

Delivery via email to: Tasha.Winship@legendseniorliving.com

February 20, 2026

License Number: AL0903

Ms. Latasha Winsip, Administrator
Arbor House Assisted Living Of Mustang
850 North Clearsprings Road
Mustang, OK 73064

Survey Event ID: UQYW11

Dear Ms. Winsip:

On **January 28, 2026**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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. 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 will be completed for each violation; and
- (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 a 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
IDRCoordinator@health.ok.gov
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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Arbor House of Mustang
Address: 850 North Clearsprings Road
City, State, Zip: Mustang, OK 73064
Provider #: AL0903
Complaint #: OK00081930
Investigation Date(s): 01/27/26-01/28/26

ALLEGATION(S)
The facility failed to provide adequate supervision to prevent resident to resident physical abuse
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 01/27/2026 at 10:40 a.m.

A sample of 9 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: Observations of resident to resident interaction, staff to resident interaction, resident behaviors, staff to resident ratio, and appearance of residents were made. Records of incident reports, resident health charts, care plans, assessments, physician orders, resident medications, and center policies were reviewed. Interviews with residents, families, and staff were conducted. Based on observation, record review, and interview, the center was in compliance with regulations.

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: 01/28/2026

INVESTIGATIVE REPORT

Facility: Arbor House of Mustang
Address: 850 Clearsprings Road
City, State, Zip: Mustang, OK 73064
Provider #: AL0903
Complaint #: OK00086662
Investigation Date(s): 01/27/26-01/28/26

ALLEGATION(S)
The center failed to ensure residents were free from abuse
The center failed to ensure assistance with toileting was provided
The center failed to ensure accurate billing
The center failed to have and/or implement a grievance process
The center failed to ensure training/in-service's were provided according to state law
The center failed to ensure a safe, clean, comfortable and homelike environment
The center failed to ensure medications were not left in residents' rooms unless the resident was assessed to be safe with medication administration
The facility failed to ensure qualified, licensed/certified staff
The center failed to ensure medications were administered according to the physician orders and medication errors are documented/addressed.
The center failed to assess, monitor and intervene for falls
The center failed to ensure accurate assessments
The center failed to ensure medications, including controlled medications and respiratory treatments, were administered by qualified staff
The center failed to ensure a safe environment
The center failed to ensure adequate staff to meet the needs of the residents

An unannounced on-site investigation was initiated 01/27/2026 at 10:40 a.m.

A sample of 9 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: Comprehensive observations, including, but not limited to, the center's structural environment of ceilings, walls, doors and frames, windows, flooring, equipment, vents, lighting, noise levels, and air temperatures were made. Observations of staff to resident ratio, medication passes, and ADL care provided to residents were made. Observations of residents' physical and behavioral conditions, attire, grooming, any odors, and skin conditions such as any bruising or skin irritation were made. Records of, including, but not limited to, residents' contracts and billing statements, health charts, physician orders, medications, assessments, and care plans were reviewed.

Records of the center's policies, filed grievances, inservices provided with staff attendance, maintenance orders, staff qualifications and personnel files, medication administration records, and schedules were reviewed. Interviews with residents, families and staff were conducted. Based on observations, record reviews, and interviews, deficiencies were cited.

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: 01/28/2026

INVESTIGATIVE REPORT

Facility: Arbor House of Mustang
Address: 850 Clearsprings Road
City, State, Zip: Mustang, OK 73064
Provider #: AL0903
Complaint #: OK00088963
Investigation Date(s): 01/27/26-01/28/26

ALLEGATION(S)
The center failed to ensure residents were free from abuse
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 01/27/2026 at 10:40 a.m.

A sample of 9 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: Observations of residents' physical and behavioral conditions, resident to resident and staff to resident interactions, and ADL care provided to residents were made. Records of residents' health charts, physician orders, assessments, care plans, incident reports, and center policies were reviewed. Interviews of residents, families, and staff were conducted. Based on observations, record reviews, and interviews, deficiencies were cited.

