OKLAHOMA
State Department
of Health

Delivery via email to: judy.kirkland@legendseniorliving.com; donna.robison@legendseniorliving.com

February 12, 2026

License Number: AL1405

Ms. Judy Kirkland, Administrator
Arbor House Assisted Living Center
4501 West Main Street
Norman, OK 73072

RE: Survey Event ID: CVDP11

Dear Ms. Kirkland:

On **February 5, 2026**, agents from our office concluded a State Licensure survey 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 **February 5, 2026**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully,

Clorissa Nubine

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Arbor House Assisted Living Center**
Address: **4501 West Main Street**
City, State, Zip: **Norman, Ok, 73072**
Provider #: **AL1405**
Complaint #: **OK00085145**
Investigation Dates: **02/04/26 and 02/05/2026**

ALLEGATIONS
The facility failed to ensure the residents' right for choice of meals.
The facility failed to ensure the residents' right for dignity and respect.

An unannounced on-site investigation was initiated 02/06/2026 at 8:53 a.m.
02/04/26
A sample of 9 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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 at other times throughout the survey. Residents were observed at lunch service, receiving meals per menu or alternate meal if requested. Staff and residents were observed interacting with each other.

Resident records were reviewed including physician orders, assessments, and service plans. Grievances, state reports, and facility policies were reviewed.

Residents were interviewed regarding meal service and staff interactions. Staff were interviewed regarding meal service policy and abuse policy.

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: 02/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1405	A. BUILDING: _____ B. WING _____	C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING CENTER	4501 WEST MAIN STREET 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 (#OK00079726 and #OK00085145) was conducted from 02/04/26 through 02/05/26. Deficiencies were cited as a result of the survey. Facility Census: 52 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide MAT- medication administration technician MG- milligram	C 000		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to ensure assessments contained a resident and/or resident representative signature for 2 (#6 and #7) of 9 sampled residents reviewed for assessments signed by a resident and/or resident representative. The resident director identified 52 residents resided in the center. Findings:	C 543		

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C 543	Continued From page 1 1. Resident #7's significant change in condition assessment, dated 03/31/25, showed the resident was alert and had good judgement. The assessment was not signed by the resident and/or the resident's representative. On 02/04/26 at 2:07 p.m., the resident director stated Resident #7's assessment was not signed by the resident. On 02/05/26 at 10:51 a.m., the health care director stated they were responsible for completing resident assessments. They stated resident representatives signed the assessments for residents with cognitive impairment. The health care director stated residents whose cognition was intact would sign their assessment. On 02/05/26 at 10:53 a.m., the health care director stated Resident #6 and Resident #7 were able to sign their assessments. They stated the appropriate time for cognitive residents to sign their assessments was about a week after completion of the assessment. 2. On 02/06/26 at 1:48 p.m., CMA #1 was observed entering Resident #6's room and asking them to sign a form. On 02/06/26 at 1:52 p.m., Resident #6 was observed asking CMA#1 if they should use the current date or date it 09/30/25. CMA #1 stated they would have to go ask. On 02/06/26 at 1:54 p.m., CMA #1 was observed returning to Resident #6's room with the form and heard stating the resident director said not to date it. A "Resident Assessment Form," dated 09/30/25,	C 543		

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C 543	Continued From page 2 showed Resident #6 admitted to the facility with diagnoses which included congestive heart failure and hypertension. Resident #6's cognition was alert and their judgement was good. On 02/04/26 at 10:55 a.m., the health care director stated the assessment form should have been signed in September 2025 and it had not been obtained in a timely manner. On 02/06/26 at 1:48 p.m., CMA #1 stated it was an assessment that should have been signed when Resident #6 admitted. On 02/06/25 at 2:05 p.m., the resident director stated they had sent CMA #1 down to Resident #6's room to obtain a signature on the assessment form. They stated, "I just thought it was best to get it signed. I guess I'm telling on myself."	C 543		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in	C1505		

