OKLAHOMA
State Department
of Health

**Delivery via email to:** kribre@brookdale.com

March 27, 2025

License Number: AL6001

Ms. Kristel Brewer, Administrator
Brookdale Stillwater
1616 East McElroy Road
Stillwater, OK 74075

**RE: Survey Event ID: PYFP11**

Dear Ms. Brewer:

On **March 19, 2025**, agents from our office concluded a State Licensure survey with complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **March 19, 2025**.

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

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

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

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

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

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

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

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

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

IDR Coordinator
IDRCoordinator@health.ok.gov
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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility:** **Brookdale Stillwater**
**Address:** **1616 E McElroy Road**
**City, State, Zip:** **Stillwater, Ok. 74975**
**Provider #:** **AL6001**
**Complaint #:** **OK00068256**
**Investigation Date:** **03/18/25 through 03/19/25**

| ALLEGATION(S) |
|---|
| #1 The center failed to ensure care and treatment was provided according to the physicians' orders and/or the plan of care |
| #2 The center failed to ensure adequate staff to meet the needs of the residents and failed to ensure call lights were answered in a timely manner. |
| #3 The center failed to ensure palatable food was served. |
| #4 The center failed to ensure residents' representatives were notified of a change in condition |

An unannounced on-site investigation was initiated 03/18/2025 at 08:00 a.m.

A sample of three participants, including any identified participants, 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 into the center. Residents were observed for staffing, dietary and abuse and neglect concerns. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and police reports. Residents and staff were asked questions regarding abuse and abuse training.

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: 03/19/2025

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility:** **Brookdale Stillwater**
**Address:** **1616 E McElroy Road**
**City, State, Zip:** **Stillwater, Ok. 74975**
**Provider #:** **AL6001**
**Complaint #:** **OK00073924**
**Investigation Date:** **03/18/25 through 03/19/25**

| ALLEGATION(S) |
|---|
| 1. The center failed to ensure a clean, comfortable and homelike environment and failed to have and/or implement an effective pest control program. |

An unannounced on-site investigation was initiated 03/18/2025 at 08:00 a.m.

A sample of three participants, including any identified participants, 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 into the center. Residents were observed for clean, comfortable and environmental concerns. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, cleaning and pest control records. Residents and staff were asked questions regarding environment and cleaning processes.

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: 03/19/2025

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility:** **Brookdale Stillwater**
**Address:** **1616 E McElroy Road**
**City, State, Zip:** **Stillwater, Ok. 74975**
**Provider #:** **AL6001**
**Complaint #:** **OK00074653**
**Investigation Date:** **03/18/25 through 03/19/25**

| ALLEGATION(S) |
|---|
| 1. The facility failed to ensure the residents were free from misappropriation of property. |

An unannounced on-site investigation was initiated 03/18/2025 at 08:00 a.m.

A sample of three participants, including any identified participants, 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 into the center. Residents were observed for misappropriation of property concerns. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and police reports. Residents and staff were asked questions regarding resident personal items/funds and reporting of incidents or complaints.

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: 03/19/2025

OKLAHOMA
State Department
of Health

# INVESTIGATIVE REPORT

**Facility:** **Brookdale Stillwater**
**Address:** **1616 E McElroy Road**
**City, State, Zip:** **Stillwater, Ok. 74975**
**Provider #:** **AL6001**
**Complaint #:** **OK00079245**
**Investigation Date:** **03/18/25 through 03/19/25**

| ALLEGATION(S) |
|---|
| 1. The center failed to ensure adequate trained staff was on duty to meet the needs of the residents. |
| 2. The center failed to ensure an accurate written record for medications and/or scheduled II medications was maintained. |

An unannounced on-site investigation was initiated 03/18/2025 at 08:00 a.m.

A sample of three participants, including any identified participants, 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 into the center. Residents were observed for staffing and medication management concerns. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and policies and procedures. Residents and staff were asked questions regarding staffing and medication management processes.

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: 03/19/2025

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL6001 | A. BUILDING: _____ B. WING _____ | C 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE STILLWATER | 1616 EAST MCELROY ROAD STILLWATER, OK 74075 |

| (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<br><br>A relicensure survey was conducted from 03/18/25 through 03/19/25. Complaint investigations (#OK00068256, OK00073924, OK00074653, and #OK00079245) were conducted in conjunction with the survey.<br><br>Facility Census: 22 | C 000 | | |
| C1923 SS=E | 310:663-19-2(a)(3) MEDICATION ADMINISTRATION<br><br>(3) An accurate written record of medications administered shall be maintained. The medication record shall include:<br>(A) The identity and signature of the person administering the medication.<br>(B) The medication administered within one hour of the scheduled time.<br>(C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method.<br>(D) Adverse reactions or results.<br>(E) Injection sites.<br>(F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident.<br>(G) Medication error incident reports.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure an accurate medication inventory for a schedule IV medication prescribed for a resident for 1 (#4) of 5 residents sampled for medication administration. | C1923 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL6001 | A. BUILDING: _____ B. WING _____ | C 03/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE STILLWATER | 1616 EAST MCELROY ROAD STILLWATER, OK 74075 |

| (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 |
|---|---|---|---|---|
| C1923 | Continued From page 1<br><br>The health and wellness director identified 22 residents received medications.<br><br>Findings:<br><br>A "Medication and Treatments Controlled Substance Count" policy, dated 05/2011, read in part, "an on-coming associate and an out-going associate should count each controlled substance and verify the amount."<br><br>Resident #4 had diagnoses which included congestive heart failure, Presence of prosthetic heart valve and type 2 diabetes mellitus.<br><br>A physician order, dated 11/11/24, showed to administer alprazolam (antianxiety medication) 0.25 mg 1 tab by mouth two times a day for anxiety.<br><br>A medication administration record, dated 03/13/25 at 9:00 p.m., showed alprazolam (antianxiety medication) 0.25 mg was administered.<br><br>An individual narcotic log, dated 3/13/25 at 8:00 p.m., showed alprazolam 0.25 mg tab was not signed out by the administering staff member.<br><br>On 03/19/25 at 4:30 p.m., the health and wellness director stated the blank on the narcotic log for alprazolam was a documentation error and the medication was not signed out in the individual narcotic log. | C1923 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to**: kribre@brookdale.com

