

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 12/05/2025

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 12/05/25. The facility was in substantial compliance.	{C 000}		

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