
Delivery via email to: sbrown@bellaroselife.com

June 11, 2025

License Number: AL7240

Sandra Brown, Administrator
Bellarose Senior Living
18001 East 51st Street
Tulsa, OK 74134

RE: Survey Event ID: SILJ11

Dear Ms. Brown:

On **May 12, 2025**, agents from our office concluded a State Licensure survey with complaint investigations 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 **May 12, 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
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, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Bellarose Senior Living AL

Address: 18001 E 51st.

City, State, Zip: Tulsa, OK, 74134

Provider #: AL7240

Complaint #: OK00062134

Investigation Date(s): 05/07/25, 05/08/25, and 05/12/25

ALLEGATION(S)
enter text The center failed to have and/or implement effective medication administration policies and procedures to prevent medication errors.
enter text The center failed to have required administrative staff to oversee operations.
enter text The center failed to provide activities of choice for residents.
enter text The center failed to provide adequate laundry services to ensure residents' belongings were not misappropriated.
enter text

An unannounced on-site investigation was initiated 05/07/2025 at 8:00 a.m.

A sample of ten 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: Upon entrance into Memory Care on different occasions residents were observed sitting in front of the T.V. Evidence was obtained through observations, interviews with residents, family members and staff.

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: 05/13/2025

INVESTIGATIVE REPORT

Facility: Bellarose Senior Living AL

Address: 18001 E 51st

City, State, Zip: Tulsa, OK, 74134

Provider #: AL7240

Complaint #: OK00065121

Investigation Date(s):

ALLEGATION(S)
enter textThe center failed to ensure incontinent care was provided in a timely manner and according to the contract, the plan of care and the standard of care.
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 05/07/2025 at 8:00 a.m.

A sample of ten 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: Upon entrance into the facility and the initial tour there was no foul odor noted throughout the facility. Observance from residents throughout the survey they were all neatly dressed with no soiled clothing. Rooms observed no foul odor detected. Record reviews of the plan of care, interviewed residents and representatives about incontinent care.

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: 05/13/2025

INVESTIGATIVE REPORT

Facility: Bellarose Senior Living

Address: 18001 E. 51st Street

City, State, Zip: Tulsa, OK 74143

Provider #: AL7240

Complaint #: OK00065352

Investigation Date(s): 05/07/25, 05/08/25 and 05/12/25

ALLEGATION(S)
The center failed to ensure a plan of care was in place and care and treatment, including therapeutic diets, was followed based on the plan of care, the physicians' orders and the contract.
The center failed to ensure food was served in a sanitary manner and according to the plan of care, the contract, the menu and the residents' preferences/intolerance lists and failed to ensure adequate dietary staff to meet the residents' needs.
The center failed to ensure billing was completed according to the contract and the standard of care.
The center failed to ensure a clean, comfortable and homelike environment.
The center failed to ensure residents' representatives received copies of medical records as requested.

An unannounced on-site investigation was initiated 05/07/2025 at 8:00a.m.

A sample of ten 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 into the facility and throughout the three-day survey. Interview and record review showed the facility failed to maintain resident records in such a form as to be readily available upon request.



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: 05/15/2025
Diane Reagle, MSN, RN.

Based on record review, observation, and interviews the facility failed to maintain resident records in such a form as to be readily available upon request for one (#4) of ten sampled residents whose records were requested for review.

Findings

A "Resident Roster", dated,05/07/2025 documented 67 residents resided in the facility.

A list of discharged residents, dated as of 05/07/2025, read in parts, "[Res #5] Physical Move-In dates: 04/22/2024 Financial Move-In: 04/22/2024 Moved Out 06/24/2025.

On 08/13/24 at 11:45 a.m. a written letter requesting medical records was presented by the resident representative to the concierge, who signed a receipt of acceptance.

On 05/15/2025 at 12:08 p.m. the resident representative stated she has not received the requested medical records.

INVESTIGATIVE REPORT

Facility: Bellarose Senior Living AL
Address: 18001 E 51st.
City, State, Zip: Tulsa, OK, 74134
Provider #: AL7240
Complaint #: OK00068897
Investigation Date(s): 5/7/25, 5/8/25, and 5/12/25

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

An unannounced on-site investigation was initiated 05/07/2025 at 8:00 a.m.

