OKLAHOMA
State Department
of Health

Delivery via email to: angie.crawford63@gmail.com

May 12, 2025

License Number: AL0908

Ms. Angie Crawford, Administrator
Carriage House Homes
11012 Coachman's Road
Yukon, OK 73099

RE: Survey Event ID: 4V5D11

Dear Ms. Crawford:

On **April 30, 2025**, agents from our office concluded a State Licensure survey with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **April 30, 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: IDRCoordinator@health.ok.gov

or mail to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Tempal Killman

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Carriage House Homes
Address: 11012 Coachman's Road
City, State, Zip: Yukon, OK 73099
Provider #: AL0908
Complaint #: OK00073975
Investigation Date(s): 04/30/25

ALLEGATION(S)
The center failed to ensure the environment was clean, free of offensive odors, and an accumulation of pet feces
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 04/30/2025 at 7:40 a.m.

A sample of 3 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: Observation at arrival of center showed no pet feces or odors from driveway to porch. The inside of the center was non odorous, had clean surfaces, and free of clutter. Observation of the back porch and back yard showed no pet feces or odors. Interview with staff, residents, and family provided verification there are no offensive odors or pet feces in or around the center.

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: 04/30/2025

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
	AL0908	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE HOMES	11012 COACHMAN'S ROAD YUKON, OK 73099

(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 and complaint survey (#OK00073975) was conducted from 01/01/25 through 01/05/25. Deficiencies were cited as a result of the survey. Facility Census: 5 Listed below are abbreviations that will be used throughout this document. CNA- certified nursing assistant	C 000		
C 961 SS=F	310:663-9-6(a) MINIMUM STAFF FOR SERVICES (a) The right number of trained staff shall be on duty, awake, and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents and to carry out all the processes listed in the continuum of care facility's, or assisted living center's, written emergency and disaster preparedness plan for fires and other natural disasters.	C 961		

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C 961	Continued From page 1	C 961		

This Rule is not met as evidenced by:
Based on record review and interview, it was determined the center failed to ensure certified staff were on duty and present in the center at all times for 3 CNAs (#2, 3, and #4) of 5 CNAs reviewed for certification.

The administrator identified 5 residents resided in the center.

Findings:

CNA #2 was hired at the center on 10/05/23.

A record review of the Oklahoma Nurse Aide Registry showed CNA #2's Long Term Care Aide certification expired in November of 2024.

CNA #3 was hired at the center on 12/03/22.

CNA #4 was hired at the center on 11/13/21.

A record review of the Oklahoma Nurse Aide Registry showed no Long Term Care Aide certifications for CNA #3 or CNA #4.

On 04/30/25 at 12:10 p.m., the administrator was asked what CNA #2's position was within the center. They stated, "CNA." They were asked what CNA #2 did for the residents. The administrator stated, "Provides direct care." The administrator was asked when the CNA last worked in the center. The administrator stated, "Last night." The administrator was asked when CNA #2's Long Term Care Aide certification

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	AL0908	A. BUILDING: _____ B. WING _____	C 04/30/2025

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C 961	Continued From page 2 expired. They stated, "I don't know off the top of my head. It's probably expired." The administrator was asked what CNA #3's position was within the center. They stated, "CNA." They were asked what CNA #3 did for the residents. The administrator stated, "Provides direct care." The administrator was asked when CNA #3 last worked. The administrator stated, "This past Sunday (04/27/25)." The administrator was asked when CNA #3's Long Term Care Aide certification expired. They stated, "[CNA #3] had CNA training during COVID, but hasn't ever taken their test." The administrator was asked if CNA #3 had ever been certified as a Long Term Care Aide. The administrator stated, "No." On 04/30/25 at 12:16 p.m., the administrator was asked what CNA #4's position was within the center. They stated, "CNA. [CNA #3] is not licensed. They had the training during COVID, but needs to take their test." The administrator was asked if CNA #4 provided direct care. The administrator stated, "Yes." The administrator was asked if CNA #4 had ever been certified as a Long Term Care Aide. The administrator stated, "No."	C 961		
C1110 SS=F	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes.	C1110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0908	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1110	Continued From page 3	C1110		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a quality assurance committee met on a quarterly basis.

