OKLAHOMA
State Department
of Health

Delivery via email to: ecook4@brookdale.com

October 30, 2025

License Number: AL5510

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

Survey Event ID: 59PC11

Dear Ms. Cook:

On **October 23, 2025,** 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 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 a virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to 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 Oklahoma City Southwest**
Address: **10001 South May Avenue**
City, State, Zip: **Oklahoma City, OK, 73159**
Provider #: **AL5510**
Complaint #: **OK00087133**
Investigation Date(s): **10/22/25 and 10/23/25**

ALLEGATION(S)
The facility failed to ensure residents were free from abuse.

An unannounced on-site investigation was initiated 10/22/2025 at 11:35 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 at other various times throughout the survey. Resident halls, rooms, and common areas were observed for staff interactions and assistance with residents. Residents were observed for signs of injury or distress.

Resident records were reviewed to include assessments, service plans, contracts, notes, and incidents. Facility policy and procedures, state reports, investigations, and grievances were reviewed.

Residents were interviewed regarding abuse.

Staff were interviewed related to the policy and procedure for abuse.

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

OKLAHOMA
State Department
of Health

Date report completed: 10/24/2025

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 10/23/2025

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 A complaint investigation (#OK00087133) was conducted on 10/22/25 through 10/23/25. Facility Census: 29 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide ED- executive director HWD- health and wellness director OSDH- Oklahoma State Department of Health	C 000		
C1512 SS=D	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		

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C1512	Continued From page 1 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 record review and interview, the center failed to follow their abuse, neglect, and exploitation policy by not: a. notifying the physician; and b. contacting families/responsible parties timely for 3 (#1, 2, and #4) of 4 sampled residents reviewed for abuse.	C1512		

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C1512	Continued From page 2	C1512		

The ED identified 29 residents resided in the center.

Findings:

A policy titled "Abuse, Neglect, and Exploitation Policy," dated 05/2021, read in part, "Brookdale is committed to maintaining a safe environment for each resident, visitor and employee. Instances or allegations of abuse, neglect or exploitation should be treated seriously and must be reported to the Executive Director or the supervisor on duty for investigation and appropriate follow up."..."a. Notifying Responsible Party. The Executive Director, or designee, or supervisor on duty should notify the resident's legally responsible party, if there is an allegation of abuse, neglect or exploitation. The notification should occur as soon as practicable."..."b. Notifying Physician. The Executive Director, or designee, or supervisor on duty should notify the resident's physician if there is an allegation of resident abuse, neglect or exploitation. the notification should occur as soon as practicable."

An initial "OSDH Incident Report Form," dated 10/10/25, read in part, "It was alleged by other associates that [CMA #1] was verbally abusive in the form of menacing towards residents." The initial report identified Residents #1 and #2. The form did not show physician notification was made.

A final "OSDH Incident Report Form," dated 10/17/25, read in part, "The allegation of abuse was substantiated due to eye witness accounts of [CMA #1] cursing at residents, menacing residents by saying 'don't hit me or I'll hit you back', or 'don't bite me or I'll bite you back', and with one resident who was hollering while

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C1512	Continued From page 3	C1512		

personal care was being provided, [CMA #1] put [their] hand over the resident's mouth stating '[they] needs to stop this damn hollering." The final report identified Residents #1, 2, and #4. The form did not show physician notification was made.

1. A "Resident Assessment Form," dated 10/03/25, showed Resident #1 had diagnosis of dementia without behavioral disturbance.

2. A "Resident Assessment Form," dated 08/06/25, showed Resident #2 had diagnosis of Alzheimer's disease.

3. A "Resident Assessment Form,"dated 07/08/25, showed Resident #4 had diagnosis of Alzheimer's.

On 10/23/25 at 1:41 p.m., the ED stated CMA #1 had concerning behavior in addition to the alleged abuse to the residents regarding hitting the community chickens with a shovel. The ED stated those who were to be notified for abuse allegations were the families, director of operations, the director clinical services, the State, Nurse Aide Registry, and Adult Protective Services. The ED stated they instructed the wellness director to notify the families/responsible parties of Residents #1,2, and #4 Thursday (10/16/25) or Friday (10/17/25) of last week. The ED stated they should have asked them to do so sooner than that.

On 10/23/25 at 2:03 p.m., the ED stated they did not notify the physician of any of the alleged allegations of abuse as they thought it was only needed if was physical.