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: 01/28/2026

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2026
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING OF MUSTANG		STREET ADDRESS, CITY, STATE, ZIP CODE 850 NORTH CLEARSPRINGS ROAD MUSTANG, OK 73064		
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C 000	INITIAL COMMENTS Complaint investigations (#OK00081930, OK00086662, and #OK00088963) were conducted on 01/27/26 through 01/28/26. Deficiencies were cited as a result of the survey. Facility Census: 60 Listed below are abbreviations that will be used throughout this document. CNA- certified nursing aide	C 000		
C 532 SS=D	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a resident assessment accurately reflected the resident's status for 1 (#8) of 9 sampled residents reviewed for assessment accuracy. The administrator identified 61 residents resided	C 532		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2026
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C 532	Continued From page 1 in the center. Findings: On 01/27/26 at 11:18 a.m., Resident #8 was observed sitting at a dining room table. CNA #1 attempted to verbally engage with Resident #8 and they did not respond. On 01/27/26 at 1:27 p.m., Resident #8 was observed using a high pitched tone attempting to communicate with CNA #1. Resident #8 was unable to form words and was unintelligible. CNA #1 stated they did not know what Resident #8 was saying. On 01/27/26 at 1:35 p.m., CNA #1 was observed pushing Resident #8 in their wheelchair to the bathroom. Resident #8 set their feet down on the floor preventing the wheelchair from moving. CNA #1 asked Resident #8 if they could lift their feet up and Resident #8 responded, "No, no, no, no, no." Resident #8 attempted to say more, but was unintelligible. CNA #2 brought wheelchair foot pedals and applied them to the wheelchair. Resident #8's feet were placed on the pedals and CNA #1 continued pushing them in their wheelchair to the bathroom. On 01/27/26 at 1:39 p.m., CNA #1 and CNA #2 were observed to don gloves to assist Resident #8 in transferring to the toilet. Resident #8 began speaking unintelligible and in a high pitched tone. CNA #1 stated, "I'm not sure what you're saying." CNA #1 and CNA #2 applied a gait belt to Resident #8 and assisted them to stand. Resident #8 was unable to bear weight as evidenced by their legs being bent in a 45 degree angle. CNA #1 and CNA #2 had Resident #8 under the arm and holding onto the gait belt. Resident #8	C 532		

Oklahoma State Department of Health

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C 532	Continued From page 2 grabbed the grab bar in the shower preventing CNA #1 and CNA #2 from transferring them to the toilet. CNA #2 stepped into the shower to complete the transfer to the toilet and stumbled, trying to help Resident #8 release the grab bar. Resident #8's legs were still bent at a 45 degree angle and was not bearing their weight enough for a safe transfer. Resident #8 released the grab bar and CNA #1 and CNA #2 both let go of the gait belt to pull down Resident #8's pants. CNA #1 and CNA #2 had to bend down significantly to pull down Resident #8's pants due to the resident not bearing enough weight to stand. CNA #1 and CNA #2 then sat Resident #8 on the toilet. They were audibly winded and sighed. On 01/28/26 at 8:44 a.m., Resident #8 was observed sitting at a dining room table. A hospice aide was present and attempted to talk with the resident. Resident #8 did not respond. A "Significant Change Comprehensive Assessment," dated 07/18/25, showed Resident #8 was admitted to the center on 04/24/25 with diagnoses to include dementia and compression fracture of the T11-T12 vertebra. The assessment showed Resident #8 had poor mobility and gait and required one staff member to assist with transfers. The assessment showed Resident #8 utilized a walker and at times utilized a wheelchair and was weight bearing. The assessment showed Resident #8 had a good ability to communicate and was interviewable. A "Negotiated Service Agreement," dated 11/17/25, showed Resident #8 required one staff member to assist with transfers and propelling their wheelchair. On 01/27/26 at 11:19 a.m., Resident #8 was	C 532		

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C 532	Continued From page 3 asked how they were feeling. They did not respond. Resident #8 was asked what it was like living in the center. They did not respond. On 01/27/26 at 1:00 p.m., CNA #1 was asked what they knew about Resident #8. They stated, "[Resident #8] is a two person transfer, [they] can't stand well anymore." CNA #1 was asked how long Resident #8 had been a two person transfer. They stated, "About five or so months." CNA #1 was asked how Resident #8 communicated. They stated, "[Resident #8] can talk to you some days, but some days [they] can't or just doesn't want to." CNA #1 stated most of the time they are unable to understand Resident #8's speech. On 01/27/26 at 1:14 p.m., CNA #2 was asked if Resident #8 was a one or two person transfer. They stated Resident #8 was a two person transfer for three months. CNA #2 stated Resident #8 had been weak and sleeping a lot, but was on hospice services. CNA #2 was asked how they knew what a resident needs such as a two person transfer. They stated, "I see they can't stand with 1 person, so I tell the nurse." CNA #2 was unaware of any resident care plans or negotiated service agreements. On 01/27/26 at 1:52 p.m., Resident #8's family member was asked how many staff members were needed to transfer Resident #8. They stated, "It should take two. This weekend there was a pretty good size person who works there and even they had help. [Resident #8] just needs two people because [they] are like a wet noodle at times." Resident #8's family member was asked how they communicated with them. They stated some days Resident #8 would not talk and other days they could not understand them.	C 532		

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C 532	Continued From page 4 On 01/27/26 at 2:36 p.m., the administrator was asked how many staff members were required to assist Resident #8 with transfers. They stated, "One if done correctly." The administrator was asked what the next step for assistance with transfers was when a resident was unable to bear weight and be transferred by two staff members. They stated, "We wouldn't be able to keep them unless it was an acute situation." The administrator stated Resident #8 was a one person assist for transfers.	C 532		
C1512 SS=D	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a	C1512		

