OKLAHOMA
State Department
of Health

Delivery via email to: KCaffey@brookdale.com

April 28, 2026

License Number: AL2401

Keli Caffey, Administrator
Brookdale Enid
4613 West Willow Road
Enid, OK 73703

Survey Event ID: MDZ011

Dear Ms. Caffey:

On **April 10, 2026**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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. 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 will be completed for each violation; and
(6) Be signed by the administrator.

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies. If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 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:

OKLAHOMA
State Department of Health

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: **Brookdale Enid**
Address: **4613 West Willow Road**
City, State, Zip: **Enid, OK. 73703**
Provider #: **AL2401**
Complaint #: **OK00088507**
Investigation Date(s): **04/09/26-04/10/26 and 04/13/26**

ALLEGATION(S)
The facility failed to ensure care was provided according to the plan of care.

An unannounced on-site investigation was initiated 04/09/2026 at 10:35 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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 were observed to be clean, dressed appropriately, and free of odors. Staff were observed assisting residents with activities of daily living and as needed.

Resident records, i.e. diagnoses, physician orders, nurse notes, incident reports, service contracts, and service/care plans. Grievances were reviewed. Incident reports with investigations were reviewed. Facility policy and procedures were reviewed. Employee files were reviewed.

Residents and staff were interviewed regarding care according to the residents' service/care plan.

The attached State form, Statement of Deficiencies, 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: 04/17/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Brookdale Enid**
Address: **4613 West Willow Road**
City, State, Zip: **Enid, OK. 73703**
Provider #: **AL2401**
Complaint #: **OK00090403**
Investigation Date(s): **04/09/26-04/10/26 and 04/13/26**

ALLEGATION(S)
The facility failed to ensure residents were provided care according to their contracted services and/or service/care plans.

An unannounced on-site investigation was initiated 04/09/2026 at 10:35 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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 were observed to be clean, dressed appropriately, and free of odors. Staff were observed assisting residents with activities of daily living and as needed.

Resident records, i.e. diagnoses, physician orders, nurse notes, incident reports, service contracts, and service/care plans. Grievances were reviewed. Incident reports with investigations were reviewed. Facility policy and procedures were reviewed. Employee files were reviewed.

Residents and staff were interviewed regarding care according to the residents' service/care plan.

The attached State form, Statement of Deficiencies, 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: 04/17/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Brookdale Enid**
Address: **4613 West Willow Road**
City, State, Zip: **Enid, OK. 73703**
Provider #: **AL2401**
Complaint #: **OK00090421**
Investigation Date(s): **04/09/26-04/10/26 and 04/13/26**

ALLEGATION(S)
The facility failed to prevent elopement of residents.

An unannounced on-site investigation was initiated 04/09/2026 at 10:35 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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 were observed to be clean, dressed appropriately, and free of odors. Residents were observed participating in various activities. Staff were observed responding to door alarms.

Resident records, i.e. diagnoses, physician orders, assessments, nurse notes, service contracts and service plans were reviewed. Incident reports with investigations were reviewed. In-services and grievances were reviewed. Facility policy and procedures were reviewed

Staff were interviewed regarding resident elopements. The staff were interviewed regarding policy and procedures related to elopements and door alarms.

The attached State form, Statement of Deficiencies, 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: 04/17/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Brookdale Enid**
Address: **4613 West Willow Road**
City, State, Zip: **Enid, OK. 73703**
Provider #: **AL2401**
Complaint #: **OK00090462**
Investigation Date(s): **04/09/26-04/10/26 and 04/13/26**

ALLEGATION(S)
The facility failed to ensure adequate supervision was provided to prevent elopements.

An unannounced on-site investigation was initiated 04/09/2026 at 10:35 a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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 were observed to be clean, dressed appropriately, and free of odors. Residents were observed participating in various activities. Staff were observed responding to door alarms.

Resident records, i.e. diagnoses, physician orders, assessments, nurse notes, service contracts and service plans were reviewed. Incident reports with investigations were reviewed. In-services and grievances were reviewed. Facility policy and procedures were reviewed

Staff were interviewed regarding resident elopements. The staff were interviewed regarding policy and procedures related to elopements and door alarms.

