OKLAHOMA
State Department
of Health

Delivery via email to: Mpollard@brookdale.com

June 5, 2023

License Number: AL7401

Ms. Mistie Pollard, Administrator
Brookdale Bartlesville North
5420 Southeast Adams Blvd
Bartlesville, OK 74006

RE: Survey Event ID: UU3I11

Dear Ms. Pollard:

On **May 25, 2023**, agents from our office concluded a State Licensure survey 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 25, 2023.

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 (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 Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action 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 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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

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

Facilities may 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.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7401	A. BUILDING: _____ B. WING _____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BARTLESVILLE NORTH	5420 SOUTHEAST ADAMS BLVD BARTLESVILLE, OK 74006

(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 survey was conducted from 05/24/23 through 05/25/23. Listed below are abbreviations that will be used throughout this document. AED - Assistant Executive Director CNA - Certifide Nurse Aide DSC - Dining Service Coordinator ED - Executive Director F - Fahrenheit HWC - Health and Wellness Coordinator LEC - Life Enrichment Coordinator MAT - Medication Administration Technician RCC - Resident Care Coordinator RSA - Resident Service Attendant	C 000		
C 391 SS=F	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 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 facility failed to ensure food was stored, prepared and served in a sanitary manner. The "Assisted Living Resident Condition and Care Overview" form documented 19 residents resided in the facility. Findings: Chapter 257 read in part, "...In equipment such	C 391		

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C 391	Continued From page 1 as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers...(A) At a frequency specified by the manufacturer, or (B) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold...310:257-3-20. Effectiveness (a) Except as provided in (b) of this Section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles...310:257-7-105. Equipment...shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor...310:257-3-12...Food employees shall clean their hands and exposed portions of their arms as specified under OAC 310:257-3-10 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (1) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (2) After using the toilet room; (3) After caring for or handling service animals or aquatic animals as specified in OAC 310:257-3-21(b); (4) Except as specified in OAC 310:257-3-18(b), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (5) After handling soiled equipment or utensils; (6) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (7) When switching between working with raw food and	C 391		

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C 391	Continued From page 2 working with ready-to-eat food; (8) Before donning gloves to initiate tasks that involve working with food; and (9) After engaging in other activities that contaminate the hands..." A facility policy, titled "TEMPERATURES AND SAFE FOOD HANDLING" revised 09/18/18, read in part, "...b. Maintain personal hygiene of food personnel. Wash hands 20 seconds. Wet hands, apply soap, lather and rub hands together 20 seconds, rinse hands, dry hands with disposable towel. Discard paper towel in a step-on trash can...o. Food and Nutrition Services personnel should wash their hands thoroughly..." On 05/24/23 at 3:30 p.m., during the initial tour of the kitchen, a container of chili was observed in the refrigerator, dated 05/23/23, and the lid was not sealed on the container. At that time the DSC stated the chili was not sealed properly and should have been thrown out. Two "Thick and Easy Drinks" were observed in the In the refrigerator which had been opened and were not dated when they were opened. On 05/24/23 at 3:41 p.m., Cook #1 was observed to touch the trash can lid to throw away trash. They then returned to the prep area touched a towel in his apron and a drink cup they were drinking from. The cook then returned to the stove and stirred the potato soup. Hand washing was not observed during this observation. On 05/24/23 at 3:46 p.m., MAT #1 was observed to enter the kitchen area. The MAT went to the refrigerator and retrieved a nectar thick liquid and poured some into a glass. They then returned the bottle to the refrigerator and left the kitchen. They were not observed to put on a hair net or	C 391		

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C 391	Continued From page 3 wash their hands when entering the kitchen. On 05/24/23 at 3:49 p.m., Cook #1 was observed to dispose of the chili at the disposal and then was observed to go to the stove and stirred the food items on the stove without washing their hands. On 05/24/23 at 3:50 p.m., an air fryer was observed sitting on the floor of the kitchen under an open counter area. On 05/24/23 at 3:52 p.m., Cook #1 was observed to don gloves and got the mixer out. They were observed to put the mixer together and mixed the potato soup. They were not observed to wash their hands before putting on the gloves. On 05/24/23 at 3:54 p.m., Cook #1 was observed to use the sanitizer cloth to wipe the counter. They then changed gloves but did not wash their hands before placing clean gloves on and returned to mixing the soup. On 05/24/23 at 3:59 p.m., the ice machine was wiped with a clean white cloth from the ice drop. The clean white cloth was observed to have a pink and brown substance on it after wiping the ice drop. At that time the DSC stated they did not know what the substances from the ice machine were. She stated the maintenance person cleaned the ice machine once a month. On 05/24/23 at 4:01 p.m., maintenance person #2 was observed to enter the kitchen. They did not put on a hair net or wash their hands. They stated they normally cleaned the ice machine at the first of the month. They were observed to stay in the kitchen and clean the ice machine.	C 391		