Oklahoma State Department of Health

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C1512	Continued From page 5 physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a resident was free from abuse and neglect for 1 (#8) of 9 sampled residents reviewed for abuse and neglect. The administrator identified 61 residents resided in the center. Findings:	C1512		

Oklahoma State Department of Health

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C1512	Continued From page 6 On 01/27/26 at 1:39 p.m., CNA #1 and CNA #2 were observed to don gloves to assist Resident #8 in transferring to the toilet. Resident #8 began speaking unintelligible and in a high pitched tone. CNA #1 stated, "I'm not sure what you're saying." CNA #1 and CNA #2 applied a gait belt to Resident #8 and assisted them to stand. Resident #8 was unable to bear weight as evidenced by their legs being bent in a 45 degree angle. CNA #1 and CNA #2 had Resident #8 under the arm and holding onto the gait belt. Resident #8 grabbed the grab bar in the shower preventing CNA #1 and CNA #2 from transferring them to the toilet. CNA #2 stepped into the shower to complete the transfer to the toilet and stumbled, trying to help Resident #8 release the grab bar. Resident #8's legs were still bent at a 45 degree angle and was not bearing their weight enough for a safe transfer. Resident #8 released the grab bar and CNA #1 and CNA #2 both let go of the gait belt to pull down Resident #8's pants. CNA #1 and CNA #2 had to bend down significantly to pull down Resident #8's pants due to the resident not bearing enough weight to stand. CNA #1 and CNA #2 then sat Resident #8 on the toilet. They were audibly winded and sighed. On 01/28/26 at 8:44 a.m., Resident #8 was observed sitting at a dining room table. A hospice aide was present and attempted to talk with the resident. Resident #8 did not respond. An undated series of three videos without time stamps was reviewed. In the videos CNA #3 was observed pushing Resident #8 in their wheelchair to the side of their bed. CNA #3 was observed standing in front of Resident #8 and pulling them forward by their neck. CNA #3 then grabbed the back of Resident #8's pants and stood them up	C1512		

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C1512	Continued From page 7 from the wheelchair. Resident #8 was observed facing the bed and fell forward, then into the floor. CNA #3 proceeded to remove Resident #8's pants while Resident #8 was saying, "No," multiple times. CNA #3 then removed Resident #8's brief and applied a new one while Resident #8 was lying on the floor. CNA #3 then walked away with the resident still on the floor. A "Significant Change Comprehensive Assessment," dated 07/18/25, showed Resident #8 was admitted to the center on 04/24/25 with diagnoses to include dementia and compression fracture of the T11-T12 vertebra. The assessment showed Resident #8 had poor mobility and gait and required one staff member to assist with transfers. A "Negotiated Service Agreement," dated 11/17/25, showed Resident #8 required one staff member to assist with transfers and propelling their wheelchair. A "Final Incident Report Form," dated 01/26/26, read in part, "On 01/21/26 at approximately 1200 [12:00 p.m.] the [Resident #8's family member] sent [administrator] a series of 3 videos, captured by [Resident #8's] in room security camera"... "the CNA [CNA #3] dropped [Resident #8] during the transfer"... "The resident is then heard saying no repeatedly. The CNA pulled the resident's pants and adult brief off of [Resident #8] and quickly puts another brief on [them], while the resident is still laying on the floor"... "After review of the videos and receiving a statement from [CNA #3] the allegation has been substantiated. [CNA #3] has been terminated." A "Training and In-service Sheet," dated 01/26/26, showed eight out of 46 employees were	C1512		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2026
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING OF MUSTANG		STREET ADDRESS, CITY, STATE, ZIP CODE 850 NORTH CLEARSPRINGS ROAD MUSTANG, OK 73064		
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C1512	Continued From page 8 educated on abuse and neglect. On 01/27/26 at 11:19 a.m., Resident #8 was asked how they were feeling. They did not respond. Resident #8 was asked what it was like living in the center. They did not respond. On 01/27/26 at 1:00 p.m., CNA #1 was asked what they knew about Resident #8. They stated, "[Resident #8] is a two person transfer, [they] can't stand well anymore." CNA #1 was asked how long Resident #8 had been a two person transfer. They stated, "About five or so months." CNA #1 was asked how Resident #8 communicated. They stated, "[Resident #8] can talk to you some days, but some days [they] can't or just doesn't want to." CNA #1 stated most of the time they were unable to understand Resident #8's speech. CNA #1 was asked when they were last educated on abuse. They stated, "It was either this month or last month." On 01/27/26 at 1:14 p.m., CNA #2 was asked if Resident #8 was a one or two person transfer. They stated Resident #8 was a two person transfer for three months. CNA #2 stated Resident #8 had been weak and sleeping a lot, but was on hospice services. CNA #2 was asked how they knew what a resident needed such as a two person transfer. They stated, "I see they can't stand with 1 person, so I tell the nurse." CNA #2 was unaware of any resident care plans or negotiated service agreements. CNA #2 was asked when they were last educated on abuse. They stated they were educated last week, but could not remember the date. On 01/27/26 at 1:52 p.m., Resident #8's family member was asked how many staff members were needed to transfer Resident #8. They	C1512		

