OKLAHOMA
State Department
of Health

Delivery via email to: ecook4@brookdale.com

August 18, 2021

License Number: AL5510

Ms. Emily Cook, Administrator
Brookdale Oklahoma City Southwest
10001 South May Avenue
Oklahoma City, OK 73159

Survey Event ID: TWEV11

Dear Ms. Cook:

On **August 10, 2021,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance

under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may <u>not</u> use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

OKLAHOMA
State Department
of Health

- 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.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Brookdale Oklahoma City Southwest Assisted Living**
Address: **10001South May Avenue**
City, State, Zip: **Oklahoma City, Oklahoma 73159**
Provider #: **AL5510**
Complaint #: **OK00057450**
Investigation Date(s): **08/06, 08/09 and 08/10/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide a safe accident free environment, adequate and appropriate medical care, ensure the needs of the residents could be met and adequate staff to supervise residents.	**S**

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 08/06/2021 at 11:55 a.m.

A sample of 4 residents including any identified resident(s), 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C 1505 and C1507 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation enter number. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Pamela Anderson for Mary Cooper

Mary Cooper RN/CHFS

Date report completed: 08/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5510	A. BUILDING: _____ B. WING _____	C 08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE OKLAHOMA CITY SOUTHWEST	10001 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73159

(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 abbreviated survey was completed on 08/06, 08/09 and 08/10/2021 to investigate complaint #OK00057450. Deficient practice was cited. Census was 30. The following abbreviations may have been utilized in the writing of this report. HWD (Health and Wellness Director) CNA (Certified Nursing Assistant) PSP (Personal Service Plan) PSA (Personal Service Assessment) SBA (Stand by Assist)	C 000		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences	C1505		

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C1505	Continued From page 1 of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the center failed to care plan fall prevention interventions for one (#3) of four sampled residents for fall prevention. This had the isolated potential for more than minimal harm. Findings: Resident #3 was admitted to the center with diagnoses which included, Alzheimer's, malignant neoplasm of breast, and Pacemaker. "Fall risk evaluation" dated 06/28/2021 documented, " ... Fall Risk Level ...Level 3 ..." Nursing progress note dated 07/03/2021 at 11:59 documented " ...Resident was on a walk when she tripped over her shoes and fell onto the cement, staff witnessed resident trip however was unable to make it to resident in time to ease fall ... Resident had abrasions to her forehead, nose and peri-orbital area of the left eye ..."	C1505		

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C1505	Continued From page 2 Emergency room document titled. "After visit summary" dated 07/03/2021 documented, " ...Fall, Closed head injury ..." Nursing progress note dated, 07/03/2021 documented, " ...Resident to be SBA /contact guard assist when ambulating outside of the community for safety ..." Nursing progress note dated 07/04/2021 documented, "Will continue with stand by assist while ambulating outside of the community ..." Resident #3's "Personal Service Plan" dated, 07/29/2021 did not document any intervention was implemented for fall that occurred on 07/03/2021. Resident #3 had a fall outside in the courtyard that resulted in transport to the emergency room. Emergency room "After visit summary" dated 07/09/2021 documented, " ...Diagnoses, Fall, Closed head injury, scalp laceration ..." On 08/06/2021 at 12:26 p.m., incident reports were reviewed and documented resident #3 has had 4 falls that resulted in head injuries, on 06/10, 07/03, 07/09, and 07/29/2021. On 08/09/2021 at 1:13 p.m., the HWD was asked when resident #3 fell outside was she alone, and should she have had stand by assist. She stated, "Yes." On 08/10/2021 at 10:14 a.m., CNA #1 was asked what happened when resident #3 fell outside in the courtyard. She stated, "She got up from her chair, tripped on her feet and fell." She was asked if staff was present, she stated. "I was there ...I was very close to her."	C1505		

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	AL5510	A. BUILDING: _____ B. WING _____	C 08/10/2021

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C1505	Continued From page 3 "Post Fall Evaluation Form-Assisted Living/Memory Care" dated 07/09/2021, at 7:30 p.m., documented " ...Additional observation/notes/comments ...I saw resident lying on the floor crying with blood all over her ..."	C1505		
C1507 SS=D	310:663-15-1 & 63 OS 1-1918(B)(7) RESIDENT RIGHTS - Reasonable Accommodation 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)(7) (7) Every resident shall have the right to reside and to receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered; This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure a fall mat was in place for one (#4) of 4 sampled residents	C1507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1507	Continued From page 4	C1507		

for fall prevention interventions. This had the isolated potential for more than minimal harm.

Resident #4 was admitted to the center with diagnoses which included, Heart Failure, Hypertension, Vascular Dementia and Seizures.

"Fall Risk Evaluation" dated 04/21/2021, documented, "...Fall Risk Level: Level 3..."

"Brookdale PSA/PSP Q&A" dated 02/19/2021, documented, " ...Escort& Mobility ...Do you use a bedside mobility device ...Additional Personalization...Level 3-Bed-Fall cushion Mat ..."

"Post Fall Evaluation Form-Assisted Living/Memory Care" dated 08/06/2021 documented, " ...fall date/time 4:25 a.m ...fall location: bedside ...What was different this time? No floor mat ..."