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C 391	Continued From page 4 On 05/24/23 at 4:03 p.m., the DSC returned to the kitchen and did not wash their hands. On 05/24/23 at 4:06 p.m., Cook #1 was observed to touch the glasses on their face, touch their shoulder, went out of the kitchen, re-entered the kitchen, got a cutting board and a knife, took them to the prep area, wiped their hand on a red towel in their apron, and stirred the potato soup which was on the stove. During this observation, the cook did not wash their hands. On 05/24/23 at 4:09 p.m., Cook #1 left the kitchen area and then returned to the kitchen and did not wash their hands. They gathered six cans of sauerkraut, placed gloves on, and opened five of the cans. Cook #1 took the cans to the trash, opened the lid with a gloved hand, put cans in the trash, touched a red cutting board hanging on the wall, and then brought the yellow cutting board and a knife out of a drawer to the prep area. They then placed the sauerkraut in a pan, cut open a bag of sausages with the knife, then cut up the sausages and placed them on the kraut in the pan while wearing the same gloves. Cook #1 touched his glasses with their gloved hand and continued cutting the sausages. During this observation, the cook did not wash their hands. On 05/24/23 at 4:14 p.m., Cook #1 touched the lid to the trash can, his glasses, and removed the gloves they had been using. He labeled and dated the bag they had placed the extra sausages in with a permanent marker. They were observed to wipe their face and touched the trash can lid and no hand washing observed. On 05/25/23 at 7:40 a.m., Cook #1 was observed preparing breakfast. They had on gloves then removed the gloves and placed oil in a skillet on	C 391		

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C 391	Continued From page 5	C 391		

the stove top to cook eggs. They were observed to touch their cap while getting bowls from the cabinet and went to the stove to stir the gravy. Cook #1 was observed to scratch the back of their neck while standing looking at the menu, then he went to the pantry, then to the freezer, moved item on the counter top, then back to the pantry. No hand washing was observed.

On 05/25/23 at 7:45 a.m., the trash can was observed to be uncovered.

On 05/25/23 at 7:47 a.m., Cook #1 left the kitchen. When they returned to the kitchen they did not wash their hands. They wiped the prep counter with the sanitizer rag, then wiped their hands on the red towel in his apron. Cook #1 then scratched their arm and stirred the gravy. Hand washing was not observed.

On 05/25/23 at 7:55 a.m., Cook #1 was observed to leave the kitchen. They returned with the maintenance person #2 and showed them a broken thermometer. Cook #1 opened a drawer and touched multiple items in the drawer. Hand washing was not observed.

On 05/25/23 at 8:01 a.m., Cook #1 placed gloves on his unwashed hands and fried two eggs in the skillet on the stove top.

On 05/25/23 at 8:05 a.m., breakfast service started. Cook #1 removed the gloves he fried the eggs in and wiped his hands on the red towel in his apron and put on a new pair of gloves without washing his hands.

On 05/25/23 at 12:17 p.m., CNA #1 was observed to enter the kitchen and wash their hands. They did not put on a hair net. They were assisting the

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C 391	Continued From page 6 cook and covering plates with plastic wrap. On 05/25/23 at 12:21 p.m., the RCC was asked about the staff using hair nets and hand washing when entering the kitchen. The RCC stated the staff should use a hair net when in the kitchen. She stated staff should wash their hands when entering the kitchen and before putting on gloves and between glove changes or when they touch anything dirty. She stated the equipment should not be on the floor in the kitchen. She stated the trash should be covered, items in the refrigerator should be labeled and dated, the ice machine should be cleaned once a month, and the lid covers should not be reused when contaminated.	C 391		
C 701 SS=D	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure hot water available for resident use did not exceed 115 degrees Fahrenheit. The "Assisted Living Resident Condition and	C 701		

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C 701	Continued From page 7 Care Overview" report, documented 19 residents resided in the facility. Findings: On 05/25/23 at 2:22 p.m.., a tour of resident rooms to obtain water temperatures was conducted. The following observations were made: a. the hot water temperature at the sink in the kitchen area for room 131 was 120.9 degrees F and the bathroom sinks for room 117 and 105 were 117.5 degrees F and 127.8 degrees F with a hand held thermometer, and b. the hot water temperature in the shower for rooms 131 and 105 were 119.0 and 117.6 degrees F with a hand held thermometer. The water temperature logs were reviewed from May 2022 to May 2023 and there was no water temperatures in the resident rooms over 113 degrees F. 05/25/23 at 2:15 p.m., Res #7 stated she had no issues with her water being to hot. 05/25/23 at 2:25 p.m., Res #9 was in the dining room playing dominoes. She stated she had not noticed her water being to hot. She stated they adjust the water for the shower to be comfortable. 05/25/23 at 2:55 p.m., Res # 6 stated he was able to adjust the water at his sink to a comfortable temperature. Stated he thought the maintenance man was adjusting the temperature to be cooler. He denied the water ever being too hot for him.	C 701		

