OKLAHOMA
State Department
of Health

Delivery via email to: Kari.Willard@Brookdale.com

May 17, 2023

License Number: AL7204

Ms. Kari Willard, Administrator
Brookdale Broken Arrow
4001 South Aspen
Broken Arrow, OK 74011

RE: Survey Event ID: 5P2911

Dear Ms. Willard:

On **May 11, 2023**, agents from our office concluded a State Licensure survey along with a complaint investigation 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 11, 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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Brookdale Broken Arrow**
Address: **4001 South Aspen**
City, State, Zip: **Broken Arrow, OK. 74011**
Provider #: **AL 7204**
Complaint #: **OK00059490**
Investigation Date(s): **05/10/23 through 05/11/23**

ALLEGATION(S)

1. The facility failed to ensure residents were properly groomed.
2. The facility failed to ensure the staff were qualified for assigned tasks.
3. The facility failed to provide an environment free of offensive odors.

An unannounced on-site investigation was initiated 05/10/2023 at 8:20 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, staff members, and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. The facility was observed to be clean and orderly. Resident halls were observed for odors and potential urine saturation of residents. Staff were observed for assisting residents with toileting needs and hydration needs. There was no offensive odor in any common area, hallways, resident's room, or dining area noted on either day. Residents were observed in the common areas, ambulating in the hallways and resting in their rooms. The residents were well groomed and had no offensive odors. Staff were observed assisting residents with activities of daily living and answering call lights. Laundry staff were observed processing, handling and storing linen. Housekeeping was observed sweeping and mopping common areas and resident bathrooms.

Resident records were reviewed including assessments, care plans, physician orders, nursing notes, treatment records, dietician notes, feeding and water intake, output records, and activities of daily living (ADL) records. The activity of daily living showed documentation of resident's showering regularly and as needed.

Residents were interviewed related to the provision of incontinent care and bathing/showering. The residents stated they did have incontinent care and bathing/showering regularly and as needed.

Staff members were interviewed regarding bathing/showering and incontinent care. They were asked about their ability to provide the appropriate care in a timely manner and they stated that the residents were appropriately provided for in a timely manner. An interview was conducted with the administrator and she stated the has never had any resident by the name the complainant named in the complaint letter.

Deficient practice was not cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Kelly Teal RN

Kelly Teal RN

Date report completed: 05/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7204	A. BUILDING: _____ B. WING _____	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BROKEN ARROW	4001 SOUTH ASPEN BROKEN ARROW, OK 74011

(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 05/10/23 through 05/11/23. A complaint investigation (#OK00059490) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CNA - certified nurse aide DM - dietary manager RCC - resident care coordinator	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 and interview, the facility failed to ensure food was stored, prepared and served in a sanitary manner. The administrator reported 68 residents resided in the facility. Findings: On 05/10/23 at 9:00 a.m., during the initial tour of the kitchen, a staff member was observed a sink and did not have on a hair net. At that time, Cook #1 said she was a CNA. Two cartons of liquid eggs were open and did not contain the date they had been opened. Two nectar consistency mango drinks observed in the refrigerator without an opened date. The food storage room was	C 391		

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	AL7204	A. BUILDING: _____ B. WING _____	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 391	Continued From page 1	C 391		

observed and the lid on the brown sugar container was not sealed, a scoop was observed laying on top of the sugar lid, not in a cover. The lid to the powered sugar was not secured onto it's container. A tub of vanilla cream icing, which had been opened but not dated, had a lid which was not on the tub securely. A sack of oats was observed sitting on top on the full oat bin. The sack had been cut and was open to air.

On 05/10/23 at 9:15 a.m., the walk in refrigerator contained multiple items which were not covered or labeled. Ten slices of cake and two bowls of salad were not dated. Mushrooms in the original container were observed to have been turning brown and not dated. A resealable bag of mushrooms dated 05/09/23 were turning brown. A container of coleslaw in the refrigerator, dated 05/08/23, open to air because the plastic wrap was not secure on the container. Observed what looked like tuna salad in a bowl was not dated or labeled. A brown substance in a plastic container was not labeled but had a date of 05/04/23.