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C1512	Continued From page 9 stated, "It should take two. This weekend there was a pretty good size person who works there and even they had help. [Resident #8] just needs two people because [they] are like a wet noodle at times." Resident #8's family member was asked how they communicated with them. They stated some days Resident #8 would not talk and other days they could not understand them. Resident #8's family member was asked about their fall on 01/20/26. They stated the camera in Resident #8's room showed CNA #3 attempted to transfer Resident #8 from their wheelchair to the bed and dropped them. Resident #8's family member stated CNA #3 was seen forcefully changing Resident #8's brief while they were lying on the floor and Resident #8 was repeating the word "No" several times. Resident #8's family member stated CNA #3 finished the brief change and was able to put Resident #8 into bed. Resident #8's family member stated they were not notified of the incident and only happened to see it while checking Resident #8's room camera. Resident #8's family member stated they were appalled by the treatment of their family member. On 01/27/26 at 2:31 p.m., the administrator was asked what the center's process was when abuse was reported. They stated, "We immediately suspended [CNA #3] and did an abuse in-service with the memory care staff." The administrator stated the rest of the staff would be educated on abuse on 01/30/26. On 01/27/26 at 2:36 p.m., the administrator was asked how many staff members were required to assist Resident #8 with transfers. They stated, "One, if done correctly."	C1512		

Delivery via email to: Tasha.Winship@legendseniorliving.com

March 5, 2026

License Number: AL0903

Ms. Latasha Winship, Administrator
Arbor House Assisted Living Of Mustang
850 North Clearsprings Road
Mustang, OK 73064

Survey Event ID: UQYW11

Dear Ms. Winship:

On **January 28, 2026**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- What training will the HCD receive regarding assessments?

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS Complaint investigations (#OK00081930, OK00086662, and #OK00088963) were conducted on 01/27/26 through 01/28/26. Deficiencies were cited as a result of the survey. Facility Census: 60 Listed below are abbreviations that will be used throughout this document. CNA- certified nursing aide	C 000		
C 532 SS=D	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a resident assessment accurately reflected the resident's status for 1 (#8) of 9 sampled residents reviewed for assessment accuracy. The administrator identified 61 residents resided	C 532	Please see attached POC	

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE *Admin.*

(X6) DATE *3/3/26*

Oklahoma State Department of Health

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C 532	Continued From page 1 in the center. Findings: On 01/27/26 at 11:18 a.m., Resident #8 was observed sitting at a dining room table. CNA #1 attempted to verbally engage with Resident #8 and they did not respond. On 01/27/26 at 1:27 p.m., Resident #8 was observed using a high pitched tone attempting to communicate with CNA #1. Resident #8 was unable to form words and was unintelligible. CNA #1 stated they did not know what Resident #8 was saying. On 01/27/26 at 1:35 p.m., CNA #1 was observed pushing Resident #8 in their wheelchair to the bathroom. Resident #8 set their feet down on the floor preventing the wheelchair from moving. CNA #1 asked Resident #8 if they could lift their feet up and Resident #8 responded, "No, no, no, no, no." Resident #8 attempted to say more, but was unintelligible. CNA #2 brought wheelchair foot pedals and applied them to the wheelchair. Resident #8's feet were placed on the pedals and CNA #1 continued pushing them in their wheelchair to the bathroom. On 01/27/26 at 1:39 p.m., CNA #1 and CNA #2 were observed to don gloves to assist Resident #8 in transferring to the toilet. Resident #8 began speaking unintelligible and in a high pitched tone. CNA #1 stated, "I'm not sure what you're saying." CNA #1 and CNA #2 applied a gait belt to Resident #8 and assisted them to stand. Resident #8 was unable to bear weight as evidenced by their legs being bent in a 45 degree angle. CNA #1 and CNA #2 had Resident #8 under the arm and holding onto the gait belt. Resident #8	C 532			