A Nursing progress note dated, 08/06/2021 at 15:05 documented, "...Note text: At approximately 04:30 a.m. when staff was conducting Q 2 hour rounds, resident was met on the floor next to her bed...Resident stated that she did hurt and staff narrowed down pain to be coming from china and left arm..."

A Nursing progress note dated, 08/07/2021 at 11:15 documented, Mobile x-ray results returned and showed possible linear lucency involving the angle of the left mandible..."

On 08/06/2021 at 12:08 p.m., resident #4 was observed sitting at the dining table eating lunch. Deep dark purple discoloration observed on resident #4's chin.

On 08/09/2021 at 09:00 a.m., resident #4 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BROOKDALE OKLAHOMA CITY SOUTHWEST	10001 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73159

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C1507	Continued From page 5 asked if she was in any pain, she replied, my lower lip doesn't feel very good, my lower jaw hurts. Resident was observed to have deep dark purple discoloration to chin, and front of neck. At 2:35 p.m., the HWD acknowledged the fall mat was not laid out, it was at the end of the bed.	C1507		

OKLAHOMA
State Department
of Health

Delivery via email to: ecook4@brookdale.com

September 13, 2021

License Number: AL5510

Ms. Emily Cook, Administrator
Brookdale Oklahoma City Southwest
10001 South May Avenue
Oklahoma City, OK 73159

Survey Event ID: TWEV11

Dear Ms. Cook:

On **August 10, 2021,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 31, 2021**.

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.

Sincerely,

Tempal Killman Digitally signed by Tempal Killman
Date: 2021.09.13 08:51:40 -05'00'

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

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/27/2021** **Facility Name:** Brookdale Oklahoma City Southwest **License Number:** AL5510 **Survey Event ID:** TWEV11 **Date Survey Completed: 8/10/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Based on observation, interview and recordreview it was determined the center failed to careplan fall prevention interventions for one (#3) offour sampled residents for fall prevention. Thishad the isolated potential for more than minimalharm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Oklahoma City Southwest regarding the Statement of Deficiencies dated 8/10/2021 . The Plan of Correction is not 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?	HWD immediately updated Resident #3's personal service plan to reflect the interventions that were noted the nurses notes. HWD and HWC were in-serviced on proper falls management/intervention care planning on 8/18/2021
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	ED reviewed all falls over the past 45 days to ensure proper care planning was in place.
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?	RN case manager or designee will review falls weekly for 4 weeks and ensure care plan fall prevention is completed for each occurance.
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 or RN case manager will review falls weekly for 4 weeks to ensure all fall interventions have been included in the affected residents care plans to ensure the continued compliance of performing this task according to current standards. HWD or ED will report audit findings in QA meetings. QA committee will monitor effectiveness of the plan Results of monitoring will be reflected in QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/31/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Emily Cook	**Date 8/27/2021**
OAC 310:663-25-4(F)	

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/27/2021** **Facility Name:** Brookdale Oklahoma City Southwest **License Number:** AL5510 **Survey Event ID:** TWEV11 **Date Survey Completed: 8/10/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1507	Based on: Based on interview and record review it wasdetermined the center failed to ensure a fall mat was in place for one (#4) of 4 sampled residents for fall prevention interventions. This had theisolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Oklahoma City Southwest regarding the Statement of Deficiencies dated 8/10/2021 . The Plan of Correction is not 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?	HWD immediately ensured fall mat was available for Resident #4 after the incident. All care staff were verbally informed of the need for a fall mat and the proper use of the fall mat for resident.
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 were in-serviced on falls management and interventions, and proper use of fall mats on 8/12/2021. All residents with falls out of bed will have a fall mat placed immediately after incident. Community will keep fall mats on hand to ensure they are always available. CMA on each shift will check each day that fall mats are in place for two 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 will ensure all care staff are aware when the need arises for a fall mat for any resident. Updates to care plans due to fall interventions will be reviewed in morning and afternoon stand up meetings so staff will be fully aware of interventions.
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.	HWD/ED or designee will review stand up meeting notes weekly to ensure all fall mat interventions have been discussed and all staff are aware of the intervention. HWD or ED will report audit findings in QA meetings. QA committee will monitor effectiveness of the plan Results of monitoring will be reflected in QA minutes.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		8/31/2021	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Emily Cole		**Date 8/27/2021**
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: ecook4@brookdale.com

October 7, 2021

License Number: AL5510
Survey Event ID: TWEV12

Ms. Emily Cook, Administrator
Brookdale Oklahoma City Southwest
10001 South May Avenue
Oklahoma City, OK 73159

Dear Ms. Cook:

On **October 1, 2021**, a desk audit revisit was conducted with your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as an Assisted Living Facility. The findings of that visit indicate that the deficiencies cited during your complaint survey on **August 10, 2021,** have now been corrected and your facility is in compliance with licensure standards effective **August 31, 2021**.

If you have any questions concerning the information in this letter, please contact this office at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE OKLAHOMA CITY SOUTHWEST	10001 SOUTH MAY AVENUE OKLAHOMA CITY, OK 73159

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{C 000}	INITIAL COMMENTS On 10/01/21 a desk audit was conducted. Sufficient evidence was submitted to clear the deficient practice.	{C 000}		

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