The administrator identified five residents resided in the center.

Findings:

Record review of internal quality assurance committee reports were reviewed from 01/09/24 through 04/20/25. There was no documentation the quality assurance committee met 01/09/24 through 04/20/25.

On 04/20/25 at 12:37 p.m., the administrator was asked for the quality assurance committee meeting reports. The administrator stated, "We are supposed to have the meetings, but we don't." The administrator was asked when the last time a quality assurance meeting was held. The administrator stated, "It's been over a year."

OKLAHOMA
State Department of Health

Delivery via email to: angie.crawford63@gmail.com

July 10, 2025

License Number: AL0908

Ms. Angela Crawford, Administrator
Carriage House Homes
11012 Coachman's Road
Yukon, OK 73099

RE: Survey Event 4V5D11

Dear Ms. Crawford:

On **April 30, 2025**, a Licensure inspection with a Complaint investigation 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 in a timely manner. **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 have been corrected and you were in substantial compliance by **June 30, 2025**.

We will conduct a revisit to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 05/19/2025
Facility Name: Carriage House Homes .
License Number: AL0908
Survey Event ID: 4V5D11.
Date Survey Completed: 4/30/2025.

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C961	Based on: Record Review and interview, it was determined the center failed to ensure certified staff were on duty and present in the center at all times.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: .

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?	No residents were directly affected. License that was expired was re instated within 24 hours of notification. The other 2 aides will be scheduled to sit for CNA license within 30 days
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No other residents involved. Facility only has 5 residents
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?	DON and Administrator will review personnel charts on monthly basis to assure no expirations take place. All renewal dates will be placed on Google calendar for updates. Testing will be completed within 30 days by the end of June 2025.
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.	Facility will perform monthly chart audits on personnel folders. All information will be obtained and reviewed for accuracy. Facility will remain 100% compliant. All staff dates of renewal will be entered into the facilities Google Calendar that is set up for alerts. Effectiveness of current system will be documented in the quarterly QA meetings and reviewed for the 100% threshold. All staff licensures are scanned into our electronic chart system (ALIS). They are kept individually in each employees personnel record.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/30/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Angie Crawford
OAC 310:663-25-4(F)

Date 5/19/2025.

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: 05/19/2025
Facility Name: Carriage House Homes .
License Number: AL0908
Survey Event ID: 4V5D11.
Date Survey Completed: 4/30/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1110.	Based on: review and interview, the facility failed to ensure a quality assurance committee met on quarterly basis

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living cenater'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?	No residents were directly impacted. Quality Assurance Meeting was not documented from 1/2025-4/2025. Meetings have taken place but were not documented. Meetings will continue to occur with staff, family and administrator. All meeting minutes will be documented immediately by Administrator and placed in the QA notebook for 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?	No other residents affected due to only 5 residents in facility.
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?	Administrator will be responsible for documenting all results of quarterly QA immediately. It will be part of our audit system and entered into the QA program. Will assign head CNA to make sure Administrator stays on track. Enter measures or systematic changes to ensure deficient practices will not recur.
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.	Will audit QA book on monthly basis to make sure notes are placed into the QA binder. Will assess the results and document. Will assign head CNA to review the QA. Will add QA documentation into our QA program to make sure it is being completed on a timely basis. Records will be evidenced by having current QA notes in binder quarterly. I
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	05/30/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Angie Crawford. **Date 05/19/2025**

OAC 310:663-25-4(F)

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department of Health

Delivery via email to: angie.crawford63@gmail.com

July 23, 2025

License Number: AL0908
Survey Event 4V5D12

Ms. Angie Crawford, Administrator
Carriage House Homes
11012 Coachman's Road
Yukon, OK 73099

Dear Ms. Crawford:

On **July 23, 2025,** an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your survey on **April 30, 2025,** have now been corrected effective **June 30, 2025.**

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

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0908	A. BUILDING: _____ B. WING _____	R 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE HOMES	11012 COACHMAN'S ROAD YUKON, OK 73099

(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 07/23/25. 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