A sample of ten 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 into the facility and throughout the three-day survey. No residents were observed being verbally, physically or psychosocially abused. Records reviewed included incident reports, in-service training regarding abuse, neglect of residents. Residents, family members and staff were questioned regarding witnessing any form of 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

Date report completed: 05/13/2025

INVESTIGATIVE REPORT

Facility: Bellarose Senior Living
Address: 18001 E. 51st Street
City, State, Zip: Tulsa, OK 74143
Provider #: AL7240
Complaint #: OK000 OK00074130
Investigation Date(s): 05/07/25, 05/08/25, and 05/12/2025

ALLEGATION(S)
The center failed to ensure residents were not involuntarily discharged.
The center failed to ensure the billing was not fraudulent.

An unannounced on-site investigation was initiated 05/07/2025 at 8:00a.m.

A sample of ten 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 into the facility and throughout the three-day survey. Records reviewed included the resident contracts, policies and procedures, and billing statements. Residents, and resident's representatives and staff were interviewed about discharge criteria and billing.

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: 05/12/2025
Diane Reagle, MSN, RN

INVESTIGATIVE REPORT

Facility: Bellarose Senior Living AL

Address: 18001 E 51st

City, State, Zip: Tulsa, OK, 74134

Provider #: AL7240

Complaint #: OK00075698

Investigation Date(s):

ALLEGATION(S)
The center failed to ensure residents were not verbally, physically or psychosocially abused.

An unannounced on-site investigation was initiated 05/07/2025 at 8:00 a.m.

A sample of ten 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 into the facility and throughout the three-day survey. No residents were observed being verbally, physically or psychosocially abused. Records reviewed included incident reports, in-service regarding abuse, neglect of residents. Residents, family members and staff were questioned regarding witnessing any form of 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

Date report completed: 05/13/2025

INVESTIGATIVE REPORT

Facility: Bellarose Senior Living AL

Address: 18001 E 51st

City, State, Zip: Tulsa, OK, 74134

Provider #: AL7240

Complaint #: OK00076369

Investigation Date(s):

ALLEGATION(S)
enter textThe center failed to ensure medications were administered as ordered by the physician.
The center failed to ensure residents' representative were informed and consented to treatment changes.
The center failed to ensure a resident's emergency call pendant was answered in a timely manner.

An unannounced on-site investigation was initiated 05/07/2025 at 8:00

A sample of ten 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 into the facility and throughout the three-day survey. Observation of medications that were administered were given correctly and as ordered by the physician. Records reviewed included the MAR'S, Physician Orders, and the CMA License. Residents, and resident's representatives and staff were interviewed about notification of treatment changes and if their call light was answered in a timely manner.

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: 05/13/2025

INVESTIGATIVE REPORT

Facility: Bellarose Senior Living
Address: 18001 E. 51st Street
City, State, Zip: Tulsa, OK 74143
Provider #: AL7240
Complaint #: OK00081436
Investigation Date(s): 05/07/25, 05/08/25, 05/12/2025

ALLEGATION(S)
Allegations: Resident/Patient/Client Rights The center failed to ensure the resident or resident's representative's right to be informed of services provided in the residents contract.

An unannounced on-site investigation was initiated 05/07/2025 at 8:00a.m.

A sample of ten 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 into the facility and throughout the three-day survey. Records reviewed included the contracts and service plans. Residents, family members and staff were questioned regarding residents and resident's representative's right to be informed of services provided in the residents contract.

