OKLAHOMA
State Department
of Health

Delivery via email to: lwinfein@oxfordseniorliving.com

April 14, 2025

License Number: AL0701

Ms. Lisa Winkfein, Administrator
Oxford Springs Durant Llc
1500 North 19th Street
Durant, OK 74701

RE: Survey Event ID: D87R11

Dear Ms. Winkfein:

On **April 8, 2025**, agents from our office concluded a State Licensure survey with complaint investigations 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 **April 8, 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:

(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

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Oxford Springs Durant AL
Address: 1500 N. 19th Ave
City, State, Zip: Durant, OK, 74701
Provider #: AL0701
Complaint #: OK00065895
Investigation Date(s): 04/07/25 and 04/08/25

ALLEGATION(S)
enter text The center failed to ensure residents were not falsely billed
enter text The center failed to ensure residents were treated with respect and dignity
enter text
enter text
enter text

An unannounced on-site investigation was initiated 04/07/2025 at 9:28a.m.

A sample of eight residents, including any identified residents, 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 into the facility and throughout the two-day survey. Residents were observed for being treated with respect and dignity, staff were observed interacting with residents treating them with respect and dignity. Records reviewed included health records, residency contracts, and summary of charges. Residents, family members and staff were asked questions regarding being treated with respect, dignity and the billing of services.

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: 04/09/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Oxford Springs Durant AL
Address: 1500 N 19th Ave
City, State, Zip: Durant, OK, 74701
Provider #: AL0701
Complaint #: OK00080289
Investigation Date(s): 04/07/25 and 04/08/25

ALLEGATION(S)
enter text enter textThe facility failed to ensure safe and sanitary measures were used to operate the ice machine.
enter text The facility failed to ensure meals were provided according to the dietician and physician orders.
enter text The facility failed to ensure sufficient nursing staff to provide care.
enter text The facility failed ensure residents admitted were not about the level of care.
enter text

An unannounced on-site investigation was initiated 04/07/2025 at 9:28a.m.

A sample of eight residents, including any identified residents, 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 into the facility and throughout the two-day survey. Residents were observed for being treated with respect and dignity, staff were observed interacting with residents treating them with respect and dignity. Records reviewed included observation of the ice machine, kitchen, physician, and dietician orders and interviews with the residents and staff. Also record review of the work schedules, and interviews with residents, family members, and employees about the level of care being provided.

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

OKLAHOMA
State Department
of Health

Long Term Care Service

Date report completed: 04/09/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0701	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS DURANT LLC	1500 NORTH 19TH STREET DURANT, OK 74701

(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 04/07/25 through 04/08/25. Complaint investigations (#OK00065895 and #OK00080289) were conducted in conjunction with the survey. Deficiencies were cited as a result of the survey and complaint investigation. Facility Census: 20 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide CNA- certified nurse aide ED- executive director LVN- licensed vocational nurse MAR- medication administration record mg - milligrams Resident- res	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: a. ensure opened food items were labeled with the open and use by date in one of one freezer observed; and b. ensure the correct chemical concentration was	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0701	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS DURANT LLC	1500 NORTH 19TH STREET DURANT, OK 74701

(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 achieved with the litmus paper test strips during the dish washing procedure. The ED identified 20 residents received nutrition from the kitchen. Findings: On 04/07/25 at 9:28 a.m., the following food items were observed opened in the freezer with no labels to show the open and use by date: a. a plastic bag three quarters full of potato cakes, b. a plastic bag half full of fish filets, c. a plastic bag half full of steak fingers, d. a plastic bag three quarters full of chicken strips, e. a Ziploc bag three quarters full of pecans, and f. a Ziploc bag three quarters full of tater tots. On 04/07/25 at 9:37 a.m., no litmus paper test strips were available to check the chemical concentration for the dish washing procedure for sanitation. A facility policy titled "Food Storage," dated 10/25/23, read in part, "All foods will be labeled and dated with an expiration date." A facility policy titled "Environmental Standards, Cleanliness and Sanitation," dated 10/25/23, read in part, "Sanitary dishwashing procedures and techniques must be followed." On 04/07/25 at 9:41 a.m., the dining service director was asked about the conditions and policies of the kitchen in regard to food not being labeled and dated, and no litmus paper test strips. The dining service director stated, "They were just given this position two days ago and	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0701	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS DURANT LLC	1500 NORTH 19TH STREET DURANT, OK 74701