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C 701	Continued From page 8 On 05/25/23 at 3:00 p.m., maintenance man #1 stated the showers have an actuator on them that shuts the hot water down at 117 degrees. On 05/25/23 at 3:22 p.m., the ED was shown the temperature logs and told her the water temperatures observed today. She confirmed the water temperatures today were to high and stated she would get the corporate maintenance involved. On 05/25/23 at 4:06 p.m., maintenance man #1 stated he stated they adjusted the water for the laundry which made the room temperatures higher. He stated he had readjusted the water and when he re checked the rooms he did not have a temp higher than 113.6 degrees F.	C 701		

OKLAHOMA
State Department
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Delivery via email to: Mpollard@brookdale.com

June 15, 2023

License Number: AL7401

Ms. Mistie Pollard, Administrator
Brookdale Bartlesville North
5420 Southeast Adams Blvd
Bartlesville, OK 74006

RE: Survey Event UU3I11

Dear Ms. Pollard:

On **May 25, 2023**, a Licensure inspection 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 **June 30, 2023**.

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,

Tempal Killman

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/9/2023** **Facility Name:** Brookdale Bartlesville North **License Number:** AL7401 **Survey Event ID:** UU3I11 **Date Survey Completed: 5/25/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 391	Based on: observation, record review, and interview, the facility failed to ensure food was stored, prepared and served in a sanitary manner.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	The items noted in the survey not to be properly covered or stored were disposed of or properly stored as applicable. Items noted in the survey without dates or labels were dated, labeled if indicated or disposed of. Items noted as being past use by date were disposed of. The trash can lid was located and put on the can. The air fryer was moved off of the floor. The maintenance technician cleaned the ice machine. The Dining Services Coordinator (DSC) inserviced cooks on adherence to handwashing policy. Staff inserviced over using hair nets while in kitchen as well as handwashing policy.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents have the potential to be affected by the alleged deficient practice. The DSC or designee audited the contents of the refrigerator and dry storage area for compliance with dating, labeling, storage and disposal. All trash cans were reviewed to verify lids were in place. The air fryer was moved from off of the floor. The ice machine was cleaned. Corrective action was taken as indicated. Cooks and staff were inserviced on handwashing.
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?	The DSC will inservice cooks and kitchen staff on the following policies: Safety and Sanitation – Labeling, Safety and Sanitation – Leftovers, Safety and Sanitation – Storage of Perishable Foods, Safety and Sanitation – Storage of Non-Perishable Food, Operations/Clinical Services – Handwashing/Hand Hygiene. Inservice records will be maintained. Maintenance staff inserviced over cleaning ice machine.
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;	To assist in sustaining the corrective actions above, the Executive Director (ED) or designee will conduct periodic random audits of food storage, dating, labeling, disposal, trash can compliance, hair net usage compliance, cleaning of ice machine and location of small kitchen appliances.

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.	Records of such random audits will be maintained and reported at the community's QA meeting. The above will be addressed and discussed at QA meeting. Audit records will be maintained for 6 months. Follow up inservices will occur as indicated and records of such inservices will be maintained.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Mistie Pollard** OAC 310:663-25-4(F)	**Date** 6/9/2023

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: 6/9/2023** **Facility Name:** Brookdale Bartlesville North **License Number:** AL7401 **Survey Event ID:** UU3I11 **Date Survey Completed: 5/25/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 701	Based on: observation, record review and interview, the facility failed to ensure hot water available for resident use did not exceed 115 degrees Farenheit.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	The issue noted in the survey was addressed. Maintenance Tech (MT) adjusted temperature on hot water tanks. Temperatures were re-checked and will continue to be monitored weekly by MT. Maintenance staff were inserviced over hot water temperature requirements.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents have the potential to be affected by the alleged deficient practice. The MT checked the temperatures and made adjustments to hot water heater. Corrective action was taken as indicated. Maintenance staff were inserviced over the monitoring of and maintenance of hot water temperatures.
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?	Maintenance staff inserviced over monitoring and maintenance of hot water temperatures.
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.	To assist in sustaining the corrective action above, the lead maintenance tech or designee will conduct periodic random audits of the hot water temperatures and logs. Records of such random audits will be maintained and reported at the community's QA meeting. The above will be addressed and discussed at QA meeting. Audit records will be maintained for 6 months. Follow up inservices will occur as indicated and records of such inservices will be maintained.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Mistie Pollard** OAC 310:663-25-4(F)	**Date** 6/9/2023

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: Angela Bates <abates@brookdale.com>

August 10, 2023

License Number: AL7401

Ms. Angela Bates, Administrator
Brookdale Bartlesville North
5420 Southeast Adams Blvd
Bartlesville, OK 74006

RE: Survey Event UU3I12

Dear Ms. Bates:

On **August 9, 2023,** a paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 25, 2023,** have now been corrected effective **June 30, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7401	A. BUILDING: _____ B. WING _____	R 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BARTLESVILLE NORTH	5420 SOUTHEAST ADAMS BLVD BARTLESVILLE, OK 74006

(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 paper/re-visit was conducted on 08/09/23. 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