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C1505	Continued From page 3 terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to administer medications as ordered for 1 (#3) of 2 sampled residents observed during medication pass. The resident director identified 52 residents resided in the center. Findings: On 02/05/26 at 9:31 a.m., MAT #1 was observed dispensing Resident #3's acetaminophen (a pain medication) 325 mg one tablet into a medication cup. On 02/05/26 at 9:41 a.m., MAT #1 was observed administering acetaminophen 325 mg one tablet to Resident #3. On 02/05/26 at 9:47 a.m., MAT #1 was observed administering one spray of azelastine (an antihistamine) in each of Resident #3's nostrils. The "Medication Administration" policy, dated 04/30/19, read in part, "Drugs shall be administered to each resident in accordance with a physician's written order."	C1505		

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C1505	Continued From page 4 Physician orders for Resident #3, dated 03/17/25, showed: a. acetaminophen 650 mg, take one tablet by mouth two times a day, and b. azelastine spray 0.1%, instill two sprays in each nostril two times a day. On 02/05/26 at 9:50 a.m., MAT #1 stated they were to check medications three times for date, dose, right resident, and right medication before administering. On 02/05/26 at 9:53 a.m., MAT #1 stated they administered one tablet of the acetaminophen to Resident #3. On 02/05/26 at 9:54 a.m., MAT #1 stated Resident #3's order was for acetaminophen 650 mg one tablet twice a day. On 02/05/26 at 9:55 a.m., MAT #1 stated the acetaminophen on hand was 325 mg. They stated they should have administered two tablets to equal 650 mg. On 02/05/26 at 9:57 a.m., MAT #1 stated they administered one spray each nostril of azelastine to Resident #3. They stated it should have been two sprays to each nostril. On 02/05/26 at 9:58 a.m., MAT #1 stated the physicians orders were not followed. On 02/05/26 at 10:56 a.m., the health care director stated staff were to follow the five rights of medication administration. On 02/05/26 at 11:00 a.m., the health care director stated if an order needed a change of	C1505		

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C1505	Continued From page 5 direction sticker, staff were to notify them.	C1505		
C1952 SS=D	310:663-19-3(b) MAINTENANCE OF RECORDS (b) Each resident's records shall be retained for at least five (5) years after the resident's transfer, discharge or death. Destruction of records shall be done in a manner to preserve resident confidentiality. This Rule is not met as evidenced by: Based on record review and interview, the center failed to maintain a resident's medication administration record and treatment administration record for five years for 1 (#2) of 3 sampled residents reviewed for assessment, monitoring, and intervention. The resident director identified 52 residents resided in the center. Findings: The "Resident Record" policy, dated 07/01/12, read in part, "All documents pertaining to the resident comprise the Resident Record." A "Move Outs" facility list, dated 01/01/25 to 05/31/25, showed Resident #2 was admitted to the facility on 01/31/25 and discharged to a nursing home on 02/28/25. A "Medication Record" dated 02/28/25, showed Resident #2's medications were released to their family. Resident #2's medical record provided by the facility on 02/04/26 was reviewed. The medication	C1952		

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C1952	Continued From page 6 administration record and treatment administration record for February 2025 was not included. On 02/04/26 at 12:25 p.m., Resident #2's representative stated the resident was discharged from the facility. On 02/05/26 at 11:17 a.m., the regional health case director stated they were to maintain resident records onsite for five years and offsite for seven years. On 02/05/26 at 1:16 p.m., the regional health case director stated they could not access Resident #2's medication administration record and treatment administration record for February 2025 in their previous electronic health record system.	C1952		
C1972 SS=D	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure staff were educated on abuse within 90 days of hire for 1 (kitchen assistant #1) of 5 sampled employees whose records were reviewed for abuse training.	C1972		

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C1972	Continued From page 7 The resident director identified 52 residents resided in the center. Findings: A review of kitchen assistant #1's employee file showed they were hired on 03/21/25. There was no documentation of abuse training within 90 days of their hire. On 02/05/26 at 11:09 a.m., the resident director stated abuse training was to be completed within 90 days of hire and as needed. They stated kitchen assistant #1's employment started on 03/21/25. On 02/05/26 at 11:10 a.m., the resident director stated kitchen assistant #1 had not completed abuse training per State regulations.	C1972		