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C 532	Continued From page 2 grabbed the grab bar in the shower preventing CNA #1 and CNA #2 from transferring them to the toilet. CNA #2 stepped into the shower to complete the transfer to the toilet and stumbled, trying to help Resident #8 release the grab bar. Resident #8's legs were still bent at a 45 degree angle and was not bearing their weight enough for a safe transfer. Resident #8 released the grab bar and CNA #1 and CNA #2 both let go of the gait belt to pull down Resident #8's pants. CNA #1 and CNA #2 had to bend down significantly to pull down Resident #8's pants due to the resident not bearing enough weight to stand. CNA #1 and CNA #2 then sat Resident #8 on the toilet. They were audibly winded and sighed. On 01/28/26 at 8:44 a.m., Resident #8 was observed sitting at a dining room table. A hospice aide was present and attempted to talk with the resident. Resident #8 did not respond. A "Significant Change Comprehensive Assessment," dated 07/18/25, showed Resident #8 was admitted to the center on 04/24/25 with diagnoses to include dementia and compression fracture of the T11-T12 vertebra. The assessment showed Resident #8 had poor mobility and gait and required one staff member to assist with transfers. The assessment showed Resident #8 utilized a walker and at times utilized a wheelchair and was weight bearing. The assessment showed Resident #8 had a good ability to communicate and was interviewable. A "Negotiated Service Agreement," dated 11/17/25, showed Resident #8 required one staff member to assist with transfers and propelling their wheelchair. On 01/27/26 at 11:19 a.m., Resident #8 was	C 532			

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C 532	Continued From page 3 asked how they were feeling. They did not respond. Resident #8 was asked what it was like living in the center. They did not respond. On 01/27/26 at 1:00 p.m., CNA #1 was asked what they knew about Resident #8. They stated, "[Resident #8] is a two person transfer, [they] can't stand well anymore." CNA #1 was asked how long Resident #8 had been a two person transfer. They stated, "About five or so months." CNA #1 was asked how Resident #8 communicated. They stated, "[Resident #8] can talk to you some days, but some days [they] can't or just doesn't want to." CNA #1 stated most of the time they are unable to understand Resident #8's speech. On 01/27/26 at 1:14 p.m., CNA #2 was asked if Resident #8 was a one or two person transfer. They stated Resident #8 was a two person transfer for three months. CNA #2 stated Resident #8 had been weak and sleeping a lot, but was on hospice services. CNA #2 was asked how they knew what a resident needs such as a two person transfer. They stated, "I see they can't stand with 1 person, so I tell the nurse." CNA #2 was unaware of any resident care plans or negotiated service agreements. On 01/27/26 at 1:52 p.m., Resident #8's family member was asked how many staff members were needed to transfer Resident #8. They stated, "It should take two. This weekend there was a pretty good size person who works there and even they had help. [Resident #8] just needs two people because [they] are like a wet noodle at times." Resident #8's family member was asked how they communicated with them. They stated some days Resident #8 would not talk and other days they could not understand them.	C 532			

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C 532	Continued From page 4 On 01/27/26 at 2:36 p.m., the administrator was asked how many staff members were required to assist Resident #8 with transfers. They stated, "One if done correctly." The administrator was asked what the next step for assistance with transfers was when a resident was unable to bear weight and be transferred by two staff members. They stated, "We wouldn't be able to keep them unless it was an acute situation." The administrator stated Resident #8 was a one person assist for transfers.	C 532			
C1512 SS=D	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a	C1512	Please see attached POC		

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C1512	Continued From page 5 physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a resident was free from abuse and neglect for 1 (#8) of 9 sampled residents reviewed for abuse and neglect. The administrator identified 61 residents resided in the center. Findings:	C1512			

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C1512	Continued From page 9 stated, "It should take two. This weekend there was a pretty good size person who works there and even they had help. [Resident #8] just needs two people because [they] are like a wet noodle at times." Resident #8's family member was asked how they communicated with them. They stated some days Resident #8 would not talk and other days they could not understand them. Resident #8's family member was asked about their fall on 01/20/26. They stated the camera in Resident #8's room showed CNA #3 attempted to transfer Resident #8 from their wheelchair to the bed and dropped them. Resident #8's family member stated CNA #3 was seen forcefully changing Resident #8's brief while they were lying on the floor and Resident #8 was repeating the word "No" several times. Resident #8's family member stated CNA #3 finished the brief change and was able to put Resident #8 into bed. Resident #8's family member stated they were not notified of the incident and only happened to see it while checking Resident #8's room camera. Resident #8's family member stated they were appalled by the treatment of their family member. On 01/27/26 at 2:31 p.m., the administrator was asked what the center's process was when abuse was reported. They stated, "We immediately suspended [CNA #3] and did an abuse in-service with the memory care staff." The administrator stated the rest of the staff would be educated on abuse on 01/30/26. On 01/27/26 at 2:36 p.m., the administrator was asked how many staff members were required to assist Resident #8 with transfers. They stated, "One, if done correctly."	C1512			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2026
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING OF MUSTANG		STREET ADDRESS, CITY, STATE, ZIP CODE 850 NORTH CLEARSPRINGS ROAD MUSTANG, OK 73064		
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C 000	INITIAL COMMENTS Complaint investigations (#OK00081930, OK00086662, and #OK00088963) were conducted on 01/27/26 through 01/28/26. Deficiencies were cited as a result of the survey. Facility Census: 60 Listed below are abbreviations that will be used throughout this document. CNA- certified nursing aide	C 000		
C 532 SS=D	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a resident assessment accurately reflected the resident's status for 1 (#8) of 9 sampled residents reviewed for assessment accuracy. The administrator identified 61 residents resided	C 532	Please see attached POC	

