OKLAHOMA
State Department
of Health

Delivery via email to: CRolf@ignitemedicalresorts.com; mskelton@ignitemedicalresorts.com; Marcie Davis <mdavis@luxelifeseniorliving.com>; Rachel Shearer <rshearer@ignitemedicalresorts.com>

May 1, 2025

License Number: AL1403

Ms. Meaghan Skelton, Administrator
Luxe Life Norman Al, Llc
1060 Rambling Oaks Drive
Norman, OK 73072

Survey Event ID: YSQ011

Dear Ms. Skelton:

On **April 20, 2025,** 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
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: Luxe Life Norman
Address: 1060 Rambling Oaks Drive
City, State, Zip: Norman, OK 73072
Provider #: AL1403
Complaint #: OK00080905
Investigation Date(s): 04/16/25-04/20/25

ALLEGATION(S)
The center failed to ensure residents were not physically, verbally or psychosocially abused
The center failed to ensure adequate hydration was provided for dependent residents
The center failed to ensure adequate staff to meet the needs of the residents
enter text
enter text

An unannounced on-site investigation was initiated 04/16/2025 at 2:00 p.m.

A sample of 6 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: The initial tour of the center showed residents were well groomed, wearing clean clothing, and showed no signs of distress. Observations of staff to resident interactions were made and no signs of abuse were shown. Record reviews of incident reports showed no allegations of abuse and no grievances had been filed with the center. Interviews with staff, residents, and families were conducted and no reports of abuse or mistreatment were identified. Hydration was offered multiple times for multiple residents with no complaints from residents or families regarding dehydration. Observation, record review, and interview showed the center failed to ensure the minimum number of staff were on duty for one of three shifts observed.

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: 04/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1403	A. BUILDING: _____ B. WING _____	C 04/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUXE LIFE NORMAN AL, LLC	1060 RAMBLING OAKS DRIVE NORMAN, OK 73072

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C 000	INITIAL COMMENTS A complaint investigation (#OK00080905) was conducted on 04/16/25 through 04/20/25. Facility Census: 59 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide CNA- certified nurse's aide DON- director of nursing	C 000		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an admission assessment was completed within 30 days before or at the time of admission for 1 (#1) of 6 residents sampled for admission assessments. The DON identified 59 residents resided in the center.	C 521		

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C 521	Continued From page 1 Findings: A policy titled, "Resident Records-Documentation Standard," dated 04/01/22, read in part, "An assessment will be completed by appropriate staff on admission." An, "Electronic Medication Administration Record," dated April 2025, showed Resident #1 was admitted to the center on 09/05/24 with diagnoses to include neurocognitive disorder with lewy bodies, other amnesia, and unspecified dementia with psychotic disturbance. A review of Resident #1's electronic medical chart showed no admission assessment. On 04/16/25 at 6:00 p.m., the DON was asked for Resident #1's admission assessment. They stated, "I don't know where they would be before I started working here." On 04/16/25 at 6:14 p.m., the DON was asked if they had found Resident #1's admission assessment. They stated, "No, not that I can locate."	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition.	C 522		

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C 522	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for 2 (#4 and #5) of 6 residents sampled for comprehensive assessments. The DON identified 59 residents resided in the center. Findings: 1. An undated "Service Plan Report," showed Resident #4 was admitted to the center on 02/16/22 with diagnoses which included Alzheimer's disease, heart failure, and chronic kidney disease. A review of Resident #4's electronic medical record showed no annual assessment had been completed for 2023, 2024, or 2025. 2. An undated, "Service Plan Report," showed Resident #5 was admitted to the center on 07/14/22 with diagnoses which included Alzheimer's disease, type 2 diabetes, and chronic obstructive pulmonary disease. A review of Resident #5's electronic medical record showed no annual assessment had been completed for 2023 or 2024. A policy titled, "Resident Records - Documentation Standard," dated 04/01/22, read in part, "An assessment will be completed by appropriate staff"..."upon resident request, and/or	C 522		