(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 they know the policy the food should have been labeled and dated." The dining service director stated, "They are hand washing the dishes since they are out of test strips, and they will be receiving a delivery of supplies in a couple of days." On 04/07/25 at 9:50 a.m., the ED was asked the conditions of the kitchen and they stated, "The dining service director was just hired in their position a few days ago." The ED stated, "They were not aware they are out of litmus test strips, and they will order some as soon as possible."	C 391		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports.	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0701	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS DURANT LLC	1500 NORTH 19TH STREET DURANT, OK 74701

(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
C1923	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure documentation of a physician order and medication administered was uploaded in the MAR for 1 (#1) of 2 sampled residents reviewed for medication administered. The ED identified 20 residents received medication. Findings: A facility policy titled "Ordering and Labeling of Medications," dated 10/25/23, read in part, "The licensed nurse, physician, PA [physicians assistant], APRN [advanced practical registered nurse], or pharmacist shall immediately record the verbal order in the resident's clinical record." Res #1's had diagnoses which included type 2 diabetes mellitus and transient cerebral ischemic attack unspecified. Res #1's "Physician Orders," dated 02/27/25, showed Gabapentin (anticonvulsant medication) 100mg twice a day. A medication card, dated 02/28/25, showed Gabapentin 100mg twice a day was administered to Res #1 on 04/07/25 at 9:56 a.m., given by CMA #1. A MAR dated 04/03/25 did not show Res #1's Gabapentin was on the list of medications to be administered. On 04/07/25 at 1:33 p.m., CMA #1 stated, "They remember giving the order to the LVN because they can't input orders." CMA #1 stated, "LVN has to put in the new order and that every order goes through the LVN first." CMA #1 stated, "They notify the LVN by placing the order in a folder in	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0701	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS DURANT LLC	1500 NORTH 19TH STREET DURANT, OK 74701

(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
C1923	Continued From page 4 the LVN's office and by text message also." CMA #1 stated, "Their policy is the LVN is required to take the order and input them into the electronic system." CMA #1 stated, "The LVN must have forgot to upload the order into the MAR." On 04/07/25 at 2:43 p.m., the ED stated, "They talked to LVN who will be off the next few days remembers getting the order and sending it to the pharmacy and they must have forgot to upload it to the MAR."	C1923		
C1972 SS=E	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure staff were educated on abuse within 90 days of hire for 3 (CMA #1, CMA #2, and CNA #1) of 5 employees whose records were reviewed for abuse training. The ED identified 20 residents resided in the facility. Findings:	C1972		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0701	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS DURANT LLC	1500 NORTH 19TH STREET DURANT, OK 74701

(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
C1972	Continued From page 5 A facility policy titled "Abuse, Neglect, or Exploitation," dated 01/18/24 read in part, "Training the community will conduct an orientation program and on-going-in service which will review residents' rights, grievance process, and community process for investigation of abuse, neglect, and exploitation of property, as well as reporting reasonable suspicion of a crime in a timely manner." 1. CMA #1 was hired 12/03/24. There was no documentation of abuse training. 2. CMA #2 was hired 09/11/24. There was no documentation of abuse training. 3. CNA #1 was hired on 08/04/24. There was no documentation of abuse training. On 04/08/25 at 2:43 p.m., the ED stated, "They or the LVN does the hiring." The ED stated, "It was their fault that the training wasn't completed."	C1972		

OKLAHOMA
State Department of Health

Delivery via email to: Lwinkfein@oxfordseniorliving.com

April 23, 2025

License Number: AL0701

Ms. Lisa Winkfein, Administrator
Oxford Springs Durant Llc
1500 North 19th Street
Durant, OK 74701

RE: Survey Event D87R11

Dear Ms. Winkfein:

On **April 8, 2025**, a Licensure inspection with complaint investigations 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 **April 23, 2025**.

