OKLAHOMA
State Department
of Health

Delivery via email to: Mpollard@brookdale.com

June 5, 2023

License Number: AL7402

Ms. Mistie Pollard, Administrator
Brookdale Bartlesville South
3737 Southeast Camelot Drive
Bartlesville, OK 74005

RE: Survey Event ID: UO6D11

Dear Ms. Pollard:

On **May 24, 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 24, 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
	AL7402	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BARTLESVILLE SOUTH	3737 SOUTHEAST CAMELOT DRIVE BARTLESVILLE, OK 74005

(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 05/23/23 through 05/24/23. Listed below are abbreviations that will be used throughout this document. AED - Assistant Executive Director DSC - Dining Service Coordinator ED - Executive Director F - fahrenheit HWC - Health and Wellness Coordinator LEC - Life Enrichment Coordinator oz - ounces 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 27 residents resided in the facility. Findings: 1. On 05/23/23 at 10:25 a.m., during the initial tour of the kitchen, Cook #1 placed two pies in the refrigerator without covers. The contents of	C 391		

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C 391	Continued From page 1 the refrigerator were observed and opened bottles of nectar thick water and juice were observed with no documentation of the dates they were opened on the bottles. A bottle of grapefruit juice was dated 09/05, as a received date, in the refrigerator but did not document the date it had been opened. There were several drinks in pitchers one orange, two dark colored drinks, and three red drinks, in the refrigerator, which did not document a label of the contents or the date prepared. A container labeled peach cobbler, dated with a used by date of 05/20/23, was observed in the refrigerator. A container, labeled carrots, was observed with the lid on the container not properly sealed and was open to air. A container, labeled minestrone was observed to have a date of 05/17/23. A container of fresh zucchini was observed to have mold on several of the zucchini. A box of red bell peppers were observed to have mold on some of the peppers. The zucchini and bell peppers were observed to have been open to air in the refrigerator. Two stalks of celery were observed in the refrigerator, one half way in a re-sealable bag and the other stalk laying beside it in the refrigerator. A box of asparagus was observed in the refrigerator did not document a received or use by date. A container of black berries was observed to have mold on the berries. A re-sealable bag of what appeared to be cooked chicken (confirmed to be chicken by Cook #1) was observed in the refrigerator and was not labeled to contents. A re-sealable bag of lunch meat was not labeled when opened but documented a use by date used by 05/22/23. Two containers of strawberries were observed and one container had mold on the berries. A container labeled pot roast was observed with a use by date of 05/20/23.	C 391		

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C 391	Continued From page 2 On 05/23/23 at 10:40 a.m., the trash can was observed full and did not have a lid. On 05/23/23 at 10:41 a.m., Cook #1 stated the food and drinks in the refrigerator should all have been labeled and dated. They stated the left overs could be kept for three days. On 05/23/23 at 10:42 a.m., the dry storage was observed. Boxes of food were observed on the floor, including one full box of Italian bread and another box of bread, which had been opened, and contained three loaves of bread. A box of sugar packets, a box of spoons, a box of soup base, two boxes of drink mix, a box of catsup, a box of stuffing mix, and a bottle of ginger ale in a plastic bag were observed sitting on the floor. A bowl covered with aluminum foil was observed on the shelf in the storage room labeled with a resident's name and "Bran Cereal" did not document a date it was placed there or when it was to have been used. On 05/23/23 at 10:47 a.m., Cook #1 stated the boxes of food should not have been on the floor in the storage room. On 05/23/23 at 10:56 a.m., Cook #1 stated they did not know where the lid to the trash can was, but confirmed it should have been covered. On 05/23/23 at 11:00 a.m., the RSA started unloading the snack cart. She was placing items back in the refrigerator such as a container of blackberries. On 05/03/23 at 11:08 a.m., the RSA stated she had washed the blackberries she took out for snack by running them under water in the original container. She stated she noticed the other	C 391		

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C 391	Continued From page 3	C 391		

container had molded berries in it. She stated she did not know the containers should have been dated.

On 05/23/23 at 11:16 a.m., the fryer and the air fryer were observed to have grease and debris on them. Cook #1 stated they had not used the fryer and did not know when it had been cleaned. They confirmed the air fryer had grease on the outside of it.

A recipe, for the 05/23/23 lunch meal, documented serving size for the veal patties was to have been 6 oz. The bread stuffing was documented to have been 1/2 cup or four oz. and the roasted zucchini was documented to have been 1/2 of a cup or four oz. The dinner roll was documented to have been 1.5 ounces for each roll.

On 05/23/23 at 11:45 a.m., Cook #1 prepared to obtain a temperature of the noon meal, she got a clean cloth and wet it under running water. She then cleaned the thermometer with the wet cloth and obtained a temperature of the salad and stated it was 52.2 degrees F. She then cleaned the thermometer with the cloth again and obtained a temperature of the veal patties and stated it was 186.9 F. Cook #1 repeated the process and obtained a temperature of the yellow squash and stated it was 129 F, the stuffing was 184.1 F, and the rolls were 196 F. The salad, rolls, and veal, were observed to sit out on the counter and the stuffing and squash were sat on the stove until the meal service started at 11:57 a.m. During meal service a 2 oz scoop was observed to have been used for measuring the servings of squash. The salad and stuffing were served with large spoons.