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C 522	Continued From page 3 yearly." On 04/16/25 at 6:00 p.m., the DON was asked for Resident #4 and Resident #5's annual assessments. They stated, "I don't know where they would be before I started working here." On 04/16/25 at 6:14 p.m., the DON was asked if they had found Resident #4 and Resident #5's annual assessments. They stated, "No, not that I can locate."	C 522		
C 963 SS=F	310:663-9-6(c) MINIMUM STAFF FOR SERVICES (c) An assisted living center shall have a minimum of two (2) staff members on duty and awake on all shifts if an assisted living center has a unit or program designed to prevent or limit resident access to areas outside the designated unit or program. A minimum of one (1) direct care staff is required to be on duty and awake at all times within the unit or program designed to prevent or limit resident access to areas outside the designated unit or program. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a minimum of 1 direct care staff was on duty at all times within a unit designed to prevent or limit resident access to areas outside the designated unit for 3	C 963		

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C 963	Continued From page 4 (#1, 2, and #3) of 6 sampled residents who resided on the secured units. The DON identified 59 residents resided in the center, 16 of which resided in the memory care unit. Findings: On 04/19/25 at 11:26 p.m., CMA #2 and CNA #2 were the only staff observed working in the center. Both staff members were observed in the memory care unit assisting a resident who had fallen. On 04/20/25 at 12:13 a.m., no staff were observed in the memory care unit. Surveyor began looking for staff in the memory care unit. On 04/20/25 at 12:21 a.m., the surveyor entered assisted living due to no staff in the memory care unit. CMA #2 and CNA #2 both were observed in assisted living walking down the South hall. On 04/20/25 at 12:30 a.m., both CMA #2 and CNA #2 were observed to still be in assisted living. No staff were observed in the memory care unit. On 04/20/25 at 12:36 a.m., surveyor entered the memory care unit again and CMA #1 was present in the memory care unit. 1. An, "Electronic Medication Administration Record," dated April 2025, showed Resident #1 was admitted to the center on 09/05/24 with diagnoses which included neurocognitive disorder with Lewy body dementia, other amnesia, and unspecified dementia with psychotic disturbance.	C 963		

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C 963	Continued From page 5 2. A "Service Plan Report," dated 03/25/25, showed Resident #2 was admitted to the center on 03/17/25 with a diagnosis unspecified dementia. 3. A "14-day Comprehensive Assessment," dated 03/14/25, showed Resident #3 was admitted to the center on 02/28/25 with diagnoses which included dementia with anxiety and frontotemporal neurocognitive disorder. A document titled, "Department Schedule April 2025," showed one CMA scheduled to work in assisted living and one CNA scheduled to work in the memory care unit for the 11:00 p.m. to 7:00 a.m. shift on 04/05/25, 04/06/25, 04/12/25, 04/13/25, 04/19/25, 04/20/25, 04/26/25, and 04/27/25. An undated document titled, "Labor Level Punch Detail," showed one staff member, a CNA, was on duty in the building from 11:00 p.m. until 12:00 a.m on 04/05/25 and 04/06/25. The document showed one CMA and one CNA were on duty for the building between 11:00 p.m. and 12:00 a.m. on 04/12/25, and one CNA was on duty in the building from 11:00 p.m. until 12:00 a.m. on 04/13/25. On 04/19/25 at 11:30 p.m., CMA #2 was asked how many employees were on duty for memory care. CMA #2 stated, "I'm up there in assisted living and [CNA #2] is back here until [CMA #1] comes at midnight." On 04/19/25 at 11:39 p.m., CNA #2 was asked how many staff were usually on duty on the weekends for the 11:00 p.m. to 7:00 a.m. shift. CNA #2 stated, "We used to have two in memory care and two in assisted living, but now it's one	C 963		

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C 963	Continued From page 6 on each end." They were asked what they do when a resident in assisted living required the assistance of two staff members. CNA #2 stated, "I go up there (to assisted living)." They were asked how often they have to leave the memory care unit with no staff in order to assist the staff member in assisted living. CNA #2 stated, "Quite often. They had to do it last weekend I know." On 04/19/25 at 11:50 p.m., CMA #2 was asked how many residents in the building require the assistance of two staff members. They stated, "Two in assisted living and three in memory care." On 04/20/25 at 12:43 a.m., LPN #1 was asked how many staff members work the 11:00 p.m. to 7:00 a.m. shift on weekends. They stated, "Two is the bare minimum." LPN #1 was asked what happens if the staff member in assisted living requires additional staff help with a resident. They stated, "Sometimes the person in memory care has to come up to help the person in assisted living. I told them we need more staff."	C 963		

