OKLAHOMA
State Department
of Health

Delivery via email to: lstewart@villagioliving.com

July 2, 2024

License Number: NH5526AL

Ms. Lydia Stewart, Administrator
Bradford Village Healthcare Center
906 North Boulevard
Edmond, OK 73034

RE: Survey Event ID: ING811

Dear Ms. Stewart:

On **June 28, 2024**, 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 **June 28, 2024**.

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

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH5526AL	A. BUILDING: _____ B. WING _____	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD VILLAGE HEALTHCARE CENTER	906 NORTH BOULEVARD EDMOND, OK 73034

(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 06/26/24 through 06/27/24. Facility Census: 43 The following abbreviations will be used throughtout this document: CDM- certified dietary manager CMA- certified medication aide	C 000		
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 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. foods were labeled, dated, and secured; b. a freezer was maintained in good repair; c. staff used hair restraint in the kitchen; and d. staff maintained infection control during food prep for one of one kitchen observation. The Executive Director identified 43 residents resided in the center. Findings: An undated "Labeling, Use-By Dates, and	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH5526AL	A. BUILDING: _____ B. WING _____	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD VILLAGE HEALTHCARE CENTER	906 NORTH BOULEVARD EDMOND, OK 73034

(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 1 Disposal of Potentially Hazardous Leftovers" policy, read in part, "All containers or packaging of potentially hazardous leftovers must be clearly labeled." The policy also read, "...Calculate the use-by date...based on food safety guidelines." An undated and untitled policy, read in part, "Wear a hair net-no loose hair is allowed." On 06/26/24 at 10:26 a.m., a tour of the kitchen was conducted. The following observations were made: a. a meat freezer with accumulation of ice buildup at the bottom and a leak on the floor of the room coming from the freezer, b. an opened bottle of barbecue sauce and mayonnaise with no date in the refrigerator, b. a clear plastic bag containing a cooked potatoe, with no label or date, and not secured, c. two clear plastic bags containing white shredded cheese with no label or date, d. a clear plastic bag containing white chopped meat with no label or date, e. a clear plastic bag containing sliced lemons with no label or date, f. a silver pan of red sauce with no label or date, g. a black plastic cup of red sauce with no label or date, h. a plastic cup of white sauce with no label or date,	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH5526AL	A. BUILDING: _____ B. WING _____	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD VILLAGE HEALTHCARE CENTER	906 NORTH BOULEVARD EDMOND, OK 73034

(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 2 i. an opened glass of banana peppers with no date, and j. Dietary Aide #2 without a hair net in the food prep area. On 06/26/26 at 10:50 a.m., the CDM stated the freezer had not been in good repair since they started working at the center on 10/23. They stated the ice will build up and they had to occasionally remove all food items from it, thaw it out to clean up the ice buildup. They stated maintenance was aware of it. They stated they check the freezer daily to ensure all foods stay frozen. On 06/26/26 at 10:56 a.m., the CDM stated all the food items above should have been secured, labeled, and dated. They stated the two bags of cheese was mozzarella and feta cheese, the red sauce was tomato sauce, the white sauce was a desert sauce, and the white chopped meat was chicken. The CDM stated the foods were put in the refrigerator the evening of 06/25/24. On 06/26/26 at 11:04 a.m., Cook #1 was observed sweeping the floor without gloves, they discarded the trash, retrieved and donned gloves without washing their hands, proceeded to grab some grapes, and put them on plates. On 06/26/26 at 11:07 a.m., Cook #1 with the same gloves, retrieved some bananas and put them on the prep counter. On 06/26/26 at 11:08 a.m., Cook #1 with the same gloves, retrieved apples and oranges from the refrigerator, washed them at the sink, and used paper towels to dry them.	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH5526AL	A. BUILDING: _____ B. WING _____	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD VILLAGE HEALTHCARE CENTER	906 NORTH BOULEVARD EDMOND, OK 73034

(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 Cook #1 did not change their gloves. On 06/26/26 at 11:09 a.m., Cook #1 with the same gloves, cut the apples on a chopping board and put them on a plate. On 06/26/26 at 11:13 a.m., Cook #1 stated they were to change their gloves between tasks. They stated they should have washed their hands after sweeping the floor. On 06/26/26 at 11:16 a.m., Dietary Aide #2 stated they were to wear a hair restraint in the kitchen. On 06/26/26 at 12:22 p.m., the Executive Director stated maintenance had replaced the seal on the freezer and they were not aware the freezer continued to have ice buildup and leak.	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 and interview, the center failed to ensure water temperatures in bathing rooms were no greater than 115 degrees	C 701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH5526AL	A. BUILDING: _____ B. WING _____	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD VILLAGE HEALTHCARE CENTER	906 NORTH BOULEVARD EDMOND, OK 73034