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: 05/12/2025
Diane Reagle, MSN, RN

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/12/2025
NAME OF PROVIDER OR SUPPLIER BELLAROSE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 18001 EAST 51ST STREET TULSA, OK 74134		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure and complaint survey (#OK00062134, OK00065121, OK00065352, OK00068897, OK00074130, OK00075698, OK00076369, and #OK00081436) was conducted from 05/07/25 through 05/08/25, and 05/12/25. Deficiencies were cited as a result of the survey. Facility Census: 67 Listed below are abbreviations that will be used throughout this document. CMA-certified medication aide CNA- certified nurse aide COPD - chronic obstructive pulmonary disease DM- diabetes mellitus DON- director of nursing ED- executive director HTN - hypertension LPN- licensed practical nurse MI - myocardial infarction Res- resident RN- registered nurse UTI- urinary tract infection	C 000		
C 328 SS=D	310:663-3-3(a)(8) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (8) planned programs for socialization, activities and exercise; and	C 328		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/12/2025
NAME OF PROVIDER OR SUPPLIER BELLAROSE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 18001 EAST 51ST STREET TULSA, OK 74134		
(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 328	Continued From page 1 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents received individualized activity programs to meet cognitive needs described in the residents' residency agreement for 2 (#4 and #6) of 10 sampled residents. The ED identified 16 residents resided in the memory care unit. Findings: On 05/07/25 at 9:01 a.m., residents in the memory care unit were observed to be watching television in the lobby. An undated facility marketing material brochure titled "Bellarose Independent Living, Assisted Living, and Memory Care," showed the service and amenities included daily activities, exercise and specialized fitness classes, and personalized activity stations. A facility residency agreement titled "The Monthly Base Fee," dated 01/12/22, showed the following services and amenities. a. non-billable planned events and activities, and b. individualized activity program to meet cognitive needs. 1. An "Oklahoma Memory Care HSE	C 328		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/12/2025
NAME OF PROVIDER OR SUPPLIER BELLAROSE SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 18001 EAST 51ST STREET TULSA, OK 74134		
(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 328	Continued From page 2 Assessment" for Res #4, dated 04/29/25, read in part "Resident requires daily reminders and physical assistance for activities." On 05/12/25 at 1:09 p.m., Res #4 was observed to be in bed. 2. An "Oklahoma Memory Care HSE Assessment" for resident #6, dated 04/29/25, read in part "Resident may require occasional verbal reminders for scheduled events." On 05/07/25 at 2:08 p.m., Res #6 along with other memory care residents were observed watching television in the lobby area. On 05/12/25 at 1:09 p.m., Res #6 along with 6 other residents were observed in memory care watching television On 05/12/25 at 1:18 p.m., CNA #3 was asked if the residents performed any activities for the day. CNA #3 stated they completed one activity that morning and they will have another activity this afternoon. The CNA was asked if they documented the activities. They stated yes. On 05/12/25 at 2:20 p.m., the ED was asked for the daily activity log sheets. The ED stated there had not been any documentation since March 2025, They stated they currently do not have a Lifestyle Pathway Director for Memory Care and have not had one for at least 3 months.	C 328			
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating	C 391			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/12/2025
NAME OF PROVIDER OR SUPPLIER BELLAROSE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 18001 EAST 51ST STREET TULSA, OK 74134		
(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 391	Continued From page 3 to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure: a. opened food items were labeled with the open and use by date in one of one walk-in freezer and one of one walk-in refrigerator; and b. opened food items were stored in plastic containers with tight fitting lids on 1 of 4 shelf units in the dry storage. The dietary manager identified 67 residents received nutrition from the kitchen. Findings: On 04/07/25 at 8:24 a.m., the following opened food items were not labeled with the open and use by dates in the walk-in freezer: a. one plastic freezer bag three quarters full of waffles, b. one plastic freezer bag three quarters full of tater tots, c. one plastic freezer bag one quarter full of chicken patties, d. one plastic freezer bag three quarters full of round biscuits, e. one plastic freezer bag three quarters full of crinkle cut fries, and f. one plastic freezer bag one quarter full of okra. On 04/07/25 at 8:37 a.m., the following opened	C 391		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/12/2025