The attached State form, Statement of Deficiencies, 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: 04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2401	A. BUILDING: _____ B. WING _____	C 04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ENID	4613 WEST WILLOW ROAD ENID, OK 73703

(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 Complaint investigations (#OK00088507, OK00090403, OK00090421, and #OK00090462) were conducted on 04/09/26 through 04/10/26 and 04/13/26. Deficiencies were cited as a result of the survey. Facility Census: 23 The following abbreviations will be used throughout the document. CMA- certified medication aide CNA- certified nurse aide Res- resident	C 000		
C1304 SS=G	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 record review and interview, the facility failed to ensure residents' service plans were followed for use of two staff and a mechanical lift for 1 (#2) of 4 sampled residents reviewed for service plans and safe transfers. The executive director identified one resident resided in the facility with service plans for two staff and a mechanical lift for transfers. Findings: On 04/09/26 at 12:00 p.m., Res #2 was observed seated in their wheelchair under the covered	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2401	A. BUILDING: _____ B. WING _____	C 04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ENID	4613 WEST WILLOW ROAD ENID, OK 73703

(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
C1304	Continued From page 1	C1304		

porch in the courtyard talking on the telephone.

On 04/10/26 at 12:34 p.m., Res #2 was observed seated in their wheelchair under the covered porch in the courtyard.

A facility policy titled "Service Plan Process Policy," dated 08/2025, read in part, "Individual resident service plans should be developed through the evaluation process or other identified systems and provide information about resident needs to the care associates. Service Plans are implemented and maintained for each resident to address these needs and preferences."

An undated face sheet showed Res #2 admitted to the facility on 01/14/25 with diagnoses which included heart failure, Parkinson's disease, depression, and anxiety.

A annual resident assessment for Res #2, dated 01/09/26, showed the resident was non-weight bearing and required the use of a mechanical lift.

A service plan for Res #2, dated 02/05/26, showed the resident required two person assist with transfers using a mechanical lift.

An "Incident Report Form," dated 12/22/25, showed CNA #3 was assisting Res #2 to get dressed for the day and while the resident was sitting on the side of the bed they began to slide out. CNA #3 stated to prevent the resident from falling, they attempted to pick the resident up and quickly transfer them to their wheelchair which caused the resident's left lateral calf to hit the wheelchair where the legs attached. The report showed Res #2 received a laceration and was sent to the emergency room for treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2401	A. BUILDING: _____ B. WING _____	C 04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ENID	4613 WEST WILLOW ROAD ENID, OK 73703

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C1304	Continued From page 2 On 04/09/26 at 1:15 p.m., the executive director stated CNA #3 should have followed the resident's service plan and transferred the resident with a mechanical lift. On 04/10/26 at 12:34 p.m., Res #2 stated CNA #3 did not use the lift to transfer them to their wheelchair. Res #2 stated CNA #3 tried to transfer them independently and they received a cut to their leg on the wheelchair and had to go to the emergency room for treatment. Res #2 stated the staff member was no longer at the facility.	C1304		
C1512 SS=G	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2401	A. BUILDING: _____ B. WING _____	C 04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ENID	4613 WEST WILLOW ROAD ENID, OK 73703

(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
C1512	Continued From page 3 physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow their door alarm response policy which resulted in an elopement for 1 (#3) of 3 sampled residents reviewed for elopement. The failure to follow the door alarm policy resulted in Res #3 sustaining facial bruising and a broken finger. The executive director identified 23 residents resided in the facility.	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2401	A. BUILDING: _____ B. WING _____	C 04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ENID	4613 WEST WILLOW ROAD ENID, OK 73703

(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
C1512	Continued From page 4 Findings: On 04/09/26 at 1:24 p.m., the executive director was observed pushing on the southeast exit door for 15 seconds until the door opened and the alarm sounded. Facility staff were observed promptly responding to the alarm. A facility policy titled "Resident Call Systems and Door Alarm Response," dated 12/2025, read in part, "When a door alarm sounds, associates should respond immediately and follow the procedures below: a. Immediately go to the area where the door alarm has sounded; b. Complete a visual check within the vicinity of the door, including areas both inside and outside the perimeter, to see if any resident or residents are outside the community; c. Close the door and reactivate the door alarm; d. Notify other associates of the alarm status; e. Verify the whereabouts of all residents in the community, using a current resident roster as a guide." An undated face sheet showed Res #3 admitted to the facility on 07/26/23, with diagnoses which included delusional disorders, vascular dementia, and depressive disorders. An Oklahoma State Department of Health incident report, dated 04/02/26, showed Res #3 was not in their room during morning bed check . An immediate elopement drill was conducted. A	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2401	A. BUILDING: _____ B. WING _____	C 04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ENID	4613 WEST WILLOW ROAD ENID, OK 73703

