OKLAHOMA
State Department
of Health

Delivery via email to: kproctor@cardinalbay.org slambright@cardinalbay.org

November 20, 2025

License Number: AL1412

Ms. Karen Proctor, Administrator
Village On The Park - Oklahoma City
1515 Kingsridge Drive
Oklahoma City, OK 73170

RE: Survey Event ID: DJ7U11

Dear Ms. Proctor:

On **November 13, 2025**, 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 **November 13, 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 LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Tempal Killman

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Village on the Park**
Address: **1515 Kingsridge Drive**
City, State, Zip: **OKC, OK. 73170**
Provider #: **AL1412**
Complaint #: **OK00067006**
Investigation Date(s): **11/10/25, 11/12/25-11/13/25**

ALLEGATION(S)
The center failed to ensure staff followed the pharmacy procedure for accurate reconciliation and accounting for controlled medications.

An unannounced on-site investigation was initiated 11/10/2025 at 10:00 a.m.

A sample of 8 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 center was conducted upon entrance and throughout the survey. Residents were observed to be clean, dressed appropriately, and free of odors. Staff were observed administering medications. Staff were observed to be assisting residents with activities of daily living and as needed. Medication carts were observed and narcotic count sheets were reconciled with controlled medications.

Resident records, i.e. diagnoses list, physician orders, progress notes, care plans, service contracts, and Hospice records were reviewed. Narcotic count records were reviewed. Center policies and procedures were reviewed. State reported incident reports with investigations were reviewed. In-services were reviewed.

Staff were interviewed regarding pharmacy policy and procedures for accurate reconciliation and accounting for controlled medications

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: 11/14/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Village on the Park**
Address: **1515 Kingsridge Drive**
City, State, Zip: **OKC, OK. 73170**
Provider #: **AL1412**
Complaint #: **OK00073971**
Investigation Date(s): **11/10/25, 11/12/25-11/13/25**

ALLEGATION(S)
The center failed to ensure a safe, clean, comfortable, and homelike environment.
The center failed to serve palatable food.

An unannounced on-site investigation was initiated 11/10/2025 at 10:00 a.m.

A sample of 8 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. The center was observed to be clean, odor free, homelike and no safety issues were observed. Resident rooms were observed to be clean, odor free and homelike. Housekeeping was observed throughout the survey cleaning the center and resident rooms. Resident rooms were observed to be mold-free and no concerns with the carpet were observed. Laundry rooms were observed to have newer washers and dryers. Staff were observed performing laundry duties throughout the survey with no concerns.

Resident records, i.e service contracts and care plans were reviewed. Maintenance records were reviewed. Grievances were reviewed.

Residents were interviewed regarding palatable meals, safe, clean, comfortable, and homelike environment. Staff were interviewed regarding palatable meals, safe, clean, comfortable, and homelike environment.

OKLAHOMA
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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: 11/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1412	A. BUILDING: _____ B. WING _____	C 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE PARK - OKLAHOMA CITY	1515 KINGSRIDGE DRIVE OKLAHOMA CITY, OK 73170

(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 (#OK00067006 and #OK00073971) was conducted on 11/10/25, and 11/12/25 through 11/13/25. Deficiencies were cited as a result of the survey. Facility Census: 40 Listed below are abbreviations that will be used throughout this document. ACMA- advanced certified medication aide Res- resident	C 000		
C1922 SS=D	310:663-19-2(a)(2) MEDICATION ADMINISTRATION (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour prior to administration. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure the correct dose of medication was administered for 1 (#8) of 2 sampled residents reviewed for medication administration. The administrator reported 40 residents resided in the center. Findings: On 11/13/25 at 9:00 a.m., ACMA #1 was observed preparing medications for Res #8. The	C1922		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1412	A. BUILDING: _____ B. WING _____	C 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE PARK - OKLAHOMA CITY	1515 KINGSRIDGE DRIVE OKLAHOMA CITY, OK 73170

(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
C1922	Continued From page 1 ACMA was observed dispensing one PreserVision capsule. (A nutritional supplement). An undated diagnoses list showed Res #8 was admitted to the facility with diagnoses which included macular degeneration, bilateral hearing loss, and vitamin deficiency. A physician order, dated 07/01/25, showed an order for PreserVision AREDS 2, give 2 capsules by mouth daily for macular degeneration. On 11/13/25 at 11:40 a.m., ACMA #1 was asked to review the order for PreserVision AREDS 2. The ACMA stated they did not administer the correct dose.	C1922		

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Delivery via email to: kproctor@cardinalbay.org slambright@cardinalbay.org

November 26, 2025

License Number: AL1412

Ms. Karen Proctor, Administrator
Village On The Park - Oklahoma City
1515 Kingsridge Drive
Oklahoma City, OK 73170

RE: Survey Event DJ7U11

Dear Ms. Proctor:

On **November 13, 2025**, 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 plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **November 24, 2025.**

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

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/24/2025** **Facility Name:** Village on the Park **License Number:** AL1412-1412 **Survey Event ID:** DJ7U11 **Date Survey Completed: 11/13/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1922	Based on: Observation, record review, and interview, the center failed to ensure the correct dose of medication was administered for r1 of 2 samploed residents reviewed for medication administration

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All CMA's will be checked off for med administration skills by the Director of Resident Care or designee by 11/24/25. The ACMA involved was removed from medication passing duties pending review and and re-training. The DRC in-serviced the employee regarding A/N/E and the 6 rights of medication assistance (including verification of med dosage against the physician's order.) A complete medication assessment was performed to verify the resident received no ill effects from the incorrect dose, and the resident's physician and responsible party were notified promptly. The correct dose was re-verified with the physician order and the resident's MAR was reviewed to ensure accuracy.
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 had the potential to be affected. All MARs were checked by the DRC to ensure accurate medication dosages and transcription. All CMA's had a med pass skills check by the DRC or designee to identify any additional competency concerns. Any discrepancies found were corrected immediately. No additional residents were identified as affected. This was completed by 11/24/25
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?	All CMA's will receive mandatory re-training of the 6 rights of medication assistance, to include verification of medication dosage against the physician order by 11/24/25. The DRC or designee will conduct random medication pass observations weekly for 2 weeks and then monthly for 3 months thereafter. All CMA's will receive annual medication administration competency reviews. Any deviations from correct procedures will result in retraining and possible disciplinary action
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained?	A. The Executive director or designee will review and sign off on the medication pass observations completed by the

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.	DRC or designee weekly for 2 weeks then monthly for 3 months until the QA committee determines continued monitoring is needed. B. The QA committee will review all audits, obererservations and competency reviews monthly and document findings during QA meetings. The QA committee will evaluate trends and determine if continued monitoring is needed beyond 90 days. C. All audits and observations will be kept in a binder and the DRC and ED office. All employee competency reviews will be kepy in the employee's files Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	**11/24/2025**
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 11/24/2025**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department of Health

Delivery via email to: kproctor@cardinalbay.org; slambright@cardinalbay.org

December 5, 2025

License Number: AL1412

Ms. Karen Proctor, Administrator
Village On The Park - Oklahoma City
1515 Kingsridge Drive
Oklahoma City, OK 73170

RE: Survey Event DJ7U12

Dear Ms. Proctor:

On **December 4, 2025,** a revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 13, 2025,** have now been corrected effective **November 24, 2025.**

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

Respectfully,

Tempal Killman

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

Enclosure

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1412	A. BUILDING: _____ B. WING _____	R-C 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE PARK - OKLAHOMA CITY	1515 KINGSRIDGE DRIVE OKLAHOMA CITY, OK 73170

(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 12/04/25. 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