On 05/10/23 at 9:30 a.m., during the tour of the memory care kitchen, two bowls of ice cream were observed in the freezer not covered, labeled, or dated. A coconut cream pie with the cover not secured was not dated. In the refrigerator two dessert cups of peaches were observed not covered, dated, or labeled. Three bowls of salad were observed not covered, dated, or labeled. The salad was observed to be turning brown. At that time, CNA #1 stated the peaches were from this morning's breakfast. CNA #1 stated she did not know when the salad was placed in the refrigerator. She stated it needed to be thrown out.

On 05/11/23 at 10:52 a.m., the DM was observed

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	AL7204	A. BUILDING: _____ B. WING _____	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 391	Continued From page 2 in the kitchen without a hair net, she was unpacking items she had bought from the store. On 05/11/23 at 11:04 am., Cook #1 took the temperature of the pork with a thermometer. She was observed to wipe the thermometer with a cloth towel and then she used it again on another container of pork. Cook #1 was observed to touch the trash can lid and then place a pair of gloves on her hands. Hand washing was not observed. Cook #2 was observed to touch the lid to the trash can then got a scoop from over the prep table. He then placed clean gloves on his hands and used the scoop to remove the pork from the food processor. Hand washing was not observed after she touched the trash can lid. Cook #2 again was observed to touch the trash can lid when throwing the gloves away and then placed the pork in the warmer and no hand washing was observed. On 05/11/23 at 11:14 a.m., Cook #1 stated she should have used an alcohol pad to clean the thermometer not a towel. On 05/11/23 at 12:02 p.m., in the memory care kitchen area the activities director entered the kitchen and retrieved a tray of food from the refrigerator. She did not wash her hands when she entered the kitchen area. Cook #2 stated the staff should have washed their hands when entering the kitchen. The RCC was observed to enter the kitchen from the dining room with a large tray in his hands. He handed the tray to Cook #2, who was in the dish room, and then retrieved a tray of beets from the refrigerator. The RCC was not observed to wash his hands when he entered the kitchen. The RCC stated he used hand sanitizer before entering the kitchen.	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7204	A. BUILDING: _____ B. WING _____	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 391	Continued From page 3 On 05/11/23 at 1:10 p.m., the DM stated the staff should wear a hair net when in the kitchen. The DM stated the staff should wash their hands when entering the kitchen and when gloves were removed, or touching anything dirty. She stated the items in the refrigerators should have been covered, labeled, and dated. She stated the lids should fit and be secure on the storage bins for food and not be left open to air and the scoop should be in a plastic bag.	C 391		
C 393 SS=F	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 cooked may be refrigerated for up to forty-eight (48) hours. This Rule is not met as evidenced by: Based on observation and interview, it was determined the center failed to monitor leftover foods to ensure potentially hazardous foods were disposed of within 24 hours and non-potentially hazardous were disposed of after 48 hours. The administrator reported 68 residents resided in the facility. Findings:	C 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7204	A. BUILDING: _____ B. WING _____	C 05/11/2023

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BROOKDALE BROKEN ARROW	4001 SOUTH ASPEN BROKEN ARROW, OK 74011

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C 393	Continued From page 4 On 05/10/23 at 9:04 a.m., observed in the small refrigerator were multiple resealable bags. One bag labeled ham was dated 04/27/23, and had a used by dated of 05/03/23 written on the bag. A bag labeled bacon was observed open to air and was dated 02/22/23 with a used by date of 05/01/23. On 05/11/23 at 9:15 a.m., in the walk-in refrigerator, a cucumber and tomato salad, which were dated 05/04/23, was in the refrigerator. A bowl of sliced yellow squash, green bell pepper, and onion mixed in a bowel together was dated 05/09/23. Cut potatoes were observed in a bin of water unable to read the date. A large container labeled beans, dated 05/19/23, with a used by date of 5/12/23, was covered with tin foil and the tin foil was torn in several places and open to air. Two resealable bags of chopped celery were dated 05/02/23. Black berries in the original container were were observed with mold. A cut onion half was observed wrapped in plastic wrap, no date or label on the onion was observed. An unknown brown substance, not labeled, was dated 05/04/23. On 05/11/23 at 9:32 a.m., a container was observed labeled cake puree and dated 05/04/23. A container labeled puree dessert, dated 05/03/23, was in the refrigerator in the memory care kitchen. On 05/11/23 at 1:10 p.m., the DM stated left overs and potentially hazardous food could be kept two days in the refrigerator.	C 393		