NAME OF PROVIDER OR SUPPLIER BELLAROSE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 18001 EAST 51ST STREET TULSA, OK 74134		
(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 391	Continued From page 4 food items were not labeled with the open and use by date in the walk-in refrigerator: a. one 24 oz plastic shaker bottle half full of Kraft grated parmesan cheese, b. one 32 oz plastic bottle half full of Motts 100% juice, and c. one 64 oz plastic bag one half full of parmesan cheese blend. On 04/07/25 at 8:42 a.m., the following food items were opened and not in storage containers with tight fitting lids on shelf #2 in the dry storage: a. one box half full of quick oats. Marked with use by date of 02/19/25, and b. one 40 oz box one third full of Jiffy brand corn muffin mix (cornbread). Marked with use by date of 02/18/25, and c. one 28 oz box a third full of Cream of Wheat (hot cereal). A facility policy titled "Food Handling," dated 01/2018, read in part, "All local, state and federal standards and regulations are followed to assure a safe sanitary food service department. On 04/07/25 at 8:47 a.m., the dietary manager was asked about the kitchen policies to ensure proper and safe food storage and to ensure all foods were labeled and dated with an expiration date. The dietary manager stated, "Many of my kitchen staff are new to the position, and are not consistent with proper storage, labeling and dating food yet. I know from my experience, all open foods should be properly stored, labeled and dated. I will throw the opened items into the trash."	C 391		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT	C 542		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/12/2025
NAME OF PROVIDER OR SUPPLIER BELLAROSE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 18001 EAST 51ST STREET TULSA, OK 74134		
(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 542	Continued From page 5 (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure: a) the admission assessments were signed and/or coordinated by an RN or physician for 3 (#1, 2, and #7) and b) the comprehensive assessment were signed and/or coordinated by an RN or physician for 2 (#3 and #5) of 10 sampled resident reviewed for assessments. The ED identified 67 residents resided at the facility. Findings: 1. Resident #1's admission assessment, dated 10/24/24, showed the resident was admitted with diagnoses which included generalized weakness, MI, Pulmonary embolism, and chronic back pain. Resident #1's admission assessment was not signed and/or coordinated by an RN or physician. 2. Resident #2's admission assessment, dated 06/08/23, showed the resident was admitted with diagnoses which included DM, Neuropathy, and HTN.	C 542		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/12/2025
NAME OF PROVIDER OR SUPPLIER BELLAROSE SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 18001 EAST 51ST STREET TULSA, OK 74134		
(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 542	Continued From page 6 Resident #2's admission assessment did not show it was signed and/or coordinated by an RN or physician. 3. Resident #7's admission assessment, dated 01/13/24, showed the resident was admitted with diagnoses which included anxiety, insomnia, gastro-esophageal reflux, HTN, and pain in right shoulder. Resident #7's admission assessment did not show it was signed and/or coordinated by an RN or physician. and 1. Resident #5's comprehensive assessment, dated 05/30/24, showed the resident was admitted with diagnoses which included HTN, DM, and UTI. Resident #5's comprehensive assessment did not show it was signed and/or coordinated by an RN or physician. 2. Resident #8's comprehensive assessment, dated 11/02/23, showed the resident was admitted with diagnoses which included DM, COPD, and asthma. Resident #8's comprehensive assessment did not show it was signed and/or coordinated by an RN or physician. On 05/08/25 at 3:35 p.m., the ED was asked why the admission and comprehensive assessments were not signed and/or coordinated by an RN or physician. The ED stated they did not know.	C 542			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/12/2025
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C 543	Continued From page 7	C 543		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure: a) the admission assessments were signed by the resident and/or resident representative for 3 (#1, 2, and #7) and b) the comprehensive assessment were signed by the resident and/or resident representative for 2 (#3 and #5) of 10 sampled resident reviewed for assessments. The ED identified 67 residents reside at the facility. Findings: 1. Resident #1's admission assessment, dated 10/24/24, showed the resident was admitted with diagnoses which included generalized weakness, MI, Pulmonary embolism, and chronic back pain. Resident #1's admission assessment was not	C 543		