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C 391	Continued From page 4 On 05/23/23 at 12:14 a.m. Cook #1 used a 1/2 of a veal patty for the last four meals. They stated it was a half serving as the kitchen had ran out of veal patties. One regular meal did not receive a roll but they served a slice of bread because they ran out of rolls. There was only one pureed meal and the cook pureed 1/2 a veal patty as they had run out of veal. The puree meal did not receive any kind of bread. On 05/23/23 at 12:25 p.m., Cook #1 stated the holding temperatures for warm food were 170 to 180 degrees F and cold foods should have been held at 52 to 60 degrees. They stated the portion sizes were on the recipe. They stated they did not use scoops for the stuffing or salad and the residents at the assisted feeding table received a 1/2 serving of a veal patty because they did not eat very much. The cook stated one resident who ate in their room also received 1/2 of the meat. Cook #1 stated the resident on the hall should have received a whole veal patty. On 05/24/23 at 8:29 a.m., the DSC stated the veal should have been 6 oz for each resident. They stated the residents who received 1/2 a patty did not get enough protein. They stated the temperatures of the hot food should have been 165 degrees F for meat and vegetables should be at 150 degrees F or above. The DSC stated cold food should have been held at 40 degrees F or below. They stated some sort of bread was always served to the residents but she had four or five residents who did not like bread so she did not know how they ran out of rolls. The DSC stated all residents should have received bread unless they did not want it. She stated the trash should always have been covered and it was now. They stated the fryer should have been cleaned at least once a week and They had not	C 391		

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C 391	Continued From page 5 used it in about two weeks. The DSC stated thermometer should have been cleaned with an alcohol pad. They stated the serving size for the stuffing and squash should have been a 1/2 a cup which was 4 oz and not 2 oz as was served on the noon meal the day before. The menu for the salad was not provided and they were not able to see the serving size. She stated they had a steam table in the kitchen. The DSC stated they left the meal in the oven on low and did not use the food warmer. 2. On 05/23/23 at 11:44 a.m., the noon meal service was observed. A staff member was observed to bring two pitchers of ice to the dining area. One of the pitchers of ice was observed to have a metal scoop placed in the ice. On 05/23/23 at 11:52 a.m., an unidentified staff member was observed to fill resident glasses with ice from the ice pitcher and return the scoop to the ice pitcher. On 05/24/23 at 8:29 a.m., the DSC stated they were not out in the dining room when they serve the drinks but thought they normally put the scoop in the ice bowl. The DSC confirmed the ice scoop should not have been returned to the ice pitcher after filling resident glasses.	C 391		
C 393 SS=E	310:663-3-8(c) FOOD PREPARTION, STORAGE AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or	C 393		

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C 393	Continued From page 6 cooked may be refrigerated for up to forty-eight (48) hours. This Rule is not met as evidenced by: Based on observation, record review, and interview, it was determined the center failed to ensure: a. leftover potentially hazardous foods were disposed of within 24 hours. b. non-potentially hazardous were disposed of after 48 hours. c. each resident received the required amount of food as per the recipe instructions for one of one meal observed. The "Assisted Living Resident Condition and Care Overview" form documented 27 residents resided in the facility. Findings: On 05/23/23 at 10:25 a.m., during the initial tour of the a container labeled peach cobbler, dated with a used by date of 05/20/23, was observed in the refrigerator. A container, labeled carrots, was observed with the lid on the container not properly sealed and was open to air. A container, labeled minestrone was observed to have a date of 05/17/23. A container labeled pot roast was observed with a use by date of 05/20/23. On 05/23/23 at 10:41 a.m., Cook #1 stated the left overs could be kept for three days.	C 393		

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C 393	Continued From page 7 A recipe, for the 05/23/23 lunch meal, documented serving sized for the veal patties was to have been 6 oz. The bread stuffing was documented to have been 1/2 cup or four oz. and the roasted zucchini was documented to have been 1/2 of a cup or four oz. The dinner roll was documented to have been 1.5 ounces for each roll. On 05/23/23 at 12:05 a.m., Cook #1 was observed to use two oz scoop for measuring the servings of squash. The salad and stuffing were served with large spoons. On 05/23/23 at 12:14 a.m. Cook #1 used a 1/2 of a veal patty for the last four meals. They stated it was a half serving as the kitchen had ran out of veal patties. One regular meal did not receive a roll but they served a slice of bread because they ran out of rolls. There was only one pureed meal and the cook pureed 1/2 a veal patty as they had run out of veal. The puree meal did not receive any kind of bread. On 05/23/23 at 12:25 p.m., Cook #1 stated the portion sizes were on the recipe. She stated she did not use scoops for the stuffing or salad and the residents at the assisted feeding table received a 1/2 serving of a veal patty because they did not eat very much. She stated one resident who ate in their room also received 1/2 of the meat. Cook #1 stated the resident on the hall should have received a whole veal patty. On 05/24/23 at 8:29 a.m., the DSC stated the veal should have been 6 oz for each resident. They stated the residents who received 1/2 a patty did not get enough protein. They stated some sort of bread was always served to the residents but they had four or five residents who	C 393		

