OKLAHOMA
State Department
of Health

Delivery via email to: SteWar@brookdale.com

October 19, 2023

License Number: AL2001

Ms. Stephanie Warner, Administrator
Brookdale Weatherford
800 Gartrell Place
Weatherford, OK 73096

RE: Survey Event ID: 5I3411

Dear Ms. Warner:

On **October 9, 2023**, 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 **October 9, 2023**.

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

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

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2001	A. BUILDING: _____ B. WING _____	10/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WEATHERFORD	800 GARTRELL PLACE WEATHERFORD, OK 73096

(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 was conducted on 10/05/23, 10/06/23, and 10/09/23. The following abbreviations will be used throughout the writing of this report. ADLs - activities of daily living ED - Executive Director HWD - Health and Wellness Director RN - Registered Nurse	C 000		
C1304 SS=D	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure annual vaccinations were completed for residents' pets that lived in the facility for two (#7 and #1) of two sampled residents reviewed for contracted	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1304	Continued From page 1 services. The Executive Director identified 21 residents resided in the center. Findings: A "Pet Policy", last revised 10/2021, read in parts, "...[Center name] allows pets in communities. This policy covers both pets owned by residents as well as pets owned by the community...The resident's pet must have regular examination and current vaccinations by a licensed veterinarian upon move in to the community and be certified to be free of disease transmittable to humans..." 1. Resident #7 had diagnoses which included muscle spasm, chronic pain, and osteoporosis. A "Residency Agreement", dated 04/26/23, read in part, "...You may have a household pet in your Suite, subject to the Operators prior written approval and subject to execution of a Pet Agreement, which is available upon request...The Operator reserves the right to require the permanent removal of your pet for failure to adhere to the Pet Agreement or Applicable polices and rules..." On 10/09/23 at 9:54 a.m., a small kitten was observed in Resident #7's room. 2. Resident #1 had diagnoses which included type two diabetes mellitus, high blood pressure, and insomnia. A "Residency Agreement", dated 03/02/23, read in part, "...You may have a household pet in your Suite, subject to the Operators prior written approval and subject to execution of a Pet	C1304		

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C1304	Continued From page 2 Agreement, which is available upon request...The Operator reserves the right to require the permanent removal of your pet for failure to adhere to the Pet Agreement or Applicable polices and rules..." On 10/05/23 at 2:50 p.m., a dog was observed in the Resident #1's room. On 10/09/23 at 11:45 a.m., the HWD was asked what the policy was regarding pets living in the center and what was required for an examination of the pet. They stated they were unsure. On 10/09/23 at 12:48 p.m., the ED stated the center did not have any documentation that annual veterinary checks and vaccinations had been completed on the residents' pets.	C1304		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living	C1912		

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C1912	Continued From page 3 center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to report and investigate an allegation of misappropriation of property for one (#7) of one sampled resident reviewed for misappropriation of property. The Executive Director identified 21 residents resided in the center. Findings: An "Abuse, Neglect & Exploitation Policy", revised 05/2021, read in parts, "...[name of facility] is	C1912		

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	AL2001	A. BUILDING: _____ B. WING _____	10/09/2023

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C1912	Continued From page 4 committed to maintaining a safe environment for each resident ...Instances or allegations of...exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow up..." Resident #7 had diagnoses which included muscle spasm, chronic pain, and osteoporosis. An admission "Resident Assessment Form", dated 05/18/23, documented Resident #7 was alert and oriented, and was independent with all ADL's. On 10/09/23 at 9:54 a.m., Resident #7 stated a jean jacket had been missing for a month and had not been resolved. They were asked if they had told anyone and they stated, they had told the HWD. On 10/09/23 at 1:46 p.m., the HWD was asked if Resident #7 had voiced concerns over missing their jean jacket. They stated, "Yes." The HWD stated a staff member told them they had found it, but they had not followed up on it. On 10/09/23 at 1:51 p.m., the ED was observed to ask Resident #7 if their jacket had been returned to them. Resident #7 stated, "No." On 10/09/23 at 3:55 p.m., RN #1 was asked what should have been done when Resident #7 had reported the jacket was missing. They stated it had been reported to the executive director and an investigation should have been started.	C1912		
C6000 SS=D	63 OS 1-1947(F) Criminal History Background Check	C6000		

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C6000	Continued From page 5 (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment.	C6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C6000	Continued From page 6 b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure criminal history background checks were completed on two private sitters who sat with Resident #4. The Executive Director identified 21 residents	C6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C6000	Continued From page 7 resided in the center. Findings: A "Standards of Performance & Conduct for Private Duty Personnel Employed by Residents", guideline, revised 08/2023, read in parts, "...For the safety and security of its Residents, [name of center] has established certain standards and guidelines for...sitters and other personnel employed or retained by its Residents...Must provide evidence of a criminal background check with results and be free of any criminal convictions related to the health and safety of the resident(s)..." Resident #4 had diagnoses which included heart failure, anxiety, and dementia. On 10/05/23 at 2:38 p.m., upon entering Resident #4's room a person introduced themself as a sitter for Resident #4. Resident #4 and a family member was observed to return from a trip outside the facility. On 10/09/23 at 12:48 p.m., the ED stated there had not been background checks completed on the private sitters for Resident #4. They were asked who was responsible to complete the background checks. They stated, it was the company policy so they should have been completed. The HWD verified there were two private sitters for Resident #4.	C6000		

