OKLAHOMA
State Department
of Health

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

October 24, 2025

License Number: AL1403

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

RE: Survey Event ID: S1H811

Dear Ms. Skelton:

On **October 9, 2025**, agents from our office concluded a State Licensure survey with complaint investigations at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **October 9, 2025**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

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

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

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

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

If you have questions or need assistance, please feel free to send an email to OSDH.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 Norma AL, LLC**
Address: **1060 Rambling Oaks Drive**
City, State, Zip: **Norman, OK. 73072**
Provider #: **AL1403**
Complaint #: **OK00085732**
Investigation Date(s): **10/07/25-10/09/25**

ALLEGATION(S)
The facility failed to have adequate staffing to meet the needs of the residents.
The facility failed to ensure residents were free from abuse/illicit behavior.

An unannounced on-site investigation was initiated 10/07/2025 at 8:50 a.m.

A sample of 11 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and throughout the survey. Clients were observed to be ambulating in the halls, in activities, and interacting with staff. Staff were observed helping residents with care and as needed.

Client records, i.e. service plans, service contracts, physician orders, and progress notes were reviewed. Employee records were reviewed. Staffing schedules were reviewed.

Staff and clients were interviewed regarding adequate staffing, abuse and illicit behavior by staff.

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: 10/16/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Luxe Life Norman AL, LLC**
Address: **1060 Rambling Oaks Drive**
City, State, Zip: **Norman, OK. 73072**
Provider #: **AL1403**
Complaint #: **OK00086809**
Investigation Date(s): **10/07/25-10/09/25**

ALLEGATION(S)
The facility to provide care according to the contracted services.
The facility failed to ensure clinical records were accurate.

An unannounced on-site investigation was initiated 10/07/2025 at 8:50 a.m.

A sample of 11 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and throughout the survey. Clients were observed in the assisted living area and the memory care area. Clients were observed to be clean, dressed appropriately and free of odors. Staff were observed providing daily care and as needed for the clients.

Client records, i.e. service contracts, service plans, physician orders, progress notes, and assessments were reviewed. Incident reports were reviewed.

Staff were interviewed regarding accurate client records. Staff and clients were interviewed regarding proving care according to the service contracts.

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: 10/16/2025

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 10/09/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey with complaints (#OK00085732 and #OK00086809) was conducted from 10/07/25 through 10/09/25. Deficiencies were cited as a result of the survey. Facility Census: 65 List below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nursing aide CPR - cardiopulmonary resuscitation MAR - medication administration record RN - registered nurse	C 000		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure direct care staff were trained in first aid and CPR for 2 (CMA #2 and CNA #1) of 5 sampled personnel files reviewed. RN #1 identified 65 residents resided in the center.	C 954		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 954	Continued From page 1 Findings: 1. An undated facility staff list showed CMA #2 was hired on 02/25/23. There was no documentation they were trained in first aid and CPR 2. An undated facility staff list showed CNA #1 was hired on 02/10/16. There was no documentation they were trained in first aid and CPR. On 10/09/25 at 3:19 p.m., the executive director reported they did not know all direct care staff had to have training over first aid and CPR.	C 954		
C1951 SS=D	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on record review and interview, the center failed to maintain accurate clinical records for 1 (#11) of 11 residents sampled for accurate records. RN #1 identified 65 residents resided in the center. Findings: A physician's order, dated 01/02/25, showed	C1951		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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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C1951	Continued From page 2 Resident #11 was to be checked every two hours checks and to ensure the resident had on a brief and socks. A May 2025 MAR showed on 05/18/25 CMA #1 documented they had checked on Resident #11 every two hours from midnight to 6:00 a.m. On 10/09/25 at 2:59 p.m., CMA #1 reported they signed off on Resident #11's every two hour checks, but they were only in memory care until midnight then went to the assisted living side. They reported they should not have signed off on the MAR because they did not visualize Resident #11 themselves.	C1951		

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November 5, 2025

License Number: AL1403

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

RE: Survey Event S1H811

Dear Ms. Skelton:

On **October 9, 2025**, a Licensure inspection with complaint investigations was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **November 7, 2025**.