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C1512	Continued From page 5 search of the perimeter of the facility was completed. Res #3 was found down the hill in the creek bed located on the back side of the facility. The creek bed was dry with no running water except for the wet ground from the current rain. Res #3 was transferred to the hospital and the resident's power of attorney was notified. On 04/02/26, an in-service was conducted with each individual employee over elopement and door alarm response. A facility "Incident Investigation" form, dated 04/02/26, showed CNA #2 stated between 1:30-2:00 a.m., the east door alarm was sounding, CNA #2 stated the door was found cracked open. CNA #2 stated they shouted outside "hello" and looked around. CNA #2 stated they did not see or hear anyone so they turned the alarm off and shut the door. The form showed Res #3 sustained facial bruising, scratches, and a fractured finger. On 04/10/26 at 12:50 p.m., CMA #2 stated there was no standing water in the creek when Res #3 was located. They stated the resident had a bruise on their right eyebrow, the right side of their chin, and on their right hand. CMA #2 stated Res #3 was brought into the facility, assessed, and sent to the emergency room for evaluation. On 04/10/26 at 1:23 p.m., the executive director stated the staff did not follow the facility's policy regarding the door alarm response.	C1512		

OKLAHOMA
State Department of Health

Delivery via email to: KCaffey@brookdale.com; jennfer.shaw@brookdale.com

May 11, 2026

License Number: AL2401

Keli Caffey, Administrator
Brookdale Enid
4613 West Willow Road
Enid, OK 73703

Survey Event ID: MDZ011

Dear Ms. Caffey:

On **April 10, 2026**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1304:** The POC does not fully include information about the following questions. No other residents may have been affected, but how will residents who have the potential to be affected be identified? Are there no other two person transfers or lift transfers in the building?

- **C1512:** Elopement drills conducted quarterly per Brookdale policy did not prevent this elopement. Should elopement drills be conducted more frequently for a period of time to ensure all staff are responding appropriately? No other residents may have been affected, but how will residents who have the potential to be affected be identified? Which residents are at risk for elopement and how will they be identified?

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

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: 5/8/2026** **Facility Name:** Brookdale ENID **License Number:** AL-2401 **Survey Event ID:** MDZ011 **Date Survey Completed: 4/9/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1304	Based on: record review and interview, the facility failed to ensure residents' service plans were followed for use of two staff and a mechanical lift for 1 (#2) of 4 sampled residents reviewed forservice plans and safe transfers.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living **Center's** Comments: The following is the Plan of Correction for Brookdale ENID regarding the Statement of Deficiencies dated 04/09/26 . The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

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?	Health and Wellness Director (HWD) had care profiles and assignments sheets available for staff to review care that should be provided to the residents but the associate failed to follow the documents provided. Investigation and OSHD notified within timeframe allowed. Associate, Medication Techinician, was terminated and Community direct care staff was re-in-serviced by Naomi Abbey, Operations Specialist, on April 28-29, 2026. Residents representative and PCP notified on December 22, 2025. HWD and Executive Director (ED) and or designee will re-inservice direct care associates on using care profiles and assignments plans provided to them during shift. Bi-weekly random checks will be conducted by Operations Specialist or designee that care associates are using assignment plans and following them to maintain compliance. By May 8, 2026 a re-in-service will be completed on following Service Plans, assignments Plans and reviewing care profile for the needed care of a resident for Certified Nursing Aides and Medication Technicians by Operations Specialist.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No other residents were affected by the deficiency cited. ED, HWD, ANM or designee will randomly review care profiles and assignment plans for updated Assignment plans and Neighborhood book which provides the Care Profiles weekly for 4 weeks.
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?	HWD, ANM, ED and or designee will review acuity report bi-weekly for the updating of assessments/ service plans as change of condition are identified.
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, HWD, ANM or designee will randomly review care profiles (Neighborhood book) and assignment plans over next 4 weeks which provides the Care Profiles/assignment plans. This will be reviewed through the **Community's** QA and daily stand up process. ED,HWD and or designed will report audit findings in QA meetings QA committee will monitor effectiveness of the plan Daily stand up form and QA meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/5/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Jennifer Shaw	**Date 5/8/2026**

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: 5/8/2026** **Facility Name:** Enid **License Number:** AL2401 **Survey Event ID:** MDZ011 **Date Survey Completed: 4/9/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1512	Based on: observation, record review, and interview, the facility failed to follow their door alarm response policy which resulted in an elopement for 1 (#3) of 3 sampled residents reviewed for elopement. The failure to follow the door alarm policy resulted in Res #3 sustaining facial bruising and a broken finger

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookale Enid regarding the Statement of Deficiencies dated 04/09/26 . The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

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?	Executive Director (ED), Health and Wellness Director (HWD) and, Operations Specialist and or designee will complete new associate training, which includes but is not limited to Night Checks Policy, Missing Resident Drills/Elopement and Abuse, Neglect and Exploitation prior to allowing newly hired associates to provide care for residents within the community. ED and HWD have been re-in-serviced on the appropriate training that is to be completed with new associates by District Director of Operations on April 2, 2026 and on Resident Rights by District Director of Clinical Services on April 28,2026.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No other residents have been affected effected by the deficiency identified. Weekly ED, HWD or designee will randomly review Acuity Report to identify residents at risk and discuss higher level of care or alternate placement as necessary.
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, HWD and/or designee will complete missing resident drills on each shift on a rotating basis for rotating shifts on a quarterly basis as per Brookdale policy. ED, HWD and/or designee will randomly review new associate training checklist within 7 days of hire.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:	ED, HWD and/or designee will complete new associate checklist before newly hired associates are allowed to provide care for residents.