Oklahoma State Department of Health

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C 543	Continued From page 8 signed by the resident and/or resident representative 2. Resident #2's admission assessment, dated 06/08/23, showed the resident was admitted with diagnoses which included DM, Neuropathy, and HTN. Resident #2's admission assessment did not show it was signed by the resident and/or resident representative 3. Resident #7's admission assessment, dated 01/13/24, showed the resident was admitted with diagnoses which included anxiety, insomnia, gastro-esophageal reflux, HTN, and pain in right shoulder. Resident #7's admission assessment did not show it was signed by the resident and/or resident representative and 1. Resident #5's comprehensive assessment, dated 05/30/24, showed the resident was admitted with diagnoses which included HTN, DM, and UTI. Resident #5's comprehensive assessment signed by the resident and/or resident representative. 2. Resident #8's comprehensive assessment, dated 11/02/23, showed the resident was admitted with diagnoses which included DM, COPD, and asthma. Resident #8's comprehensive assessment did not show it was signed by the resident and/or resident representative.	C 543		

Oklahoma State Department of Health

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C 543	Continued From page 9	C 543		
C 952 SS=E	On 05/08/25 at 3:35 p.m., the ED was asked why the admission and comprehensive assessments signed by the resident and/or resident representative. The ED stated they did not know. 310:663-9-5(b) STAFF QUALIFICATIONS (b) Each assisted living center shall ensure that staff members providing socialization, activity, and exercise services are qualified by training. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff performing activities were qualified by training to provide activities for 2 (#4 and #6) of 10 sampled residents. The ED identified 16 residents reside in memory	C 952		

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C 952	Continued From page 10 care. Findings: On 05/07/25 at 2:08 p.m., Res #4 was observed watching television in the memory care unit along with five other residents. On 05/12/25 at 1:09 p.m., Res #4 was observed watching television in the memory care unit along with 6 other residents. On 05/12/25 at 1:22 p.m., CNA #3 was asked if the residents in memory care did any activities for the day. The CNA stated they assisted the residents with an activity that morning. CNA #3 also stated they will do another activity with the residents this afternoon. On 05/12/25 at 1:44 p.m., the ED was asked about the activities in memory care. They stated they rely on the CMA and CNAs to do the daily activities since they don't have a pathway director for memory care.	C 952		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.	C 954		

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C 954	Continued From page 11 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure direct care staff had first aid and cardiopulmonary resuscitation training for 1 (CMA #1) of 5 sampled personnel files reviewed. The ED identified 67 residents reside in the facility. Findings: A facility position description titled "Certified Medication Aide (Oklahoma only)," dated 04/01/23, read in part, "Minimum Skills, Knowledge, and Abilities must have First aid certification per state requirements." An undated facility staff list showed CMA #1 was hired on 09/19/24. There was no documentation on first aid and cardiopulmonary resuscitation training. An in-service sheet, dated 03/07/25, for first aid training was provided and CMA #1 did not attend the in-service. On 05/12/25 at 3:10 p.m., the ED was asked the requirements for first aid and cardiopulmonary resuscitation training. The ED stated CMA #1's certification expired in December 2024, and they had not renewed their training.	C 954		
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)	C1505		

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C1505	Continued From page 12 (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 of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents were administered the correct medication for 1 (#4) of 10 sampled residents reviewed for medication errors. The ED identified 67 residents reside in the facility.	C1505		

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C1505	Continued From page 13 Findings: Res #4's diagnoses included Alzheimer's disease bilateral leg edema, chronic kidney disease, depression, and hypothyroidism. A progress note, dated 01/06/24, read in part, "Resident was given another resident's medication this morning." On 05/08/25 at 1:40 p.m., the ED was asked did they know what medication was administered and they stated they didn't know. The ED was asked why there was no documentation of resident being monitored. The ED stated they really don't know why because they were not employed at the facility at the time of the incident.	C1505		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (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. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports.	C1923		

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C1923	Continued From page 14 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an accurate complete record of an incident log sheet was completed for 1 (#4) of 10 sampled residents reviewed for medication errors. The ED identified 67 residents reside in the facility. Findings: Resident #4's diagnoses included Alzheimer's Disease, bilateral leg edema, chronic kidney disease, depression, and hypothyroidism. A position description titled "Certified Medication Aide (Oklahoma only)," dated 11/2023, read in part, "Record any incidents, errors, accidents, and hazards." An undated facility policy titled "Medication Policy and Procedures" read in part, "Any error or omission of medications should be verbally reported immediately to Resident Services Management Personnel and an Incident Report completed." A progress note for Resident #4, dated 01/06/24, read in part, "Resident was given another resident's medication this morning. Will continue to monitor and keep physician updated throughout the day." On 05/08/25, the ED presented an incomplete resident incident log sheet for Resident #4, for a	C1923		