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Delivery via email to: mskelton@ignitemedicalresorts.com; Marcie Davis <mdavis@luxelifeseniorliving.com>; Rachel Shearer <rshearer@ignitemedicalresorts.com>

May 9, 2025

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Ms. Meaghan Skelton, Administrator
Luxe Life Norman Al, Llc
1060 Rambling Oaks Drive
Norman, OK 73072

Survey Event ID: YSQ011

Dear Ms. Skelton:

On **April 20, 2025,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 18, 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

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C 000	INITIAL COMMENTS A complaint investigation (#OK00080905) was conducted on 04/16/25 through 04/20/25. Facility Census: 59 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide CNA- certified nurse's aide DON- director of nursing	C 000	**C 000** **LUXE LIFE NORMAN AL, LLC makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. LUXE LIFE NORMAN AL, LLC is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes LUXE LIFE NORMAN AL, LLC's written credible allegation of compliance for the deficiencies noted.**	
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an admission assessment was completed within 30 days before or at the time of admission for 1 (#1) of 6 residents sampled for admission assessments. The DON identified 59 residents resided in the center.	C 521		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Meaghan Skelton | TITLE: LNHA | (X6) DATE: 5/7/2025

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C 521	Continued From page 1 Findings: A policy titled, "Resident Records-Documentation Standard," dated 04/01/22, read in part, "An assessment will be completed by appropriate staff on admission." An, "Electronic Medication Administration Record," dated April 2025, showed Resident #1 was admitted to the center on 09/05/24 with diagnoses to include neurocognitive disorder with lewy bodies, other amnesia, and unspecified dementia with psychotic disturbance. A review of Resident #1's electronic medical chart showed no admission assessment. On 04/16/25 at 6:00 p.m., the DON was asked for Resident #1's admission assessment. They stated, "I don't know where they would be before I started working here." On 04/16/25 at 6:14 p.m., the DON was asked if they had found Resident #1's admission assessment. They stated, "No, not that I can locate."	C 521	**C 521** **It is the facility's policy to complete admission assessments within thirty (30) days before, or at the time of admission, for all residents as required by state regulations.** **Corrective Action for Affected Residents: On 04/19/25, the Director of Nursing completed a comprehensive admission assessment for Resident #1. The assessment was reviewed and signed by RN and placed in the resident's electronic medical record as well as a binder in the office.** **Identifying other Residents having the Potential to be Affected: On 04/17/25, the Director of Nursing conducted an audit of all current residents' medical records to ensure admission assessments were completed within the required time frame. Any identified missing or incomplete admission assessments were completed immediately.** **Measures put into place or Systemic Changes: The VP of Clinical will in-service Clinical Nursing Officer by 4/27/25 on the requirement to complete admission assessments within thirty (30) days before, or at the time of admission. The in-service will include proper documentation procedures and timeframes for completion. The QA was completed for the process. A new admission checklist has been implemented that includes verification of completed admission assessment. The VP of Clinical or designee will review all new admissions within 24 hours to ensure admission assessments are completed timely.**	
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition.	C 522		

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C 522	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for 2 (#4 and #5) of 6 residents sampled for comprehensive assessments. The DON identified 59 residents resided in the center. Findings: 1. An undated "Service Plan Report," showed Resident #4 was admitted to the center on 02/16/22 with diagnoses which included Alzheimer's disease, heart failure, and chronic kidney disease. A review of Resident #4's electronic medical record showed no annual assessment had been completed for 2023, 2024, or 2025. 2. An undated, "Service Plan Report," showed Resident #5 was admitted to the center on 07/14/22 with diagnoses which included Alzheimer's disease, type 2 diabetes, and chronic obstructive pulmonary disease. A review of Resident #5's electronic medical record showed no annual assessment had been completed for 2023 or 2024. A policy titled, "Resident Records - Documentation Standard," dated 04/01/22, read in part, "An assessment will be completed by appropriate staff"..."upon resident request, and/or	C 522	**C 521 Continued:** **Plan to Monitor Performance The VP of Clinical Operations or designee will audit 100% of new admissions weekly for 4 weeks, then 50% of new admissions weekly for 4 weeks, then 25% of new admissions weekly for 4 weeks to ensure admission assessments are completed within the required timeframe.** **The Chief Nursing Officer will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. The facility will be in substiantial compliance by 5/18/2025.** **C 522:** **It is the facility's policy to complete comprehensive assessments within fourteen (14) days after admission, once every twelve (12) months thereafter, and promptly after a significant change in the resident's condition.** **Corrective Action for Affected Residents: On 04/17/25, completed comprehensive assessments for Resident #4 and Resident #5. The assessments were reviewed and signed/ verbal acknowledgment by family or POA and RN or MD.** **Identifying other Residents having the Potential to be Affected: On 04/17/25, the VP of Clinical conducted an audit of all current residents' medical records to identify any other residents with overdue annual comprehensive assessments. Any identified overdue assessments will be completed by 5/18/2025.**	