(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 701	Continued From page 4 Fahrenheit. The Executive Director identified 43 residents resided in the center. Findings: On 06/26/24 at 1:03 p.m., the hot water temperature of the bathroom sink in room 101 was 136.7 degrees Fahrenheit. On 06/26/24 at 1:05 p.m., Resident #3 stated the water was too hot and they had to let it run for a while to prevent burning themselves. On 06/26/24 at 1:14 p.m., the hot water temperature of the bathroom sink in room 102 was 136 degrees Fahrenheit. Resident #8 stated the water was too hot, so they had to be careful when using the sink. On 06/26/24 at 1:35 p.m., the Maintenance Supervisor stated they checked the temperature of the water monthly. On 06/26/24 at 1:40 p.m., the Maintenance Supervisor and Maintenance #1 checked room 101 and room 102 bathroom sink temperatures. They stated the water temperatures were high. They were not sure what the exact temperatures for bathing should be, but stated it should be less than 120 degrees Fahrenheit.	C 701		
C6000 SS=E	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to,	C6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH5526AL	A. BUILDING: _____ B. WING _____	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD VILLAGE HEALTHCARE CENTER	906 NORTH BOULEVARD EDMOND, OK 73034

(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
C6000	Continued From page 5 an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this	C6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH5526AL	A. BUILDING: _____ B. WING _____	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD VILLAGE HEALTHCARE CENTER	906 NORTH BOULEVARD EDMOND, OK 73034

(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
C6000	Continued From page 6 section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services. This Rule is not met as evidenced by: Based on record review and interview, the center failed to conduct registry screening and background checks in a timely manner for three (CMA #1, CMA #2, and Dietary Aide #1) of five sampled personnel files reviewed. The Executive Director identified 43 residents resided in the center. Findings:	C6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH5526AL	A. BUILDING: _____ B. WING _____	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD VILLAGE HEALTHCARE CENTER	906 NORTH BOULEVARD EDMOND, OK 73034

(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
C6000	Continued From page 7 CMA #1 was hired on 02/26/24. Their registry screening and background check was completed on 04/15/24. CMA #2 was hired on 03/06/24. Their registry screening and background check was completed on 04/12/24. Dietary Aide #1 was hired on 05/12/24. Their registry screening and background check was completed on 06/26/24. On 06/27/24 at 9:12 a.m., the Executive Director stated registry screening and background checks were to be completed a week or two upon hire. They stated the registry screening and background check for CMA #1, CMA #2, and Dietary Aide #1 were not completed in a timely manner.	C6000		

OKLAHOMA
State Department
of Health

Delivery via email to: Lydia Stewart <lstewart@villagioliving.com>

July 22, 2024

License Number: NH5526AL

Ms. Lydia Stewart, Administrator
Bradford Village Healthcare Center
906 North Boulevard
Edmond, OK 73034

RE: Survey Event ING811

Dear Ms. Stewart:

On **June 28, 2024**, 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 16, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/9/2024** **Facility Name:** Click here to enter facility name. **License Number:** NH5526AL **Survey Event ID:** ING811 **Date Survey Completed: 6/28/2024**
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 391	Based on: Based on observation, record review, and interview, the center failed to ensure: a. foods were labeled, dated, and secured; b. a freezer was maintained in good repair; c. staff used hair restraint in the kitchen; and d. staff maintained infection control during food prep for one of one kitchen observation. The Executive Director identified 43 residents resided in the center. Findings: An undated "Labeling, Use-By Dates, and Disposal of Potentially Hazardous Leftovers" policy, read in part, "All containers or packaging of potentially hazardous leftovers must be clearly labeled." The policy also read, "...Calculate the use-by date...based on food safety guidelines." An undated and untitled policy, read in part, "Wear a hair net-no loose hair is allowed." On 06/26/24 at 10:26 a.m., a tour of the kitchen was conducted. The following observations were made: a. a meat freezer with accumulation of ice buildup at the bottom and a leak on the floor of the room coming from the freezer, b. an opened bottle of barbecue sauce and mayonnaise with no date in the refrigerator, b. a clear plastic bag containing a cooked potatoe, with no label or date, and not secured, c. two clear plastic bags containing white shredded cheese with no label or date, d. a clear plastic bag containing white chopped meat with no label or date, e. a clear plastic bag containing sliced lemons with no label or date, f. a silver pan of red sauce with no label or date, g. a black plastic cup of red sauce with no label or date, h. a plastic cup of white sauce with no label or date, i. an opened glass of banana peppers with no date, and j. Dietary Aide #2 without a hair net in the food prep area. On 06/26/26 at 10:50 a.m., the CDM stated the freezer had not been in good repair since they started working at the center on 10/23. They stated the ice will build up and they had to occasionally remove all food items from it, thaw it out to clean up the ice buildup. They stated maintenance was aware of it. They stated they check the freezer daily to ensure all foods stay frozen. On 06/26/26 at 10:56 a.m., the CDM stated all the food items above should have been secured, labeled, and dated. They stated the two bags of cheese was mozzarella and feta cheese, the red sauce was tomato sauce, the white sauce was a desert sauce, and the white chopped meat was chicken. The CDM stated the foods were put in the refrigerator the evening of 06/25/24. On 06/26/26 at 11:04 a.m., Cook #1 was observed sweeping the floor without gloves, they discarded the trash, retrieved and donned gloves without washing their hands, proceeded to grab some grapes, and put them on plates. On 06/26/26 at 11:07 a.m., Cook #1 with the same gloves, retrieved some bananas and put them on the prep counter. On 06/26/26 at 11:08 a.m., Cook #1 with the same gloves, retrieved apples and oranges from the refrigerator, washed them at the sink, and used paper towels to dry them. Cook #1 did not change their gloves. On 06/26/26 at 11:09 a.m., Cook #1 with the same gloves, cut the apples on a chopping board and put them on a