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C1923	Continued From page 15 medication error on 01/06/24. The incident log sheet was to record the immediate actions to be taken. On 05/08/25 at 1:40 p.m., the ED stated they did not know which medication was administered, nor why the incident report was not completed since they were not working at the facility during this time.	C1923		
C1953 SS=D	310:663-19-3(c) MAINTENANCE OF RECORDS (C) Records for the previous twelve (12) months of operation, whether original, electronic, or microfilm copies, shall be maintained in such form as to be legible and readily available upon request of the attending physician, the assisted living center and any person authorized by law to make such a request. Records more than twelve (12) months old, whether original, electronic, or microfilm copies, shall be maintained in such form as to be legible and available within seventy-two (72) hours upon request of the attending physician, the continuum of care facility or assisted living center, and any person authorized by law to make such a request. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain resident records in such a form as to be readily available upon request for 1 (#5) of 10 sampled residents whose records were requested for review. The ED identified 67 residents resided in the facility. Findings:	C1953		

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C1953	Continued From page 16 A policy "Policy and Procedure Transfer or Discharge," dated 10/18/22, read in part, "Resident's health care information should be provided to transferring entity or responsible party upon transfer or discharge." A list of discharged residents, dated as of 05/07/25, read in part, "[Res #5] Physical Move-In dates: 04/27/2024 Financial Move-In: 04/22/2024. Moved Out 06/24/202.". On 05/08/25 at 3:39 p.m., the ED was asked if medical records were requested and released for Resident #5. The ED stated the medical records were requested by the residents representative. The ED was asked to provide documentation the records were sent per the request. The ED did not provide documentation the records were released to the resident representative.	C1953		
C1972 SS=B	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure staff were educated on abuse training within 90 days of hire for 1 (CMA #1) of 5	C1972		

Oklahoma State Department of Health

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C1972	Continued From page 17 employees whose records were reviewed for abuse training. The ED identified 67 residents reside in the facility: Findings: CMA #1 was hired on 09/19/24 and abuse training was completed on 03/19/25 according to the continuing education log sheet. No documentation of training was completed within 90 days of hire. On 05/12/25 at 3:10 p.m., the ED stated they did not know CMA #1 did not have their abuse training within 90 days of hire. The ED could not provide a policy on abuse training.	C1972			

Delivery via email to: sbrown@bellaroselife.com

June 25, 2025

License Number: AL7240

Sandra Brown, Administrator
Bellarose Senior Living
18001 East 51st Street
Tulsa, OK 74134

RE: Survey Event SILJ11

Dear Ms. Brown:

On **May 12, 2025**, a Licensure inspection with complaint investigation 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 **August 1, 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, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure and complaint survey (#OK00062134, OK00065121, OK00065352, OK00068897, OK00074130, OK00075698, OK00076369, and #OK00081436) was conducted from 05/07/25 through 05/08/25, and 05/12/25. Deficiencies were cited as a result of the survey. Facility Census: 67 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide CNA- certified nurse aide COPD - chronic obstructive pulmonary disease DM- diabetes mellitus DON- director of nursing ED- executive director HTN - hypertension LPN- licensed practical nurse MI - myocardial infarction Res- resident RN- registered nurse UTI- urinary tract infection	C 000		
C 328 SS=D	310.663-3-3(a)(8) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (8) planned programs for socialization, activities and exercise; and	C 328	Refer to POC Template, Survey Event ID # SILJ11, ID Prefix Tag C 328	08/01/2025

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Sandra Brown

Executive Director

6/23/2025

Oklahoma State Department of Health

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C 328	Continued From page 1 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents received individualized activity programs to meet cognitive needs described in the residents' residency agreement for 2 (#4 and #6) of 10 sampled residents. The ED identified 16 residents resided in the memory care unit. Findings: On 05/07/25 at 9:01 a.m., residents in the memory care unit were observed to be watching television in the lobby. An undated facility marketing material brochure titled "Bellarose Independent Living, Assisted Living, and Memory Care," showed the service and amenities included daily activities, exercise and specialized fitness classes, and personalized activity stations. A facility residency agreement titled "The Monthly Base Fee," dated 01/12/22, showed the following services and amenities. a. non-billable planned events and activities, and b. individualized activity program to meet cognitive needs. 1. An "Oklahoma Memory Care HSE	C 328		