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	AL1403	A. BUILDING: _____ B. WING _____	C 04/20/2025

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C 522	Continued From page 3 yearly." On 04/16/25 at 6:00 p.m., the DON was asked for Resident #4 and Resident #5's annual assessments. They stated, "I don't know where they would be before I started working here." On 04/16/25 at 6:14 p.m., the DON was asked if they had found Resident #4 and Resident #5's annual assessments. They stated, "No, not that I can locate."	C 522	**C 522 Continued:** **Measures put into place or Systemic Changes: The VP of Clinical will in-service Clinical Nursing Officer by 4/17/2025 on the requirement to complete comprehensive assessments within 14 days of admission and annually thereafter. The Clinical Nursing Officer or designee will review the tracking system weekly to ensure timely completion of assessments.** **Plan to Monitor Performance: The VP of Clinical Operation will audit 25% of resident records weekly for 4 weeks, then monthly for 2 months to ensure comprehensive assessments are completed within required time frames. Results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. The facility will be in substiantial compliance by 5/18/2025.**	
C 963 SS=F	310:663-9-6(c) MINIMUM STAFF FOR SERVICES (c) An assisted living center shall have a minimum of two (2) staff members on duty and awake on all shifts if an assisted living center has a unit or program designed to prevent or limit resident access to areas outside the designated unit or program. A minimum of one (1) direct care staff is required to be on duty and awake at all times within the unit or program designed to prevent or limit resident access to areas outside the designated unit or program. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a minimum of 1 direct care staff was on duty at all times within a unit designed to prevent or limit resident access to areas outside the designated unit for 3	C 963	**C 963** **It is the facility's policy to maintain a minimum of two staff members on duty and awake on all shifts, with at least one direct care staff member on duty and awake at all times within the memory care unit designed to prevent or limit resident access to areas outside the designated unit.**	

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C 963	Continued From page 4 (#1, 2, and #3) of 6 sampled residents who resided on the secured units. The DON identified 59 residents resided in the center, 16 of which resided in the memory care unit. Findings: On 04/19/25 at 11:26 p.m., CMA #2 and CNA #2 were the only staff observed working in the center. Both staff members were observed in the memory care unit assisting a resident who had fallen. On 04/20/25 at 12:13 a.m., no staff were observed in the memory care unit. Surveyor began looking for staff in the memory care unit. On 04/20/25 at 12:21 a.m., the surveyor entered assisted living due to no staff in the memory care unit. CMA #2 and CNA #2 both were observed in assisted living walking down the South hall. On 04/20/25 at 12:30 a.m., both CMA #2 and CNA #2 were observed to still be in assisted living. No staff were observed in the memory care unit. On 04/20/25 at 12:36 a.m., surveyor entered the memory care unit again and CMA #1 was present in the memory care unit. 1. An, "Electronic Medication Administration Record," dated April 2025, showed Resident #1 was admitted to the center on 09/05/24 with diagnoses which included neurocognitive disorder with Lewy body dementia, other amnesia, and unspecified dementia with psychotic disturbance.	C 963	**C 963 Continued:** **Corrective Action for Affected Residents:On 04/20/25, the Director of Nursing immediately reviewed the care needs of Residents #1, #2, and #3 to ensure their safety was not compromised during the identified period. No adverse events were identified during the time period when staffing levels were inadequate in the memory care unit.** **Identifying other Residents having the Potential to be Affected:On 04/20/25, the Administrator and Director of Nursing conducted a review of all current residents in the memory care unit to identify those requiring assistance of two staff members. All 16 residents residing in the memory care unit have the potential to be affected by this alleged deficient practice.** **Measures put into place or Systemic Changes:** **1.The Administrator revised the staffing schedule effective 04/21/25 to ensure a minimum of two staff members are assigned to the memory care unit on all shifts, with at least one dedicated staff member remaining in the unit at all times.** **2.The Director of Nursing will in-service all staff members on:** **- Staffing requirements for the memory care unit** **-Protocol for obtaining additional assistance without leaving the memory care unit un staffed** **- Use of call systems to request assistance** **-The Administrator implemented a new policy requiring staff to obtain relief coverage before leaving the memory care unit for any reason.** **-The Director of Nursing created a staffing contingency plan to address call-offs and emergencies.**	