	plate. On 06/26/26 at 11:13 a.m., Cook #1 stated they were to change their gloves between tasks. They stated they should have washed their hands after sweeping the floor. On 06/26/26 at 11:16 a.m., Dietary Aide #2 stated they were to wear a hair restraint in the kitchen. On 06/26/26 at 12:22 p.m., the Executive Director stated maintenance had replaced the seal on the freezer and they were not aware the freezer continued to have ice buildup and leak.

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?	1.) All dining associates will be inserviced on the following: a. Proper label and dating of food items b. Proper storage of food items c. Appropriate infection control procedures d. Use of hairnets while working in the kitchen and dining room. 2.) Removed and discarded any identified potentially unsafe food items identified 3.) The signed inservice documentation will be maintained in the inservice binder.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Regular Audits and Inspections: • Weekly Audits: The ED will conduct weekly random audits of the kitchen and food storage areas using a checklist. This checklist will include checks for proper labeling, dating, securing of food items, freezer maintenance, staff use of hair restraints, and adherence to infection control practices. • Monthly Inspections: Thorough monthly inspections by the Clinical Dietitian Manager (CDM) or a designated supervisor to ensure ongoing compliance and to identify any areas needing improvement. Ongoing Training: • Dining staff will be inserviced on food safety, labeling, hygiene practices, and infection control. • Ensure that all new hires receive this training as part of their onboarding process. • Inservice and document adherence to food safety and infection control policies among all staff. Maintenance and Equipment Checks:

	• Regular Maintenance: Dining staff is to report any equipment or maintenance issues to the Executive Director who will ensure these work orders are entered into a ticket on TELS, the automated work order system utilized at the community.
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.	1. Weekly audits of the kitchen and food storage areas that includes checks for proper labeling, dating, securing of food items, freezer maintenance, staff use of hair restraints, and adherence to infection control practices. 2. The Registered Dietician will conduct a monthly audit or the kitchen and food storage areas that includes checks for proper labeling, dating, securing of food items, feezer maintenance, staff use of hair restraints, and adherence to infection control practices as part of their monthly visit. Results of these audits will be reviewed with the QA committee. Monthly QA Committee meetings will review audit and inspection results, discuss any identified deficiencies, and evaluate the effectiveness of implemented corrective actions. Monthly QA Committee meetings to review the implementation of corrective actions, discuss audit findings, evaluate compliance, and address any new issues that arise. Regular maintenance checks of kitchen equipment, especially the freezer, are part of the QA system. Document all maintenance activities and repairs. Maintaining standardized forms and checklists for audits and inspections, forms to document training sessions, including attendance, materials covered and ensuring these documents are consistently used and updated as needed.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/16/2024
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. Melissa Stewart RD 7/16/24
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: 7/9/2024** **Facility Name:** Villagio of Bradford Village **License Number:** NH5526AL **Survey Event ID:** ING811 **Date Survey Completed: 6/28/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 701	Based on: The center failed to ensure water temperatures in bathing rooms were no greater than 115 degrees Fahrenheit. The Executive Director identified 43 residents resided in the center. Findings: On 06/26/24 at 1:03 p.m., the hot water temperature of the bathroom sink in room 101 was 136.7 degrees Fahrenheit. On 06/26/24 at 1:05 p.m., Resident #3 stated the water was too hot and they had to let it run for a while to prevent burning themselves. On 06/26/24 at 1:14 p.m., the hot water temperature of the bathroom sink in room 102 was 136 degrees Fahrenheit. Resident #8 stated the water was too hot, so they had to be careful when using the sink. On 06/26/24 at 1:35 p.m., the Maintenance Supervisor stated they checked the temperature of the water monthly. On 06/26/24 at 1:40 p.m., the Maintenance Supervisor and Maintenance #1 checked room 101 and room 102 bathroom sink temperatures. They stated the water temperatures were high. They were not sure what the exact temperatures for bathing should be, but stated it should be less than 120 degrees Fahrenheit.