OKLAHOMA
State Department
of Health

Delivery via email to: judy.kirkland@legendseniorliving.com; Tasha.Winship@legendseniorliving.com

February 24, 2026

License Number: AL1405

Ms. Judy Kirkland, Administrator
Arbor House Assisted Living Center
4501 West Main Street
Norman, OK 73072

RE: Survey Event CVDP11

Dear Ms. Kirkland:

On **February 5, 2026,** agents from our office completed an Assisted Living Center survey 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:

- C543 no staff education and QAPI monitoring

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 2/20/2026
	Facility Name: Arbor House Norman AL
	License Number: AL 1405
	Survey Event ID: CVDP11
	Date Survey Completed: 2/5/2026

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 543	Based on: Observation, record review and interview, the center failed to ensure assessments contained a resident and/or resident representative signature for 2 (#6 and #7) of 9 sampled residents reviewed for assessments signed by a resident and/or resident representative.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penality (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulartory requirements. In this document, we have outlined specific actions in resonse to each allegation(s) or findings. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	Residence Director or Designee will ensure assessments are presented to reach resident when due and signed at the time of discussion as identified on the SOD to ensure accuracy and compliance with 310:663-5-4(c) Conduct of Assessment.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Residence Director and Nursing Team will have care plan meetings with each resident/POA with a change of condition or scheduled assessment due.
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.	Residence Director and Health Care Director will keep record of each assessment and care plan meeting completed in community for accuracy with 310:663-5-4(c) Conduct of Assessment. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/15/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Judy Kirkland, RD OAC 310:663-25-4(F)	**Date 2/20/2026**

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.			

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 2/20/2026
	Facility Name: Arbor House Norman AL
	License Number: AL 1405
	Survey Event ID: CVDP11
	Date Survey Completed: 2/5/2026

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505	Based on: observation, record review, and interview, the center failed to administer medications as ordered for 1 (#3) of 2 sampled residents observed during medication pass.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penality (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulartory requirements. In this document, we have outlined specific actions in resonse to each allegation(s) or findings. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	Residence Director or Designee will ensure a review of medication administration records for resident #3 as identified on the SOD to ensure accuracy and compliance with 310:663-15-1 & OS 1-1918(B)(5) Resident Rights-Medical Care
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The Residence Director, Nursing Team, Certified Medication Aides, and Medication Aide Techs will be inserviced on Medication Administration as outlined in 310:663-15-1 & OS 1- 1918(B)(5) Residents Rights- Medical Care. The "Medication Administration" policy, dated 04/30/19, read in part, "Drugs shall be administered to each resident in accordance with a physician's written order."
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.	a. The Residence Director or Designee will audit a sampling of the medication administration records for the accuracy per physician orders in accordance with 310:663-15-1 & OS 1- 1918(B)(5) Residents Rights-Medical Care. b. Review of the audit (sampling) of medication administration will be incorporated into the QA meeting and the need for any additional intervention will be out into place. c. A review of the audit (sampling) will be kept with the QA minutes.

	Enter methods to keep monitoring records:		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	3/18/2026		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Judy Kirkland, RD** OAC 310:663-25-4(F)		**Date 2/20/2026**	
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.			

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 2/20/2026
	Facility Name: Arbor House Norman AL
	License Number: AL 1405
	Survey Event ID: CVDP11
	Date Survey Completed: 2/5/2026

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1952	Based on: SS=D310:663-19-3(b) MAINTENANCE OF RECORDS(b) Each resident's records shall be retained for at least five (5) years after the resident's transfer, discharge or death. Destruction of records shall be done in a manner to preserve resident confidentiality.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penality (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulartory requirements. In this document, we have outlined specific actions in resonse to each allegation(s) or findings. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	Residence Director or Designee will ensure all records be retained for 5 years after discharge date as identified on the SOD to ensure accuracy and compliance with 310:663-19-3 MAINTENANCE OF RECORDS
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Residence Director and Nursing Team will conduct audit of all stored charts to ensure proper destroy dates are present. Training on closure of charts will be conducted for all designees.
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.	Residence Director and Health Care Director will conduct monthly compliance checks during QE to ensure records are stored properly for each resident for a minimum of 5 years to be compliant with 310:663-19-3 Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/15/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Judy Kirkland, RD OAC 310:663-25-4(F)	**Date 2/20/2026**

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.