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE *Admin.*

(X6) DATE *3/3/26*

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2026
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C 532	Continued From page 1 in the center. Findings: On 01/27/26 at 11:18 a.m., Resident #8 was observed sitting at a dining room table. CNA #1 attempted to verbally engage with Resident #8 and they did not respond. On 01/27/26 at 1:27 p.m., Resident #8 was observed using a high pitched tone attempting to communicate with CNA #1. Resident #8 was unable to form words and was unintelligible. CNA #1 stated they did not know what Resident #8 was saying. On 01/27/26 at 1:35 p.m., CNA #1 was observed pushing Resident #8 in their wheelchair to the bathroom. Resident #8 set their feet down on the floor preventing the wheelchair from moving. CNA #1 asked Resident #8 if they could lift their feet up and Resident #8 responded, "No, no, no, no, no." Resident #8 attempted to say more, but was unintelligible. CNA #2 brought wheelchair foot pedals and applied them to the wheelchair. Resident #8's feet were placed on the pedals and CNA #1 continued pushing them in their wheelchair to the bathroom. On 01/27/26 at 1:39 p.m., CNA #1 and CNA #2 were observed to don gloves to assist Resident #8 in transferring to the toilet. Resident #8 began speaking unintelligible and in a high pitched tone. CNA #1 stated, "I'm not sure what you're saying." CNA #1 and CNA #2 applied a gait belt to Resident #8 and assisted them to stand. Resident #8 was unable to bear weight as evidenced by their legs being bent in a 45 degree angle. CNA #1 and CNA #2 had Resident #8 under the arm and holding onto the gait belt. Resident #8	C 532		

Oklahoma State Department of Health

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C 532	Continued From page 2 grabbed the grab bar in the shower preventing CNA #1 and CNA #2 from transferring them to the toilet. CNA #2 stepped into the shower to complete the transfer to the toilet and stumbled, trying to help Resident #8 release the grab bar. Resident #8's legs were still bent at a 45 degree angle and was not bearing their weight enough for a safe transfer. Resident #8 released the grab bar and CNA #1 and CNA #2 both let go of the gait belt to pull down Resident #8's pants. CNA #1 and CNA #2 had to bend down significantly to pull down Resident #8's pants due to the resident not bearing enough weight to stand. CNA #1 and CNA #2 then sat Resident #8 on the toilet. They were audibly winded and sighed. On 01/28/26 at 8:44 a.m., Resident #8 was observed sitting at a dining room table. A hospice aide was present and attempted to talk with the resident. Resident #8 did not respond. A "Significant Change Comprehensive Assessment," dated 07/18/25, showed Resident #8 was admitted to the center on 04/24/25 with diagnoses to include dementia and compression fracture of the T11-T12 vertebra. The assessment showed Resident #8 had poor mobility and gait and required one staff member to assist with transfers. The assessment showed Resident #8 utilized a walker and at times utilized a wheelchair and was weight bearing. The assessment showed Resident #8 had a good ability to communicate and was interviewable. A "Negotiated Service Agreement," dated 11/17/25, showed Resident #8 required one staff member to assist with transfers and propelling their wheelchair. On 01/27/26 at 11:19 a.m., Resident #8 was	C 532			

Oklahoma State Department of Health

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C 532	Continued From page 3 asked how they were feeling. They did not respond. Resident #8 was asked what it was like living in the center. They did not respond. On 01/27/26 at 1:00 p.m., CNA #1 was asked what they knew about Resident #8. They stated, "[Resident #8] is a two person transfer, [they] can't stand well anymore." CNA #1 was asked how long Resident #8 had been a two person transfer. They stated, "About five or so months." CNA #1 was asked how Resident #8 communicated. They stated, "[Resident #8] can talk to you some days, but some days [they] can't or just doesn't want to." CNA #1 stated most of the time they are unable to understand Resident #8's speech. On 01/27/26 at 1:14 p.m., CNA #2 was asked if Resident #8 was a one or two person transfer. They stated Resident #8 was a two person transfer for three months. CNA #2 stated Resident #8 had been weak and sleeping a lot, but was on hospice services. CNA #2 was asked how they knew what a resident needs such as a two person transfer. They stated, "I see they can't stand with 1 person, so I tell the nurse." CNA #2 was unaware of any resident care plans or negotiated service agreements. On 01/27/26 at 1:52 p.m., Resident #8's family member was asked how many staff members were needed to transfer Resident #8. They stated, "It should take two. This weekend there was a pretty good size person who works there and even they had help. [Resident #8] just needs two people because [they] are like a wet noodle at times." Resident #8's family member was asked how they communicated with them. They stated some days Resident #8 would not talk and other days they could not understand them.	C 532			