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?	1. The temperature on the hot water heater was immediately turned down. 2. Maintenance staff were inserviced on appropriate water temperature policies and documentation of this can be found in the inservice binder
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents had the potential to be affected
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	1. Daily random water temperature checks at multiple points throughout the facility, including all resident-accessible areas was implemented 2. A detailed log of all temperature checks is being kept, including the date, time, location, and recorded temperature.
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.	1. Maintenance staff will perform daily checks of water temperatures at random resident-accessible outlets, ensuring compliance with the 115 degrees Fahrenheit limit. 2. Each check will be logged with the date, time, location, and temperature recorded. Maintenance will review daily temperature logs to ensure all recorded temperatures remain within the acceptable range of 115 degrees Fahrenheit The QA committee will review all data, audit results, and feedback in their monthly meetings. The log containing the daily random temperature checks will be maintained in a binder and available for review at any time.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/16/2024
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Lydia Stewart ED	**Date** Enter a date of signature. 7/16/24
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: 7/9/2024** **Facility Name:** Villagio of Bradford Village **License Number:** NH5526AL **Survey Event ID:** ING811 **Date Survey Completed: 6/28/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C6000	Based on: record review and interview, the center failed to conduct registry screening and background checks in a timely manner for three (CMA #1, CMA #2, and Dietary Aide #1) of five sampled personnel files reviewed. The Executive Director identified 43 residents resided in the center. Findings CMA #1 was hired on 02/26/24. Their registry screening and background check was completed on 04/15/24. CMA #2 was hired on 03/06/24. Their registry screening and background check was completed on 04/12/24. Dietary Aide #1 was hired on 05/12/24. Their registry screening and background check was completed on 06/26/24. On 06/27/24 at 9:12 a.m., the Executive Director stated registry screening and background checks were to be completed a week or two upon hire. They stated the registry screening and background check for CMA #1, CMA #2, and Dietary Aide #1 were not completed in a timely 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?	1. Immediate registry screenings and background checks for all current employees who have not yet undergone the process was completed. 2. The registry screenings and background checks for CMA #1, CMA #2, and Dietary Aide #1 are documented appropriately in their personnel files.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	1. A checklist is included in each new hire's personnel file, documenting the completion of the registry screening and background check before the hire date. 2. All hiring managers were inserviced of the background check policy and signed inservice forms are located in the inservice binder. 3. The Executive Director has completed an audit of personnel files to verify that all required checks are completed. 4. The Executive Director will conduct random checks monthly to ensure the background checks have been completed.

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.	1. Monthly random audits of personnel files to ensure compliance with background check policies will be completed by the Executive Director. 2. Background check compliance will be included into the monthly QA program and addressing any non-compliance 1.Monthly random audits of personnel files to ensure compliance with background check policies will be completed by the Executive Director. 2.Background check compliance will be included into the monthly QA program and will be addressing any non-compliance Regular monthly QA meetings will include a focus on background check compliance, with participation of the Executive Director and staff. Periodic internal audits to verify that background check records are complete, accurate, and up-to-date will be conducted by the Executive Director and audit results kept in the QA binder
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/16/2024
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. Lydia Stewart ED OAC 310:663-25-4(F)	**Date** Enter a date of signature. 7/16/24
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: lstewart@villagioliving.com

August 7, 2024

License Number: NH5526AL

Ms. Lydia Stewart, Administrator
Bradford Village Healthcare Center
906 North Boulevard
Edmond, OK 73034

RE: Survey Event ING812

Dear Ms. Stewart:

On **August 1, 2024,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 28, 2024,** have now been corrected effective **July 16, 2024.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH5526AL	A. BUILDING: _____ B. WING _____	R 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADFORD VILLAGE HEALTHCARE CENTER	906 NORTH BOULEVARD EDMOND, OK 73034

(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 08/01/24. 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