OKLAHOMA
State Department
of Health

Delivery via email to: e000819925@brookdale.com

November 6, 2023

License Number: AL2001

Ms. Stephanie Warner, Administrator
Brookdale Weatherford
800 Gartrell Place
Weatherford, OK 73096

RE: Survey Event 5I3411

Dear Ms. Warner:

On **October 9, 2023**, 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 have been corrected and you were in substantial compliance by **November 3, 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: 10/24/2023

Facility Name: Brookdale Senior Living

License Number: AL2001

Survey Event ID: SI3411

Date Survey Completed: 10/9/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304	Based on: Based on observation, record review, and interview, the center failed to ensure annual vaccinations were completed for residents' pets that lived in the facility for two (#7 and #1) of two sampled residents reviewed for contracted services.

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?	All families/residents have now provided community with current vaccination record, provided with a copy of the community pet policy, and ED will monitor annual compliance.
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 and community management has been inserviced on the community pet policy and proper process for the community accepting a resident pet. An Admission checklist has been created and will be utilized by any staff completing admission paperwork. Pet policy receipt and vaccination record will be added to the checklist.
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 staff will be educated on the pet policy at hire and routinely thereafter. Admission checklist will be utilized by admissions staff.
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.	ED will monitor all admissions and any pets brought in after admission to ensure proper records are received immediately. ED will monitor and keep a complete list and all vaccination records together in survey ready binder. ED will add this to QA process to be monitored for expiring or new pet records needed. ED will create and utilize a monitoring record specific to pet records and sign off monthly ensuring they are current and complete in addition to quarterly QA meeting review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/3/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	Date 10/24/2023

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

Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

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

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/24/2023** **Facility Name:** Brookdale Senior Living **License Number:** AL2001 **Survey Event ID:** 5I3411 **Date Survey Completed: 10/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1912	Based on: Based on record review and interview, the center failed to report and investigate an allegation of misappropriation of property for one (#7) of one sampled resident reviewed for misappropriation of property.

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?	Resident #7 provided with information on resident rights, grievance process, and proper reporting on A/N/E to ED.
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 inserviced on A/N/E and proper reporting procedures. HWD inserviced on proper reporting and proper notification of ED of any reports of A/N/E. Residents notified in Resident Council on October 6 (prior to survey end) of grievance policy, Rights regarding A/N/E, their right to place a camera in their room, and reporting of A/N/E to ED. ED will interview residents and responsible parties to determine need for further investigation.
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?	ED will randomly check in with residents and responsible parties to determine if there are any concerns regarding A/N/E.
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.	ED will randomly check in with residents and responsible parties to determine if there are any concerns regarding A/N/E. ED will monitor and maintain records of resident interviews and monitor grievances and state reportables. ED will add to QA process to ensure team continues to be aware of policy and may discuss any concerns or needs related to this tag.

	ED will create and utilize a monitoring record specific to and sign off and complete in addition to quarterly QA meeting review and documentation.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/3/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. S— M. Warner	**Date 10/24/2023**

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

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

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/24/2023** **Facility Name:** Brookdale Senior Living **License Number:** AL2001 **Survey Event ID:** 5I3411 **Date Survey Completed: 10/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C6000	Based on: Based on observation, record review, and interview, the center failed to ensure criminal history background checks were completed on two private sitters who sat with Resident #4.

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?	Background checks will be completed and maintained by community. ED will provide responsible party and sitters a copy of the community Private Sitter Policy.
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 inserviced on Private Sitter Policy. A checklist for new admissions will be created and will include background policy receipt and background check completion. ED or designee will monitor all new admissions and sign off on checklist to ensure completion. If any resident has a need in the future for a private sitter, resident and or responsible party will be educated on Private Sitter Policy and background check will be immediately obtained.
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?	A checklist for new admissions will be created and will include background policy receipt and background check completion. ED or designee will monitor all new admissions and sign off on checklist to ensure completion. If any resident has a need in the future for a private sitter, resident and or responsible party will be educated on Private Sitter Policy and background check will be immediately obtained.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:	ED will randomly audit files of any resident that has a private sitter to ensure proper documentation and background checks are on file.

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.	ED will create and document on monitoring record any concerns found with file audit. ED will add to QA process to ensure team continues to be aware of policy and may discuss any concerns or needs related to this tag. ED will create and utilize a monitoring record specific to this tag, sign off and complete in addition to quarterly QA meeting review and documentation.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/3/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. S. M. Warner	**Date 10/24/2023**

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

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

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department
of Health

Delivery via email to: swarner@oxfordseniorliving.com

December 29, 2023

License Number: AL2001

Ms. Stephanie Warner, Administrator
Brookdale Weatherford
800 Gartrell Place
Weatherford, OK 73096

RE: Survey Event 5I3412

Dear Ms. Warner:

On **December 26, 2023,** 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 on **October 9, 2023,** have now been corrected effective **November 3, 2023.**

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
	AL2001	A. BUILDING: _____ B. WING _____	R 12/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS WEATHERFORD	800 GARTRELL PLACE WEATHERFORD, OK 73096

(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 12/26/23. 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