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C 532	Continued From page 4 On 01/27/26 at 2:36 p.m., the administrator was asked how many staff members were required to assist Resident #8 with transfers. They stated, "One if done correctly." The administrator was asked what the next step for assistance with transfers was when a resident was unable to bear weight and be transferred by two staff members. They stated, "We wouldn't be able to keep them unless it was an acute situation." The administrator stated Resident #8 was a one person assist for transfers.	C 532			
C1512 SS=D	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a	C1512	Please see attached FOC		

Oklahoma State Department of Health

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C1512	Continued From page 5 physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a resident was free from abuse and neglect for 1 (#8) of 9 sampled residents reviewed for abuse and neglect. The administrator identified 61 residents resided in the center. Findings:	C1512		

Oklahoma State Department of Health

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C1512	Continued From page 6 On 01/27/26 at 1:39 p.m., CNA #1 and CNA #2 were observed to don gloves to assist Resident #8 in transferring to the toilet. Resident #8 began speaking unintelligible and in a high pitched tone. CNA #1 stated, "I'm not sure what you're saying." CNA #1 and CNA #2 applied a gait belt to Resident #8 and assisted them to stand. Resident #8 was unable to bear weight as evidenced by their legs being bent in a 45 degree angle. CNA #1 and CNA #2 had Resident #8 under the arm and holding onto the gait belt. Resident #8 grabbed the grab bar in the shower preventing CNA #1 and CNA #2 from transferring them to the toilet. CNA #2 stepped into the shower to complete the transfer to the toilet and stumbled, trying to help Resident #8 release the grab bar. Resident #8's legs were still bent at a 45 degree angle and was not bearing their weight enough for a safe transfer. Resident #8 released the grab bar and CNA #1 and CNA #2 both let go of the gait belt to pull down Resident #8's pants. CNA #1 and CNA #2 had to bend down significantly to pull down Resident #8's pants due to the resident not bearing enough weight to stand. CNA #1 and CNA #2 then sat Resident #8 on the toilet. They were audibly winded and sighed. On 01/28/26 at 8:44 a.m., Resident #8 was observed sitting at a dining room table. A hospice aide was present and attempted to talk with the resident. Resident #8 did not respond. An undated series of three videos without time stamps was reviewed. In the videos CNA #3 was observed pushing Resident #8 in their wheelchair to the side of their bed. CNA #3 was observed standing in front of Resident #8 and pulling them forward by their neck. CNA #3 then grabbed the back of Resident #8's pants and stood them up	C1512		

Oklahoma State Department of Health

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C1512	Continued From page 7 from the wheelchair. Resident #8 was observed facing the bed and fell forward, then into the floor. CNA #3 proceeded to remove Resident #8's pants while Resident #8 was saying, "No," multiple times. CNA #3 then removed Resident #8's brief and applied a new one while Resident #8 was lying on the floor. CNA #3 then walked away with the resident still on the floor. A "Significant Change Comprehensive Assessment," dated 07/18/25, showed Resident #8 was admitted to the center on 04/24/25 with diagnoses to include dementia and compression fracture of the T11-T12 vertebra. The assessment showed Resident #8 had poor mobility and gait and required one staff member to assist with transfers. A "Negotiated Service Agreement," dated 11/17/25, showed Resident #8 required one staff member to assist with transfers and propelling their wheelchair. A "Final Incident Report Form," dated 01/26/26, read in part, "On 01/21/26 at approximately 1200 [12:00 p.m.] the [Resident #8's family member] sent [administrator] a series of 3 videos, captured by [Resident #8's] in room security camera"...the CNA [CNA #3] dropped [Resident #8] during the transfer"...The resident is then heard saying no repeatedly. The CNA pulled the resident's pants and adult brief off of [Resident #8] and quickly puts another brief on [them], while the resident is still laying on the floor"...After review of the videos and receiving a statement from [CNA #3] the allegation has been substantiated. [CNA #3] has been terminated." A "Training and In-service Sheet," dated 01/26/26, showed eight out of 46 employees were	C1512			