We will conduct a revisit for 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 relicensure survey with complaints (#OK00085732 and #OK00086809) was conducted from 10/07/25 through 10/09/25. Deficiencies were cited as a result of the survey. Facility Census: 65 List below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nursing aide CPR - cardiopulmonary resuscitation MAR - medication administration record RN - registered nurse	C 000	**C-000** **Ignite Medical Resorts Norman 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. Ignite Medical Resorts Norman 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 Ignite Medical Resorts Norman's written credible allegation of compliance for the deficiencies noted.**	
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure direct care staff were trained in first aid and CPR for 2 (CMA #2 and CNA #1) of 5 sampled personnel files reviewed. RN #1 identified 65 residents resided in the center.	C 954	**C-954** **Corrective Action for Affected Residents: On 10/09/25, CMA #2 and CNA #1 were identified of not having completed First Aid and CPR training. On 10/09/25, CMA #2 and CNA #1 were sent First Aid and CPR learning modules to complete. Documentation of trainings are placed in their personnel files.** **Identifying other Residents having the Potential to be Affected: On 10/09/25, the Director of Human Resources (HR) or designee conducted an audit of personnel files for direct care staff to identify any additional staff members lacking current First Aid and CPR certification. All staff were assigned the First Aid and CPR learning modules.** **Measures put into place or Systemic Changes: The HR or designee developed a tracking system to monitor First Aid and CPR training for direct care staff. The Executive Director or designee will in-service supervisory staff on 10/14/25 regarding the requirement for direct care staff to maintain current First Aid and CPR training. The HR or designee revised the new hire orientation checklist to include verification of First Aid and CPR training prior to providing direct resident care. The facility's policy and procedure for staff qualifications was updated to reflect these requirements.**	

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C 954	Continued From page 1 Findings: 1. An undated facility staff list showed CMA #2 was hired on 02/25/23. There was no documentation they were trained in first aid and CPR 2. An undated facility staff list showed CNA #1 was hired on 02/10/16. There was no documentation they were trained in first aid and CPR. On 10/09/25 at 3:19 p.m., the executive director reported they did not know all direct care staff had to have training over first aid and CPR.	C 954	**C-954** **Plan to Monitor Performance: The HR or designee will audit personnel files of direct care staff weekly for 4 weeks, then monthly for 2 months to ensure compliance with First Aid and CPR training requirements. The HR or designee will maintain a certification tracking log and send notifications to staff and their supervisors 30 days prior to certification expiration. Results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review the data and make recommendations for additional corrective actions if needed.** **Date of Compliance: 11/7/2025** **C-1951** **Corrective Action for Affected Residents: On 10/09/25, the Director of Nursing (DON) or designee conducted an audit of Resident #11's Medication Administration Record (MAR) for accuracy of documentation regarding every two-hour checks. The DON or designee provided immediate re-education to CMA #1 regarding proper documentation practices and the importance of only documenting care that was personally provided. The DON or designee conducted a review of Resident #11's care to ensure all required checks were completed as ordered.** **Identifying other Residents having the Potential to be Affected: The DON or designee conducted an audit of residents with orders for routine checks to identify potential documentation discrepancies. A review of staff assignments and documentation was completed to ensure accuracy of clinical records.** **Measures put into place or Systemic Changes: The DON or designee will in-service Licensed nurses and Certified Medication Aides (CMAs) on proper documentation practices, including: - Only documenting care personally provided - Accurate completion of MARs - Importance of maintaining accurate clinical records - Process for proper hand-off communication between shifts - Consequences of false documentation**	
C1951 SS=D	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on record review and interview, the center failed to maintain accurate clinical records for 1 (#11) of 11 residents sampled for accurate records. RN #1 identified 65 residents resided in the center. Findings: A physician's order, dated 01/02/25, showed	C1951		

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C1951	Continued From page 2 Resident #11 was to be checked every two hours checks and to ensure the resident had on a brief and socks. A May 2025 MAR showed on 05/18/25 CMA #1 documented they had checked on Resident #11 every two hours from midnight to 6:00 a.m. On 10/09/25 at 2:59 p.m., CMA #1 reported they signed off on Resident #11's every two hour checks, but they were only in memory care until midnight then went to the assisted living side. They reported they should not have signed off on the MAR because they did not visualize Resident #11 themselves.	C1951	**C-1951** **The facility has implemented a process where supervisors will verify staff assignments against documentation during shift changes. The DON or designee will review and update the facility's documentation policy to reflect these changes by 11/7/2025.** **Plan to Monitor Performance: The Unit Manager or designee will conduct random audits of 10% of residents with orders for routine checks three times per week for four weeks, then weekly for eight weeks to ensure documentation accuracy. Results of these audits will be reviewed by the DON or designee.** **The DON or designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.** **Date of Compliance: 11/7/2025**	

OKLAHOMA
State Department
of Health

Delivery via email to: mskelton@ignitemedicalresorts.com; mdavis@luxelifeseniorliving.com; rshearer@ignitemedicalresorts.com; Chelsey Rolf <crolf@ignitemedicalresorts.com>

November 14, 2025

License Number: AL1403

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

RE: Survey Event S1H812

Dear Ms. Skelton:

On **November 10, 2025,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your relicensure survey with complaints on **October 10, 2025,** have now been corrected effective **November 7, 2025.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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	AL1403	A. BUILDING: _____ B. WING _____	R-C 11/10/2025

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 An offsite/paper revisit was conducted on 11/10/25. 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