OKLAHOMA
State Department
of Health

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

July 21, 2026

License Number: AL7204

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

RE: Survey Event ID: EWUL11

Dear Ms. Willard:

On **July 10, 2026**, 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 **July 10, 2026**.

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: IDRCoordinator@health.ok.gov

or mail 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,

Tempal Killman

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: BROOKDALE BROKEN ARROW
Address: 4001 SOUTH ASPEN
City, State, Zip: BROKEN ARROW, OK, 74011, TULSA
Provider #: AL7204
Complaint #: OK00091384
Investigation Date: 08/25/25 through 08/28/25

ALLEGATION(S)
1.The facility failed to ensure residents were free from abuse

An unannounced on-site investigation was initiated 07/08/2026 at 10:30 a.m.

A sample of nine participants, including any identified participants, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, 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 various times throughout the survey. Residents were observed for outward signs of abuse and neglect. Residents named in the complaint were observed for abusive behavior or signs of emotional distress.

Resident records were reviewed including admission records, progress notes, physician orders, assessments, care plans, hospital records and medication administration and treatment records. Incident reports were reviewed. Staffing records were reviewed.

Residents were interviewed regarding the allegation of the complaint. They were asked if they felt safe at the facility. They were interviewed regarding staff availability and response to their needs and requests for assistance.

Resident representatives were interviewed regarding the allegation of the complaint. They were asked if their loved ones were safe living at the facility

Staff were interviewed regarding the allegations of the complaint. They were interviewed regarding abuse and neglect. They were interviewed regarding staffing and staff training.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 07/10/2026

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 _____	C 07/10/2026

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 with complaint (#OK00090872) was conducted from 07/08/26 through 07/10/26. Deficiencies were cited. Facility Census: 71	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 facility failed to ensure: a. foods were labeled, dated, and covered; and b. expired foods were discarded. The dietary manager identified 71 residents received nutrition from the kitchen. Findings: On 07/08/26 at 1:00 p.m., a tour of the dining room was conducted. The following observations were made: a. a plastic pitcher of brown tea colored liquid without a cover, label, or date; b. two clear plastic pitchers with clear liquid without covers, labels, or dates; and c. a plastic pitcher with yellow colored liquid without a label or date.	C 391		

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

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 07/10/2026

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 391	Continued From page 1 On 07/08/26 at 1:05 p.m. a tour of the kitchen was conducted. The following observations were made in the refrigerator: a. an opened container of sour cream with a received date of 06/30/26 but no date of when opened, b. an opened 32-ounce container of key lime juice with an open date of 03/25/25 and a manufacturer date of "best before 04/15/25," c. an opened one-gallon container of prepared mustard with a manufacturer "best by date 02/21/25," d. an opened one-gallon container of vinaigrette dressing with an opened date of 08/16/25, and e. a plastic container with a foil covering labeled "onion" dated 07/01/26. A "Refrigerated Storage Reference Guide," dated 01/09/20, showed recommended storage times for open salad dressing as three months and sliced/diced onions as three to five days. A policy titled "Labeling - DS-04.028," dated 03/2026, read in part, "all prepared items must have a label with the name of the item, date and time prepared, by whom and discard/use by date." On 07/08/26 at 1:30 p.m. the dietary manager stated expired items should have been discarded. The dietary manager stated prepared food items and opened food items should be labeled and dated.	C 391		

OKLAHOMA
State Department
of Health

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

July 29, 2026

License Number: AL7204

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

RE: Survey Event EWUL11

Dear Ms. Willard:

On **July 10, 2026**, a Licensure inspection with complaint 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 24, 2026**.

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: 7/21/2026** **Facility Name:** Brookdale Broken Arrow **License Number:** AL-7204 **Survey Event ID:** EWUL11 **Date Survey Completed: 7/10/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391	Based on: Observation, record review, andinterview, the facility failed to ensure:(a). foods were labeled, dated, and covered; and (b.) expired foods were discarded.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The following is the Plan of Correction for Brookdale Broken Arrow regarding the Statement of Deficiencies dated 07/10/26 . The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

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 labeling, first in first out procedures(FIFO) , expired items, shelf life for items, food covering. DSM will complete random spot checks weekly in food storage, freezers and refrigerators. 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, labeling, dates, expiring food, 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 over the next x3 months, train with new hire staff in the kitchen and will review each quarterly in inservice for dining 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 reviewed in QA and inservice will be signed off by all applicable participants. Random checks will be 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 labeling, FIFO, dating and covering food and beverage guidelines. This will be discussed in the next QA. Check off sheet will be reviewed and kept for approx. 6 months. These will be signed off on by the DSM, Executive

	Director/ Associate Executive Director and kept in a binder for the x2 months.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/24/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Kari Willard OAC 310:663-25-4(F)	**Date 7/21/2026**

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

August 26, 2026

License Number: AL7204

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

Survey Event ID: EWUL12

Dear Ms. Willard:

On **August 24, 2026,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **July 10, 2026,** have now been corrected effective **August 24, 2026.**

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

Respectfully,

Malinda Perry

Malinda Perry, Enforcement Analyst
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
	AL7204	A. BUILDING: _____ B. WING _____	R 08/24/2026

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 08/24/26. All deficiencies from the 07/10/26 survey were cleared.	{C 000}		

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