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C 393	Continued From page 8 did not like bread so they did not know how they ran out of rolls. The DSC stated all residents should have received bread unless they did not want it. She stated the serving size for the stuffing and squash should have been a 1/2 cup which was four oz and not two oz as was served on the noon meal the day before.	C 393		

OKLAHOMA
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Delivery via email to: Mpollard@brookdale.com

June 19, 2023

License Number: AL7402

Ms. Mistie Pollard, Administrator
Brookdale Bartlesville South
3737 Southeast Camelot Drive
Bartlesville, OK 74005

RE: Survey Event UO6D11

Dear Ms. Pollard:

On **May 24, 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 **July 10, 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: 6/7/2023** **Facility Name:** Brookdale Bartlesville South **License Number:** AL-7204 **Survey Event ID:** U06D11 **Date Survey Completed: 5/24/2023**

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: Staff will be inserviced on food storage, preparation and sanitation. Dining staff will be retrained on proper sanitary measures and safe food handling.

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 or moldy were disposed of. The trash can lid was located and put on the can. The items noted in the dry storage area were reviewed and placed on shelf or dispoed of if indicated. The fryer and air fryer were cleaned. The Dining Services Coordinator (DSC) inserviced cooks on adherence to recipe portions and temperature taking procedures. The DSC inserviced dining staff on the serving food 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 fryer and air fryer were cleaned. Corrective action was taken as indicated. The Associate Director of Dining Services will complete inservice with all cooks on June 14, 2023 to address issues and train them on deficient practices.
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 – Hot Holding, Safety and Sanitation – Storage of Perishable Foods, Safety and Sanitation – Storage of Non-Perishable Food, Safety and Sanitation – Thermometer Use, Sanitation – Cleaning the Deep Fat Fryer, Standard Portions. The DSC will inservice staff responsible for delivering meals and beverage on the Serving Food Policy. Inservice records will be maintained.

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 actions above, the Executive Director (ED) or designee will conduct periodic random audits of food storage, dating, labeling, disposal, trash can compliance, fryer cleanliness and adherence to diets and portions. Random audits will be completed by ED or designee. Records of such random audits will be maintained and reported at the community's 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?	7/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Mistie Pollard** OAC 310:663-25-4(F)	**Date 6/7/2023**

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: 6/7/2023** **Facility Name:** Brookdale Bartlesville South **License Number:** AL7402 **Survey Event ID:** U06D11 **Date Survey Completed: 5/24/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C393	Based on: Observation, record review, and interview, it was determined the center failed to ensure: leftover potentially hazardous foods were disposed of within 24 hours, non-potentially hazardous foods were disposed of after 48 hours, each resident received the required amount of food as per the recipe instructions for one of one meal observed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Staff will be inserviced on food storage of leftover food items. Dining staff will be retrained on safe food handling and disposal of potentially hazardous foods within the proper time period. Dining staff will be inserviced by Associate Director of Dining Services over above issues as well as making sure each resident receives the required amount of food per the recipe instructions.

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 or moldy were disposed of. The Dining Services Coordinator (DSC) inserviced cooks on adherence to recipe portions.
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 for compliance with dating, labeling, storage and disposal. Corrective action was taken as indicated. The DSC inserviced cooks on adherence to recipe portions.
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 and Associate Director of Dining Services will inservice the cooks and kitchen staff on the following policies: Safety and Sanitation – Labeling, Safety and Sanitation – Leftovers, Safety and Sanitation – Hot Holding, Safety and Sanitation – Storage of Perishable Foods, Safety and Sanitation – Storage of Non-Perishable Foods, Safety and Sanitation – Thermometer Use, Sanitation – Cleaning the Deep Fat Fryer, Standard Portions.
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	To assist in sustaining the corrective actions above, the Executive Director or designee will conduct periodic random audits of food storage, dating, labeling, disposal and adherence to diets and portions. Records of such random audits will be maintained and reported at the community's QA meeting.

c. How monitoring records will be kept to evidence the correction.	This will be discussed in the next 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?	7/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Mistie Pollard** OAC 310:663-25-4(F)	**Date 6/7/2023**

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.

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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: AL7402

Ms. Angela Bates, Administrator
Brookdale Bartlesville South
3737 Southeast Camelot Drive
Bartlesville, OK 74005

RE: Survey Event UO6D12

Dear Ms. Bates:

On **August 9, 2023,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 24, 2023,** have now been corrected effective **July 10, 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
	AL7402	A. BUILDING: _____ B. WING _____	R 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BARTLESVILLE SOUTH	3737 SOUTHEAST CAMELOT DRIVE BARTLESVILLE, OK 74005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 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