Oklahoma State Department of Health

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C1512	Continued From page 8 educated on abuse an neglect. On 01/27/26 at 11:19 a.m., Resident #8 was asked how they were feeling. They did not respond. Resident #8 was asked what it was like living in the center. They did not respond. On 01/27/26 at 1:00 p.m., CNA #1 was asked what they knew about Resident #8. They stated, "[Resident #8] is a two person transfer, [they] can't stand well anymore." CNA #1 was asked how long Resident #8 had been a two person transfer. They stated, "About five or so months." CNA #1 was asked how Resident #8 communicated. They stated, "[Resident #8] can talk to you some days, but some days [they] can't or just doesn't want to." CNA #1 stated most of the time they were unable to understand Resident #8's speech. CNA #1 was asked when they were last educated on abuse. They stated, "It was either this month or last month." On 01/27/26 at 1:14 p.m., CNA #2 was asked if Resident #8 was a one or two person transfer. They stated Resident #8 was a two person transfer for three months. CNA #2 stated Resident #8 had been weak and sleeping a lot, but was on hospice services. CNA #2 was asked how they knew what a resident needed such as a two person transfer. They stated, "I see they can't stand with 1 person, so I tell the nurse." CNA #2 was unaware of any resident care plans or negotiated service agreements. CNA #2 was asked when they were last educated on abuse. They stated they were educated last week, but could not remember the date. On 01/27/26 at 1:52 p.m., Resident #8's family member was asked how many staff members were needed to transfer Resident #8. They	C1512			

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C1512	Continued From page 9 stated, "It should take two. This weekend there was a pretty good size person who works there and even they had help. [Resident #8] just needs two people because [they] are like a wet noodle at times." Resident #8's family member was asked how they communicated with them. They stated some days Resident #8 would not talk and other days they could not understand them. Resident #8's family member was asked about their fall on 01/20/26. They stated the camera in Resident #8's room showed CNA #3 attempted to transfer Resident #8 from their wheelchair to the bed and dropped them. Resident #8's family member stated CNA #3 was seen forcefully changing Resident #8's brief while they were lying on the floor and Resident #8 was repeating the word "No" several times. Resident #8's family member stated CNA #3 finished the brief change and was able to put Resident #8 into bed. Resident #8's family member stated they were not notified of the incident and only happened to see it while checking Resident #8's room camera. Resident #8's family member stated they were appalled by the treatment of their family member. On 01/27/26 at 2:31 p.m., the administrator was asked what the center's process was when abuse was reported. They stated, "We immediately suspended [CNA #3] and did an abuse in-service with the memory care staff." The administrator stated the rest of the staff would be educated on abuse on 01/30/26. On 01/27/26 at 2:36 p.m., the administrator was asked how many staff members were required to assist Resident #8 with transfers. They stated, "One, if done correctly."	C1512			



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 2/23/2026

Facility Name: Arbor House of Mustang

License Number: AL 903

Survey Event ID: UQYW11

Date Survey Completed: 1/28/2026

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 532

Based on: Observation, record review, and interview, the center failed to ensure a resident assessment accurately reflected the resident's status for 1 (#8) of 9 sampled residents reviewed for assessment accuracy.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Preparation and execution of this Plan of Corrections are not an admission or agreement by the provider of the truth of the allegations in the statement of deficiencies. This Plan of Correction has been prepared and executed solely as it is required by state and federal law. Please accept this Plan of Corrections as our credible allegation of compliance.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident #8 was immediately reassessed, proper DME was requested and delivered and implemented into the residents plan of care (01/27/2026).

All Resident's transfer statuses will be reviewed and updated on the assessment if needed.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

There is a potential for all residents to be affected by the identified practice. The Healthcare Director, Regional Healthcare Specialist and/or the Residence Director will review all residents transfer status and will update the resident's service plan if needed.

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) All Resident's transfer statuses will be reviewed and updated on the assessment if needed.
- 2) Change of conditions will be discussed at the morning meeting daily to determine if the residents Service Agreement reflects the residents needs.
- 3) Change in conditions and those residents Service Agreements will be reviewed monthly during the QMPI to ensure that all Service Agreements meet each residents needs.
- 4) Every 90 days the HCD will re-evaluate the residents to ensure the Service Plan is up to date and reflects the residents needs.

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;

- 1) Residents who have a change in condition will be discussed during the morning meeting each day. 2) The HCD will then review the residents service plan to ensure that the residents needs are met. 3) All residents with a change in condition and their service plans will be

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.		reviewed at the monthly QMPI Committee Meeting. 4) This plan of corrections will be reviewed at the monthly QMPI Meeting to ensure continued compliance and to determine if the plan remains effective. 5) The re-evaluation and updated service plan will become of the residents record. QMPI Minutes will be kept in the Residence Directors office.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/23/2026	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required.		Date Enter a date of signature	
OAC 310:663-25-4(F)		03/03/2026	
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.			