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: 4/18/2025** **Facility Name:** Oxford Springs Durant AL **License Number:** AL0701 **Survey Event ID:** D87R11 **Date Survey Completed: 4/8/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: a. ensure opened food items were labeled with the open and used by date in one of one freezer obserd; and b. ensure the correct chemical concentration was achieved with the litmus paper test strips during the dish washing procedure.

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?	a. Unlabeled food was immediately removed from the freezer on 4/8/2025 and anything else was labeled and dated; b. chemical concentration test strips were ordered on 4/9/2025 and received on 4/10/2025.
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 in the community 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?	ED will conduct in-service training on all dietary policies with dietary staff and emphasize the importance of both a. labeling/dating food and b. ensuring we do not run out of dishmachine testing supplies.
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.	ED and Dietary Services Director reviewing three times for the first three weeks, then weekly to ensure proper labeling and supplies are adhered to and follow up during quarterly QA meeting. ED and Dietary Services Director will review monthly. ED will include in QA to monitor. ED will store in QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/10/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required OAC 310:663-25-4(F)	Tina Wink/Owner, ED	**Date 4/23/2025**	

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: 4/18/2025** **Facility Name:** Oxford Springs Durant AL **License Number:** AL0701 **Survey Event ID:** D87R11 **Date Survey Completed: 4/8/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1923	Based on: the facility failed to ensure documentation of a physician order and medication administered was uploaded in the MAR for 1 (#1) of 2 sampled residents reviewed for medication administered.

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?	The order was immediately entered into EMAR prior to survey exit.
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 in the community 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?	RCD will collect orders and complete order entry. At the end of each day RCD and ED, or designee will verify orders have been entered in EMAR. RCD and ED will in-service Medication Aides on notifying the RCD or ED when medications are in the building without being in the EMAR.
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.	RCD and ED or designee will meet daily for four weeks to ensure all orders are uploaded into EMAR. Med-Cart audit will be completed monthly and PRN by RCD or designee. Will review audits in our monthly QA meetings for effectiveness of plan. All records will be kept in our QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/23/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required	**Date 4/23/2025**

Lisa Winkelein, ED

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: 4/18/2025** **Facility Name:** Oxford Springs Durant AL **License Number:** AL0701 **Survey Event ID:** D87R11 **Date Survey Completed: 4/8/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1972	Based on: record review, and interview, the facility failed to ensure staff were educated on abuse within 90 days of hire for 3 (CMA #1, CMA #2 and CNA #1) of 5 employees whose records were reviewed for abuse training.

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?	CMA #1, CMA #2 and CNA #1 were educated on abuse, neglect and exploitation policy to review.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Al residents in the community 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?	ED or designee will audit all employee files for potential risk. Upon results of audit will ensure all staff is in-serviced on abuse, neglect and exploitation policy and procedures. All new hires will have abuse, neglect and exploitation training prior to starting their role.
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.	ED or designee will review checklist to ensure all new hires have completed abuse, neglect and exploitation will have education prior to beginning job duties. ED or designee will review checklist on or prior to start date. ED to review quarterly training to ensure compliance. ED or designee will keep training records in the QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/23/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Ana Martinez, ED	**Date 4/23/2025**

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: Lwinkfein@oxfordseniorliving.com

May 7, 2025

License Number: AL0701

Ms. Lisa Winkfein, Administrator
Oxford Springs Durant Llc
1500 North 19th Street
Durant, OK 74701

RE: Survey Event D87R12

Dear Ms. Winkfein:

On **May 5, 2025,** 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 with complaints on **April 8, 2025,** have now been corrected effective **April 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
	AL0701	A. BUILDING: _____ B. WING _____	R-C 05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS DURANT LLC	1500 NORTH 19TH STREET DURANT, OK 74701

(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 05/05/25. 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