On 10/23/25 at 2:08 p.m., the HWD stated they

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C1512	Continued From page 4 notified the families/responsible parties of Residents #1, 2, and #4 of the alleged abuse on 10/22/25. When asked why the notification occurred 12 days after the allegation, they stated it was an oversight and they were waiting for the final approval to terminate the CMA and the investigation was over. The HWD stated the notification was not done timely.	C1512		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure allegations of abuse were reported within 1 business day of the incident to OSDH for 3 (#1, 2, and #4) of 4 sampled residents reviewed for abuse. The ED identified 29 residents resided in the center. Findings:	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1911	Continued From page 5 An initial "OSDH Incident Report Form," dated 10/10/25, read in part, "It was alleged by other associates that [CMA #1] was verbally abusive in the form of menacing towards residents." The initial report identified Residents #1 and #2. A final "OSDH Incident Report Form," dated, 10/17/25, read in part, "The allegation of abuse was substantiated due to eye witness accounts of [CMA] #1 cursing at residents, menacing residents by saying 'don't hit me or I'll hit you back' or 'don't bite me or I'll bite you back', and with one resident who was hollering while personal care was being provided, [CMA #1] put [their] hand over the resident's mouth stating '[they] needs to stop this damn hollering." The final report identified Residents #1, 2, and #4. 1. A "Resident Assessment Form," dated 07/08/25, showed resident #4 had diagnosis of Alzheimer's. 2. A "Resident Assessment Form," dated 08/06/25, showed resident #2 had diagnosis of Alzheimer's disease. 3. A "Resident Assessment Form," dated 10/03/25, showed resident #1 had diagnosis of Dementia without behavioral disturbance. On 10/23/25 at 1:41 p.m., the ED stated the actual incident with CMA #1 occurred on the weekend of 10/04/25 and 10/05/25. The ED stated they received the formal statements on Thursday 10/09/25. They stated the incident was reported mid week. The ED stated the policy was to report immediately. The ED stated the associates were trained to report immediately. The ED stated the associates that reported were	C1911		

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C1911	Continued From page 6 new, and did not know what to do. The ED stated the two associates who had worked with CMA #1 had realized after talking to each other about CMA #1's behavior being more than just the CMA being odd, they notified the ED. On 10/23/25 at 1:45 p.m., the ED stated since the staff witnessed the abuse on the weekend and not reported until mid-week, it was not reported timely.	C1911		

OKLAHOMA
State Department
of Health

Delivery via email to: ecook4@brookdale.com

November 14, 2025

License Number: AL5510

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

Survey Event ID: 59PC11

Dear Ms. Cook:

On **October 23, 2025,** 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 **December 8, 2025**.

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: 11/13/2025** **Facility Name:** Brookdale Oklahoma City Southwest **License Number:** AL-5510 **Survey Event ID:** 59PC11 **Date Survey Completed: 10/23/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1512	Based on: record review and interview, the centerfailed to follow their abuse, neglect, and exploitation policy by not: a. notifying the physician; and b. contacting families/responsible parties timely for 3 (#1, 2, and #4) of 4 sampled residents reviewed for abuse.

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 10/23/2025 . 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?	HWD notified physicians for residents. Families of affected residents had been notified by HWD on 10/23/2025. HWD and ED were in-serviced on appropriate notification timelines concerning abuse, neglect, or exploitation according to policy and procedure.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents have the potential to be effected but none were identified. ED, HWD and or designee will complete a progress note in resident electronic chart regarding the communication with family and physician on allegations of abuse, neglect, or exploitation. ED, HWD or designee will randomly review allegations of abuse, neglect, or exploitation charting over the next 45 days for timely notifications.
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 randomly review allegations of abuse, neglect, or exploitation over the next 4 weeks to ensure appropriate timeliness of notifications. ED, HWD and/or designee will review reportable events during the daily stand up meeting and record on the Daily Stand up Form for the next 45 days.
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;	ED, HWD and/or designee will randomy review incidents of allegations of abuse, neglect, or exploitation over the next 4 weeks for timely notifications. This will be review through the QA and daily stand up process.

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 and or designed will report audit findings in QA meetings for the next 60 days 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?	12/8/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Emily Cook **Date 11/13/2025**

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

Addendum Date	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: 11/13/2025** **Facility Name:** Brookdale Oklahoma City Southwest **License Number:** AL-5510 **Survey Event ID:** 59PC11 **Date Survey Completed: 10/23/2025**
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1911	Based on: Record review and interview, the center failed to ensure allegations of abuse were reported within 1 business day of the incident to OSDH for 3 (#1, 2, and #4) of 4 sampled residents reviewed for abuse.
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 10/23/2025 . 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?	ED and HWD immediately in-serviced associates on abuse, neglect, and exploitation policy and procedure and reporting any alleged incident to ED or HWD within 24 hours of occurrence.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents have the potential to be affected but none were identified. ED,HWD and/or designee will review incidents during daily stand up meetings to identify residents that have the potential to be affected over the nex 45 days.
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?	Area Nurse Manager will in-service ED/HWD and associates on timely notifications of allegations of abuse, neglect, or exploitation.
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 and/or Area Nurse Manager will review incidents allegations of abuse, neglect, or exploitation over the next 4 weeks during daily stand up form. HWD or ED will report audit findings in QA meetings for the next 60 days QA committee will monitor effectiveness of the plan Results of the monitoring will be reflected in QA minutes
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/8/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Emily Cook	Date 11/13/2025

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

Addendum Date	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

December 15, 2025

License Number: AL5510

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

Survey Event ID: 59PC12

Dear Ms. Cook:

On **December 12, 2025,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **October 23, 2025,** have now been corrected effective **December 8, 2025.**

If you have any questions concerning the information in this letter, please contact me 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
	AL5510	A. BUILDING: _____ B. WING _____	R-C 12/12/2025

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 offsite/paper revisit was conducted on 12/12/25. The facility was in substantial compliance.	{C 000}		

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