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.	This will be reviewed through the Community's QA and daily stand up process. ED,HWD and or designed will report audit findings in QA meetings QA committee will monitor effectiveness of the plan Daily stand up form and QA meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/1/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 5/8/2026**

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: KCaffey@brookdale.com; jennfer.shaw@brookdale.com

May 14, 2026

License Number: AL2401

Keli Caffey, Administrator
Brookdale Enid
4613 West Willow Road
Enid, OK 73703

Survey Event ID: MDZ011

Dear Ms. Caffey:

On **April 10, 2026,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your Amended 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 **June 5, 2026**.

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/8/2026** **Facility Name:** Brookdale ENID **License Number:** AL-2401 **Survey Event ID:** MDZ011 **Date Survey Completed: 4/9/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304	Based on: record review and interview, the facility failed to ensure residents' service plans were followed for use of two staff and a mechanical lift for 1 (#2) of 4 sampled residents reviewed forservice plans and safe transfers.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living **Center's** Comments: The following is the Plan of Correction for Brookdale ENID regarding the Statement of Deficiencies dated 04/09/26 . The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

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?	Health and Wellness Director (HWD) had care profiles and assignments sheets available for staff to review care that should be provided to the residents but the associate failed to follow the documents provided. Investigation and OSHD notified within timeframe allowed. Associate, Medication Techinician, was terminated and Community direct care staff was re-in-serviced by Naomi Abbey, Operations Specialist, on April 28-29, 2026. Residents representative and PCP notified on December 22, 2025. HWD and Executive Director (ED) and or designee will re-inservice direct care associates on using care profiles and assignments plans provided to them during shift. Bi-weekly random checks will be conducted by Operations Specialist or designee that care associates are using assignment plans and following them to maintain compliance. By May 8, 2026 a re-in-service will be completed on following Service Plans, assignments Plans and reviewing care profile for the needed care of a resident for Certified Nursing Aides and Medication Technicians by Operations Specialist.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	2 other residents have the potential to be affected by the deficiency cited. 2 residents that are person transfers were interviewed and had not been transferred by 1 associate. Associates providing care to the residents with 2 person transfer on care plan were interviewed and confirm using 2 people to provide transfers. ED, HWD, ANM or designee will randomly review care profiles and assignment plans for updated Assignment

	plans and Neighborhood book which provides the Care Profiles weekly for 4 weeks.
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?	HWD, ANM, ED and or designee will review acuity report bi-weekly for the updating of assessments/ service plans as change of condition are identified.
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, HWD, ANM or designee will randomly review care profiles (Neighborhood book) and assignment plans over next 4 weeks which provides the Care Profiles/assignment plans. This will be reviewed through the **Community's** QA and daily stand up process. ED,HWD and or designed will report audit findings in QA meetings QA committee will monitor effectiveness of the plan Daily stand up form and QA meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/5/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Jennifer Shaw	**Date 5/8/2026**

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	5/13/2026	**Submitted by**	Jennifer Shaw

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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: 5/8/2026** **Facility Name:** Enid **License Number:** AL2401 **Survey Event ID:** MDZ011 **Date Survey Completed: 4/9/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1512	Based on: observation, record review, and interview, the facility failed to follow their door alarm response policy which resulted in an elopement for 1 (#3) of 3 sampled residents reviewed for elopement. The failure to follow the door alarm policy resulted in Res #3 sustaining facial bruising and a broken finger

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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 other residents have the potential to be affected. All resident BIMS were reviewed, any resident identified below a 13 was reviewed for appropriateness. ED, HWD or designee will randomly review Acuity Report to identify residents at risk and discuss higher level of care or alternate placement as necessary weekly for 4 weeks.
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, HWD and/or designee will complete random missing resident drills on each shift each week for 4 weeks. ED, HWD and/or designee will randomly review new associate training checklist within 7 days of hire.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:	ED, HWD and/or designee will complete new associate checklist before newly hired associates are allowed to provide care for residents.

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.	This will be reviewed through the Community's QA and daily stand up process. ED,HWD and or designed will report audit findings in QA meetings QA committee will monitor effectiveness of the plan Daily stand up form and QA meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/1/2026
OSDH Response: Element accepted Yes ☐ No ☐	

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Addendum Date	5/13/2026	**Submitted by**	Jennifer Shaw

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