April 15, 2025

License Number: AL6001

Kristel Brewer, Administrator
Brookdale Stillwater
1616 East McElroy Road
Stillwater, OK 74075

**RE: Survey Event PYFP11**

Dear Ms. Brewer:

On **March 19, 2025**, a Licensure inspection with complaint investigations was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **April 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

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Protective Health Services
Long Term Care Service

**OPTIONAL PLAN OF CORRECTION TEMPLATE**

**Current Date: 4/8/2025**
**Facility Name:** Brookdale Stillwater Assisted Living
**License Number:** AL6001
**Survey Event ID:** PYFP11
**Date Survey Completed: 3/19/2025**

**SUMMARY OF DEFICIENCY CITED BY OSDH**

| | |
|---|---|
| ID Prefix Tag: C1923 | Based on: This Rule is not met as evidenced by: Based on record review and interview, the facilityfailed to ensure an accurate medication inventoryfor a schedule IV medication prescribed for aresident for 1 (#4) of 5 residents sampled formedication administration. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Associate was immediately in-serviced and a intial Corrective Action Presented.

| 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? | Center staff failed to follow medication and treatments controlled<br>Substance count policy. Associate failed to count out and document On the narcotic count sheet before leaving shift. Med aide received a Initial corrective action and immediate in-service for occurrence. Random audit of Narcotic count sheet will be completed by HWD/ED or designee weekly and PRN |
| 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 in the community have the potential<br>to be affected but none were identified as being affected. |
| 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? | Medication techs will be re-in serviced on following medication and treatment. Controlled substance policy. Random audits of Narcotic Count Sheet Will be reviewed weekly and PRN by ED/HWD or designee. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | Enter methods to ensure corrections are sustained:<br>Continued compliance will be monitored during initial, quarterly, annually and prn QA process by the ED, HWD, department managers and/or designees.<br>Enter methods to incorporate into QA system:<br>Enter methods to keep monitoring records: |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 5/8/2025 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

**Administrator's Signature** Administrator signature required. **Date** Enter a date of signature.

Krystal Bauer, LPN CAO 4/8/2025

| 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.<br>Facility in Compliance by: Click here to enter a date. | | | |

OKLAHOMA
State Department
of Health

**Delivery via email to**: kribre@brookdale.com

April 15, 2025

License Number: AL6001

Kristel Brewer, Administrator
Brookdale Stillwater
1616 East McElroy Road
Stillwater, OK 74075

**RE: Survey Event PYFP11**

Dear Ms. Brewer:

*This notice replaces and corrects the letter from the Department sent this morning,* ***April 15, 2025.***

On **March 19, 2025**, a Licensure inspection with complaint investigations was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 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

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Long Term Care Service

**OPTIONAL PLAN OF CORRECTION TEMPLATE**

**Current Date: 4/8/2025**
**Facility Name:** Brookdale Stillwater Assisted Living
**License Number:** AL6001
**Survey Event ID:** PYFP11
**Date Survey Completed: 3/19/2025**

**SUMMARY OF DEFICIENCY CITED BY OSDH**

| | |
|---|---|
| ID Prefix Tag: C1923 | Based on: This Rule is not met as evidenced by: Based on record review and interview, the facilityfailed to ensure an accurate medication inventoryfor a schedule IV medication prescribed for aresident for 1 (#4) of 5 residents sampled formedication administration. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Associate was immediately in-serviced and a intial Corrective Action Presented.

| 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? | Center staff failed to follow medication and treatments controlled<br>Substance count policy. Associate failed to count out and document On the narcotic count sheet before leaving shift. Med aide received a Initial corrective action and immediate in-service for occurrence. Random audit of Narcotic count sheet will be completed by HWD/ED or designee weekly and PRN |
| 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 in the community have the potential<br>to be affected but none were identified as being affected. |
| 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? | Medication techs will be re-in serviced on following medication and treatment. Controlled substance policy. Random audits of Narcotic Count Sheet Will be reviewed weekly and PRN by ED/HWD or designee. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | Enter methods to ensure corrections are sustained:<br>Continued compliance will be monitored during initial, quarterly, annually and prn QA process by the ED, HWD, department managers and/or designees.<br>Enter methods to incorporate into QA system:<br>Enter methods to keep monitoring records: |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 5/8/2025 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

**Administrator's Signature** Administrator signature required. **Date** Enter a date of signature.

Krystal Bauer, LPN CAO 4/8/2025

| 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.<br>Facility in Compliance by: Click here to enter a date. | | | |

OKLAHOMA
State Department of Health

**Delivery via email to:** kribre@brookdale.com

May 13, 2025

License Number: AL6001

Kristel Brewer, Administrator
Brookdale Stillwater
1616 East McElroy Road
Stillwater, OK 74075

**RE: Survey Event PYFP12**

Dear Ms. Brewer:

On **May 12, 2025,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey with complaints on **March 19, 2025,** have now been corrected effective **May 8, 2025.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL6001 | A. BUILDING: _____ B. WING _____ | R-C 05/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BROOKDALE STILLWATER | 1616 EAST MCELROY ROAD STILLWATER, OK 74075 |

| (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<br><br>An offsite/paper revisit was conducted on 05/12/25. 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