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OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/20/2026** **Facility Name:** Arbor House Norman AL **License Number:** AL 1405 **Survey Event ID:** CVDP11 **Date Survey Completed: 2/5/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1972	Based on: 310:663-19-4(c) POLICIES The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penality (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulartory requirements. In this document, we have outlined specific actions in resonse to each allegation(s) or findings. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	Residence Director or Designee will ensure all employees will receive abuse and neglect training within 90 days of hire and annually after to maintain compliance of 310:663-19-4 POLICIES
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A review of all current associates was completed by the RD to ensure abuse and neglect training has been completed within 90 days of hire. All current employees were foun to be in compliance of 310:663-19-4 POLICIES.
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?	Residence Director or Designee will do monthly QE reviews to ensure all employees are within compliance of 310:663-19-4 POLICIES
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.	Residence Director or Designee will keep record of each abuse and neglect training completed in community for accuracy. Submit monthly training logs for new hires to QMPI committee to review for accuracy and compliance. Monthly review of new hire training logs will be updated and submitted to QMPI for 90 days to verify interventions are timely and effective. Abuse and Neglect training log will be kept in a separate binder in Resident Director's office.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		3/15/2026	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Judy Kirkland, RD** OAC 310:663-25-4(F)			**Date 2/20/2026**
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OKLAHOMA
State Department
of Health

Delivery via email to: judy.kirkland@legendseniorliving.com; Tasha.Winship@legendseniorliving.com

April 16, 2026

License Number: AL1405

Ms. Judy Kirkland, Administrator
Arbor House Assisted Living Center
4501 West Main Street
Norman, OK 73072

RE: Survey Event CVDP11

Dear Ms. Kirkland:

On **February 5, 2026**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your amended 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 **March 15, 2026**.

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,

Clorissa Nubine

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

Enclosure

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/20/2026** **Facility Name:** Arbor House Norman AL **License Number:** AL 1405 **Survey Event ID:** CVDP11 **Date Survey Completed: 2/5/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 543	Based on: Observation, record review and interview, the center failed to ensure assessments contained a resident and/or resident representative signature for 2 (#6 and #7) of 9 sampled residents reviewed for assessments signed by a resident and/or resident representative.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penality (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulartory requirements. In this document, we have outlined specific actions in resonse to each allegation(s) or findings. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	HCD reviewed the assessment with residents #6 and #7 and obtained proper signature an to ensure accuracy and compliance with 310:663-5-4(c) Conduct of Assessment.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	HCD or designee will have care plan meetings with each resident/POA with a change of condition or scheduled assessment due. HCD will be In Serviced on OK regulatory requirements for timely, accurate and signed documentation. Completed 2/20/26
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.	Health Care Director or designee will keep record of each assessment and care plan meeting completed in community for accuracy with 310:663-5-4(c) Conduct of Assessment. Residence Director and HCD or designee will audit 100% of newly completed assessments during monthly QA meetings. HCD or designee will audit 10 randomly selected resident assesments weekly for 4 weeks. HCD or designee will report results to QA committee to determine the need for future action. HCD or designee will move to a spot check quarterly if compliance remains 100%
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		3/15/2026	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Judy Kirkland, RD** OAC 310:663-25-4(F)			**Date 2/20/2026**
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OKLAHOMA
State Department
of Health

Delivery via email to: judy.kirkland@legendseniorliving.com; tasha.winship@legendseniorliving.com

April 29, 2026

License Number: AL1405
Survey Event ID: CVDP12

Ms. Judy Kirkland, Administrator
Arbor House Assisted Living Center
4501 West Main Street
Norman, OK 73072

Dear Ms. Kirkland:

On **April 28, 2026**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **February 5, 2026,** have now been corrected and your facility is in compliance with licensure standards effective **March 18, 2026**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, 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
	AL1405	A. BUILDING: _____ B. WING _____	R-C 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING CENTER	4501 WEST MAIN STREET 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 An offsite/paper revisit was conducted on 04/28/26. 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