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C 963	Continued From page 5 2. A "Service Plan Report," dated 03/25/25, showed Resident #2 was admitted to the center on 03/17/25 with a diagnosis unspecified dementia. 3. A "14-day Comprehensive Assessment," dated 03/14/25, showed Resident #3 was admitted to the center on 02/28/25 with diagnoses which included dementia with anxiety and frontotemporal neurocognitive disorder. A document titled, "Department Schedule April 2025," showed one CMA scheduled to work in assisted living and one CNA scheduled to work in the memory care unit for the 11:00 p.m. to 7:00 a.m. shift on 04/05/25, 04/06/25, 04/12/25, 04/13/25, 04/19/25, 04/20/25, 04/26/25, and 04/27/25. An undated document titled, "Labor Level Punch Detail," showed one staff member, a CNA, was on duty in the building from 11:00 p.m. until 12:00 a.m on 04/05/25 and 04/06/25. The document showed one CMA and one CNA were on duty for the building between 11:00 p.m. and 12:00 a.m. on 04/12/25, and one CNA was on duty in the building from 11:00 p.m. until 12:00 a.m. on 04/13/25. On 04/19/25 at 11:30 p.m., CMA #2 was asked how many employees were on duty for memory care. CMA #2 stated, "I'm up there in assisted living and [CNA #2] is back here until [CMA #1] comes at midnight." On 04/19/25 at 11:39 p.m., CNA #2 was asked how many staff were usually on duty on the weekends for the 11:00 p.m. to 7:00 a.m. shift. CNA #2 stated, "We used to have two in memory care and two in assisted living, but now it's one	C 963	**C963 Continued:** **Plan to Monitor Performance:** **1.The Nurse Supervisor will conduct daily staffing audits for all shifts to ensure compliance with staffing requirements for 4 weeks, then weekly for 8 weeks, and monthly thereafter.** **2. The Director of Nursing will review staff schedules weekly to ensure adequate coverage is planned for all shifts.** **3.The Administrator will conduct random checks of the memory care unit during night and weekend shifts 3 times per week for 4 weeks, then weekly for 8 weeks.** **4. Any identified deficiencies will be corrected immediately and staff will be re-educated as needed.** **The Administrator will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for three consecutive months.** **The facility will be in substiantial compliance by 5/18/2025.**	

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C 963	Continued From page 6 on each end." They were asked what they do when a resident in assisted living required the assistance of two staff members. CNA #2 stated, "I go up there (to assisted living)." They were asked how often they have to leave the memory care unit with no staff in order to assist the staff member in assisted living. CNA #2 stated, "Quite often. They had to do it last weekend I know." On 04/19/25 at 11:50 p.m., CMA #2 was asked how many residents in the building require the assistance of two staff members. They stated, "Two in assisted living and three in memory care." On 04/20/25 at 12:43 a.m., LPN #1 was asked how many staff members work the 11:00 p.m. to 7:00 a.m. shift on weekends. They stated, "Two is the bare minimum." LPN #1 was asked what happens if the staff member in assisted living requires additional staff help with a resident. They stated, "Sometimes the person in memory care has to come up to help the person in assisted living. I told them we need more staff."	C 963		

OKLAHOMA
State Department of Health

Delivery via email to: mskelton@ignitemedicalresorts.com; mdavis@luxelifeseniorliving.com; rshearer@ignitemedicalresorts.com

June 4, 2025

License Number: AL1403

Ms. Meaghan Skelton, Administrator
Luxe Life Norman Al, Llc
1060 Rambling Oaks Drive
Norman, OK 73072

Survey Event ID: YSQ012

Dear Ms. Skelton:

On **May 27, 2025,** an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your Complaint Investigation on **April 20, 2025,** have now been corrected effective **May 18, 2025.**

If you have any questions concerning the information in this letter, please contact me 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

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 05/27/25. 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