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C 328	Continued From page 2 Assessment" for Res #4, dated 04/29/25, read in part "Resident requires daily reminders and physical assistance for activities." On 05/12/25 at 1:09 p.m., Res #4 was observed to be in bed. 2. An "Oklahoma Memory Care HSE Assessment" for resident #6, dated 04/29/25, read in part "Resident may require occasional verbal reminders for scheduled events." On 05/07/25 at 2:08 p.m., Res #6 along with other memory care residents were observed watching television in the lobby area. On 05/12/25 at 1:09 p.m., Res #6 along with 6 other residents were observed in memory care watching television On 05/12/25 at 1:18 p.m., CNA #3 was asked if the residents performed any activities for the day. CNA #3 stated they completed one activity that morning and they will have another activity this afternoon. The CNA was asked if they documented the activities. They stated yes. On 05/12/25 at 2:20 p.m., the ED was asked for the daily activity log sheets. The ED stated there had not been any documentation since March 2025, They stated they currently do not have a Lifestyle Pathway Director for Memory Care and have not had one for at least 3 months.	C 328		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating	C 391	Refer to POC Template, Survey Event ID # SILJ11, ID Prefix Tag C 391	08/01/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/12/2025
NAME OF PROVIDER OR SUPPLIER BELLAROSE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 18001 EAST 51ST STREET TULSA, OK 74134		
(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 391	Continued From page 3 to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure: a. opened food items were labeled with the open and use by date in one of one walk-in freezer and one of one walk-in refrigerator; and b. opened food items were stored in plastic containers with tight fitting lids on 1 of 4 shelf units in the dry storage. The dietary manager identified 67 residents received nutrition from the kitchen. Findings: On 04/07/25 at 8:24 a.m., the following opened food items were not labeled with the open and use by dates in the walk-in freezer: a. one plastic freezer bag three quarters full of waffles, b. one plastic freezer bag three quarters full of tater tots, c. one plastic freezer bag one quarter full of chicken patties, d. one plastic freezer bag three quarters full of round biscuits, e. one plastic freezer bag three quarters full of crinkle cut fries, and f. one plastic freezer bag one quarter full of okra. On 04/07/25 at 8:37 a.m., the following opened	C 391		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/12/2025
NAME OF PROVIDER OR SUPPLIER BELLAROSE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 18001 EAST 51ST STREET TULSA, OK 74134		
(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 391	Continued From page 4 food items were not labeled with the open and use by date in the walk-in refrigerator: a. one 24 oz plastic shaker bottle half full of Kraft grated parmesan cheese, b. one 32 oz plastic bottle half full of Motts 100% juice, and c. one 64 oz plastic bag one half full of parmesan cheese blend. On 04/07/25 at 8:42 a.m., the following food items were opened and not in storage containers with tight fitting lids on shelf #2 in the dry storage: a. one box half full of quick oats. Marked with use by date of 02/19/25, and b. one 40 oz box one third full of Jiffy brand corn muffin mix (cornbread). Marked with use by date of 02/18/25, and c. one 28 oz box a third full of Cream of Wheat (hot cereal). A facility policy titled "Food Handling," dated 01/2018, read in part, "All local, state and federal standards and regulations are followed to assure a safe sanitary food service department. On 04/07/25 at 8:47 a.m., the dietary manager was asked about the kitchen policies to ensure proper and safe food storage and to ensure all foods were labeled and dated with an expiration date. The dietary manager stated, "Many of my kitchen staff are new to the position, and are not consistent with proper storage, labeling and dating food yet. I know from my experience, all open foods should be properly stored, labeled and dated. I will throw the opened items into the trash."	C 391		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT	C 542	Refer to POC Template, Survey Event ID # SILJ11, ID Prefix Tag C 542	08/01/2025