OKLAHOMA
State Department
of Health

Delivery via email to: Kari.Willard@Brookdale.com

May 30, 2023

License Number: AL7204

Ms. Kari Willard, Administrator
Brookdale Broken Arrow
4001 South Aspen
Broken Arrow, OK 74011

Survey Event ID: 5P2911

Dear Ms. Willard:

On **May 11, 2023,** a Relicensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. **Our acceptance does not absolve the facility's responsibility** for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 15, 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: 5/17/2023

Facility Name: Brookdale Broken Arrow

License Number: AL-7204

Survey Event ID: 5P2911

Date Survey Completed: 5/12/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391	Based on: Observation 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?	Staff will be inserviced on food storage, preparation and sanitation. Dining staff will be retrained on proper sanitary measures and safe food handling. DSM will complete random spot checks weekly in food storage and sanitation. This will be added to QA as well.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Monitoring of the food storage, preparation and sanitation with the dietary staff and procedures will help identify and prevent resident from being 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?	Will complete ongoing training with staff.
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.	This deficient practice will be discussed in QA and inservice will be signed off by all applicable participants such as cooks, floor staff, and DSC. Random checks in place by community Executive Director/Associate Executive Director for accuracy of storage, preparation, sanitation, and accountability. Check off form created and completed with random walk throughs. Review and training of the storage, preparation and sanitation guidelines. This will be discussed in the next QA. Check off sheet will be reviewed and kept for 6 months. These will be signed off on by the DSM, Executive Director/ Associate Executive Director and kept in a binder for the next 2 months.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Kari Willard** **Date 5/17/2023**

OAC 310:663-25-4(F)			
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: 5/17/2023** **Facility Name:** Brookdale Broken Arrow **License Number:** AL-7204 **Survey Event ID:** 5P2911 **Date Survey Completed: 5/12/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C393	Based on: observation and interview, it was determined the center failed to monitor leftover foods to ensure potentially hazardous foods were disposed of within 24 hours and non-potentially hazardous were disposed of after 48 hours.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Staff will be inserviced on food storage of leftover food. Dining staff will be retrained on safe food handling and potentially hazardous food.

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?	Staff will be inserviced on food storage of leftover food. Dining staff will be retrained on safe food handling and potentially hazardous food. DSM will complete random spot checks randomly monitoring leftovers. This will be added to QA as well.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Monitoring of the leftovers and food storage will be checked randomly to prevent residents to be potentially 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?	Will complete ongoing training with staff monthly for three months.
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.	This deficient practice will be discussed in QA and inservice will be signed off by all applicable participants such as cooks, floor staff, and DSC. Random checks in place by community Executive Director/Associate Executive Director for food storage/ leftovers and potentially hazardous food. Check off form created and completed with random walk throughs. Review and training of the storage, preparation and sanitation guidelines and leftovers. This will be discussed in the next QA. Check off sheet will be reviewed and kept for 6 months. These will be signed off on by the DSM, Executive Director/ Associate Executive Director and kept in a binder for the next 6 months.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Kari Willard OAC 310:663-25-4(F)			**Date 5/17/2023**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department of Health

Delivery via email to: kari.willard@brookdale.com

June 20, 2023

License Number: AL7204

Ms. Kari Willard, Administrator
Brookdale Broken Arrow
4001 South Aspen
Broken Arrow, OK 74011

RE: Survey Event 5P2912

Dear Ms. Willard:

On **June 19, 2023,** 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 **May 11, 2023,** have now been corrected effective **June 15, 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
	AL7204	A. BUILDING: _____ B. WING _____	R-C 06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE BROKEN ARROW	4001 SOUTH ASPEN BROKEN ARROW, OK 74011

(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 06/19/23. 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