OKLAHOMA
State Department
of Health

Delivery via email to: lstewart@villagioliving.com

December 11, 2025

License Number: NH5526AL

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

RE: Survey Event ID: MFLL11

Dear Ms. Stewart:

On **November 18, 2025**, 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 **November 18, 2025**.

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

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

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

- Address how corrective action will be accomplished for affected residents;
- Address how other residents with the potential to be affected will be identified;
- Address measures or systemic changes to ensure the deficiency will not recur;
- Indicate how the center plans to monitor performance to ensure corrections are sustained;
- Include dates when corrective action and monitoring will be completed for each violation;
- 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 OSDH.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 _____	11/18/2025

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 11/17/25 through 11/18/25. Facility Census: 42 Listed below are abbreviations that will be used throughout this document: ED - executive director	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 center failed to ensure the following during 1 of 1 kitchen observation: a. the foods in the refrigerators were labeled, dated, and covered, b. the kitchen floors were kept clean and free of debris, and c. the can opener was cleaned between use. The ED identified 42 residents received nutrition from the kitchen. Findings: On 11/17/25 at 9:20 a.m., the following observations were made in the refrigerator under the counter by the serving area: a. an opened 3-liter container of cranberry juice was not labeled or dated,	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 _____	11/18/2025

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BRADFORD VILLAGE HEALTHCARE CENTER	906 NORTH BOULEVARD EDMOND, OK 73034

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C 391	Continued From page 1 b. an opened 3-quart container of apple juice was not labeled or dated, and c. an opened 64-ounce container of prune juice was not labeled or dated. On 11/17/25 at 9:35 a.m., the floor under the cooking appliances and sink areas was observed to have a dark buildup of debris and grease. On 11/17/25 at 9:40 a.m., the counter mounted can opener was observed to have dark colored debris on the area that pierces canned foods for opening. An undated policy titled "Smallware Cleaning Policy" read in part, "all smallware's must be washed, rinsed, and sanitized immediately after use." On 11/17/25 at 9:45 a.m., cook #1 was asked about labeling and dating food items in the refrigerator. Cook #1 stated all opened items should be labeled and dated when they are opened in the refrigerators. Cook #1 was shown the can opener and was asked about the cleaning process for it. Cook #1 stated it was cleaned after each use and not sure why it had food build up on it. Cook #1 was asked about the debris on the floor under the sink and throughout the kitchen area. Cook #1 stated the floors were getting really bad and needed a good cleaning and they just had not done it yet.	C 391		

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Delivery via email to: lstewart@villagioliving.com

December 22, 2025

License Number: NH5526AL

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

RE: Survey Event MFLL11

Dear Ms. Stewart:

On **November 18, 2025**, 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 **December 23, 2025**.

We will conduct a revisit for 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: 12/18/2025** **Facility Name:** Bradford Village **License Number: NH5526AL** **Survey Event ID:** MFLL11 **Date Survey Completed: 11/18/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 391	Based on: Based on observation, record review, andinterview, the center failed to ensure the followingduring 1 of 1 kitchen observation:a. the foods in the refrigerators were labeled,dated, and covered,b. the kitchen floors were kept clean and free ofdebris, andc. the can opener was cleaned between use.The ED identified 42 residents received nutrition from the kitchen.

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?	Immediately upon identification, all opened food and beverage items in the refrigerators were labeled, dated, and properly covered. The cranberry juice, apple juice, and prune juice containers identified during the survey were discarded. Properly labeled and dated products were the replacements. The kitchen floors, including areas under cooking appliances and sink areas, were thoroughly cleaned. The counter-mounted can opener was immediately cleaned and sanitized prior to being returned to use.
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 (42 residents) receive nutrition services from the kitchen. Therefore, all residents were considered potentially affected. A full inspection of all refrigerators, food storage areas, kitchen equipment, and kitchen floors was completed to ensure compliance with food safety and sanitation requirements.
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 documented daily kitchen audit was created and will be completed three times a week by the Executive Director and copies of the audit kept in the QA binder. 2. A weekly cleaning schedule for floors and equipment was implemented and will be reviewed by the ED when completed and results kept in the QA binder. 3. Dietary staff were in-serviced on proper food labeling, dating, covering of food items, cleaning and sanitizing of smallwares (including the can opener), and kitchen sanitation expectations 4. A third party vendor was hired to conduct quarterly

	cleaning and repairs to the kitchen appliances including the ice machine, freezers, refigerators, coffee machine, and sandwich fridge
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.	Routine Inspections: The Executive Director or designee will conduct weekly kitchen sanitation and food safety inspections three times a week for the next months, followed by monthly inspections thereafter. Inspections will include refrigerator labeling and dating, cleanliness of kitchen floors (including under equipment), and sanitation of smallwares such as the can opener. 1.Documentation and Checklists: Dietary staff will complete daily food storage and sanitation checklists and weekly deep-cleaning logs. These records will be reviewed by management for completeness and compliance. 2.Staff Accountability: Any deficiencies identified during monitoring will be addressed immediately through corrective action and staff re-education. Repeated issues will be managed according to the facility's corrective action process. 1.The identified deficiency and corrective actions will be logged as a QA issue and tracked until sustained compliance is demonstrated. 2.Results from kitchen inspections, sanitation audits, and monitoring tools will be reviewed during QA meetings to evaluate trends related to food storage, sanitation, and equipment cleaning. 3.Food safety compliance (proper labeling and dating, cleanliness of floors and equipment, and smallware sanitation) will be added as a quality indicator monitored by the QA committee. The facility will maintain daily food storage and sanitation checklists, kitchen inspection/audit forms, and documenting compliance with labeling, dating, cleaning of floors, and sanitation of equipment and smallwares. Monitoring records will be maintained in a designated QA binder or electronic folder, readily available for review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed? OSDH Response: Element accepted Yes ☐ No ☐	Click here to enter a date when corrective action will be completed. 12/23/25
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 12/19/25
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: Lydia Stewart <lstewart@villagioliving.com>

December 26, 2025

License Number: NH5526AL

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

RE: Survey Event MFLL12

Dear Ms. Stewart:

On **December 26, 2025,** 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 **November 18, 2025,** have now been corrected effective **December 23, 2025.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH5526AL	A. BUILDING: _____ B. WING _____	R 12/26/2025

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 12/26/25. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE