
Delivery via email to: swarner@oxfordseniorliving.com

April 23, 2025

License Number: AL2001

Ms. Stephanie Warner, Administrator
Oxford Springs Weatherford
800 Gartrell Place
Weatherford, OK 73096

RE: Survey Event ID: DNMS11

Dear Ms. Warner:

On **April 7, 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 **April 7, 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,



Lisa Calvin, Enforcement Analyst II
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: AL2001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/07/2025
NAME OF PROVIDER OR SUPPLIER OXFORD SPRINGS WEATHERFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 800 GARTRELL PLACE WEATHERFORD, OK 73096		
(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 was conducted on 04/07/25. Facility Census: 30 Listed below are abbreviations that will be used throughout this document. DON- director of nursing	C 000		
C 371 SS=D	310:663-3-6(a) MANAGEMENT OF RISK (a) If a resident's preference or decision places the resident or others at risk or is likely to lead to an adverse consequence, the assisted living center shall advise the resident and the resident's representative of such risk or consequences. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to advise a resident and the resident's representative of the risks associated with the use of a bed rail for 1 (#1) of 8 sampled residents reviewed for risk management. The DON identified 30 residents resided in the center. Findings: On 04/07/25 at 9:37 a.m., Resident #1's bed was observed to have a half rail located on the upper left side of the bed.	C 371		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 371	Continued From page 1 A policy titled "Risk Management," revision date of 10/25/23, read in part, "If a resident's preference or decision places the resident or others at risk or is likely to lead to an adverse consequence, the assisted living center shall advise the resident and the resident's representative of such risk or consequences." Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sacroiliitis (inflammation of the pelvis, sacrum, and ilium), and history of falls. A physician's order, dated 06/28/24, read in part, "Half bed rails in place on bed for positioning." Resident #1's "Service Plan," dated 01/28/25, read in part, "Fall interventions- 06/28/24 INTERVENTION: Resident requested half rails to bed for reposition and order received for this." On 04/07/25 at 9:38 a.m., Resident #1 was asked why they used the half bed rail. Resident #1 stated, "To help position and get out of bed." Resident #1 stated they "Fell out of bed a while ago." Resident #1 was asked if they were aware of any risks associated with using the bed rail. They stated, "No." On 04/07/25 at 10:53 a.m., the DON was asked if the resident had a negotiated risk agreement or documentation showing the resident and/or representative was notified of the risks associated with using the bed rail. The DON stated, "I don't have it."	C 371		

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C 522	Continued From page 2	C 522		
C 522 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a significant change assessment was completed for 1 (#1) of 8 residents sampled for assessments. The DON identified 30 residents resided in the center. Findings: A policy titled "Assessment and Service Plan," revised 10/21/23, read in part, "An assessment must be conducted: Immediately upon any significant change in the resident's mental or physical condition." Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sarcoiliitis (inflammation of the pelvis, sacrum, and ilium), and history of falls.	C 522		

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C 522	Continued From page 3 A "14-day Assessment," dated 07/11/24, showed Resident #1 was full weight bearing with full range of motion to extremities. The resident's mobility, strength, and gait were documented as "good." A hospital "After Visit Summary," dated 12/25/24, read in part, "Your discharge diagnosis is Pelvic Fracture." An "Annual Assessment," dated 01/23/25, showed Resident #1 was partial weight bearing with limited range of motion to extremities due to a fractured hip. The resident's mobility and strength were documented as "fair" and their gait was documented as "poor." On 04/07/25 at 11:50 a.m. the DON was asked if the resident's change in mobility between assessments was caused by the pelvic fracture they sustained. They stated, "Yes." The DON was asked what the policy was for completing a significant change assessment. They stated, "Do it when a change in the resident happens." The DON was asked if a significant change assessment was completed for Resident #1. The DON stated, "No, I thought I just needed to complete the annual assessment since it was around the time it happened."	C 522		
C 543 SS=D	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.	C 543		

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C 543	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the center failed to include a personal interview between the resident and/or the residents representative for 3 (#1, 2, and #3) of 8 residents sampled for comprehensive assessments. The DON identified 30 residents resided in the center. Findings: 1. Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sarcoiliitis (inflammation of the pelvis, sacrum, and ilium), and history of falls. Resident #1's "Annual Assessment," dated 07/11/24, did not show a personal interview between the resident and/or the resident's representative. 2. Resident #2 was admitted to the center on 04/16/24. An undated "Diagnosis Sheet" showed the resident had diagnoses which included disorientation, cardiac murmur, and essential hypertension. Resident #2's "Annual Assessment," dated 01/22/25, did not show a personal interview between the resident and/or the resident's	C 543		

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C 543	Continued From page 5 representative. 3. Resident #3 was admitted to the center on 05/06/22. An undated "Diagnosis Sheet" showed the resident had diagnoses which included type 2 diabetes and Alzheimer's disease. Resident #3's "Annual Assessment," dated 01/21/25, did not show a personal interview between the resident and/or the resident's representative. On 04/07/25 at 10:30 a.m., the DON was asked if the residents or their representatives were interviewed and signed their annual assessments. The DON stated, "No."	C 543		
C 544 SS=D	310:663-5-4(d) CONDUCT OF ASSESSMENT (d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be available upon request to the following: (1) the resident; (2) the resident's personal physician; (3) the resident's representative; and (4) the Department. This Rule is not met as evidenced by: Based on record review and interview, the center failed to maintain comprehensive admission assessments for 1 (#1) of 8 residents sampled for assessments. The DON identified 30 residents resided in the	C 544		

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C 544	Continued From page 6 center. Findings: Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sarcoiliitis (inflammation of the pelvis, sacrum, and ilium), and history of falls. There was not a comprehensive admission assessment for Resident #1. On 04/07/25 at 10:39 a.m., the DON was asked for the comprehensive admission assessments for resident #1. The DON stated, "I cannot find it."	C 544		
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 terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and	C1505		

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C1505	Continued From page 7 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 record review and interview, the center failed to follow physician orders for 2 (#1 and #2) of 8 sampled residents reviewed for physician orders. The DON identified 30 residents resided in the center. Findings: 1. Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sarcoiliitis (inflammation of the pelvis, sacrum, and ilium), and history of falls. A physician's order, dated 08/11/24, read in part, "monthly vital signs."	C1505		

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C1505	Continued From page 8 A review of Resident #1's "Weight Summary" showed the last weight obtained was 09/11/24. There were no weights recorded for October, November, or December of 2024. There were no weights recorded for January, February, or March of 2025. 2. Resident #2 was admitted to the center on 04/16/24. An undated "Diagnosis Sheet" showed the resident had diagnoses which included disorientation, cardiac murmur, and essential hypertension. A physician's order, dated 08/11/24, read in part, "monthly vital signs." A review of the Resident #2's "Weight Summary" showed the last weight obtained was 09/11/24. There were no weights recorded for October, November, or December of 2024. There were no weights recorded for January, February, or March of 2025. On 04/07/25 at 11:52 a.m., the DON was asked when the last time Residents #1 and #2 were weighed. The DON stated, "It will tell you in their chart." The DON was shown the last weights were in September of 2024 and was asked if that was the last time the residents were weighed. The DON stated, "Yes." The DON was asked if they were aware of any physicians orders to weigh the residents. The DON stated, "No, but we are supposed to weigh them monthly."	C1505		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1)	C1911		

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C1911	Continued From page 9 Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the center failed to submit an incident report to the Department within 1 business day of the incident's discovery for 2 (#2 and #3) of 8 residents sampled for incident reports. The DON identified 30 residents resided in the center. Findings:	C1911		

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C1911	Continued From page 10 1. Resident #2 was admitted to the center on 04/16/24. An undated "Diagnosis Sheet" showed the resident had diagnoses which included disorientation, cardiac murmur, and essential hypertension. An "Incident Report Form," dated 10/31/24, read in part, "Fell in bathroom resulting in laceration to left eyebrow and black eye. Resulted in stitches to left eyebrow." The Department did not receive the incident report form until 11/05/24. 2. Resident #3 was admitted to the center on 05/06/22. An undated "Diagnosis Sheet" showed the resident had diagnoses which included type 2 diabetes and Alzheimer's disease. An "Incident Report Form," dated 10/31/24, read in part, "Fell"... "hit back of head. Has approximately 2 cm [centimeter] laceration to back of head." A nurse's note, dated 11/01/24, read in part, "Resident arrived back to facility"... "received 3 staples to the back of head." The Department did not receive the incident report form until 11/05/24. On 04/07/25 at 4:00 p.m. the administrator was asked what the policy was on notifying the Department of reportable incidents. They stated, "One day. I did not know the reports had not been sent until I saw them on November 5th and I sent them in immediately."	C1911		

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C1912	Continued From page 11	C1912		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement.	C1912		

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(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
C1912	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to submit an incident report to the Oklahoma State Department of Health for 1 (#1) of 8 sampled residents reviewed for incident reports. The DON identified 30 residents resided in the center. Findings: Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sacroiliitis (inflammation of the pelvis, sacrum, and ilium), and history of falls. A hospital "After Visit Summary," dated 12/25/24, read in part, "Your discharge diagnosis is Pelvic Fracture." A review of the center's incident reports did not show an incident report was initiated. On 04/07/25 at 10:55 a.m. the administrator was asked for the incident report involving Resident #1's pelvic fracture. On 04/07/25 at 4:15 p.m. the administrator was asked again for the incident report involving Resident #1's pelvic fracture. The administrator	C1912		

Oklahoma State Department of Health

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C1912	Continued From page 13 stated, "I cannot find it."	C1912		

Delivery via email to: Stephanie Warner <swarner@oxfordseniorliving.com>

May 7, 2025

License Number: AL2001

Ms. Stephanie Warner, Administrator
Oxford Springs Weatherford
800 Gartrell Place
Weatherford, OK 73096

RE: Survey Event DNMS11

Dear Ms. Warner:

On **April 7, 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 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 20, 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, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure survey was conducted on 04/07/25. Facility Census: 30 Listed below are abbreviations that will be used throughout this document. DON- director of nursing	C 000		
C 371 SS=D	310:663-3-6(a) MANAGEMENT OF RISK (a) If a resident's preference or decision places the resident or others at risk or is likely to lead to an adverse consequence, the assisted living center shall advise the resident and the resident's representative of such risk or consequences. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to advise a resident and the resident's representative of the risks associated with the use of a bed rail for 1 (#1) of 8 sampled residents reviewed for risk management. The DON identified 30 residents resided in the center. Findings: On 04/07/25 at 9:37 a.m., Resident #1's bed was observed to have a half rail located on the upper left side of the bed.	C 371	<i>See attached POC template. gw</i>	

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

0699

DNMS11

If continuation sheet 1 of 14

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/07/2025
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C 371	Continued From page 1 A policy titled "Risk Management," revision date of 10/25/23, read in part, "If a resident's preference or decision places the resident or others at risk or is likely to lead to an adverse consequence, the assisted living center shall advise the resident and the resident's representative of such risk or consequences." Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sacroiliitis (inflammation of the pelvis, sacrum, and ilium), and history of falls. A physician's order, dated 06/28/24, read in part, "Half bed rails in place on bed for positioning." Resident #1's "Service Plan," dated 01/28/25, read in part, "Fall interventions- 06/28/24 INTERVENTION: Resident requested half rails to bed for reposition and order received for this." On 04/07/25 at 9:38 a.m., Resident #1 was asked why they used the half bed rail. Resident #1 stated, "To help position and get out of bed." Resident #1 stated they "Fell out of bed a while ago." Resident #1 was asked if they were aware of any risks associated with using the bed rail. They stated, "No." On 04/07/25 at 10:53 a.m., the DON was asked if the resident had a negotiated risk agreement or documentation showing the resident and/or representative was notified of the risks associated with using the bed rail. The DON stated, "I don't have it."	C 371		

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C 522	Continued From page 2	C 522	<i>See attached POC template. SW</i>	
C 522 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a significant change assessment was completed for 1 (#1) of 8 residents sampled for assessments. The DON identified 30 residents resided in the center. Findings: A policy titled "Assessment and Service Plan," revised 10/21/23, read in part, "An assessment must be conducted: Immediately upon any significant change in the resident's mental or physical condition." Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sarcoillitis (inflammation of the pelvis, sacrum, and ilium), and history of falls.	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 3 A "14-day Assessment," dated 07/11/24, showed Resident #1 was full weight bearing with full range of motion to extremities. The resident's mobility, strength, and gait were documented as "good." A hospital "After Visit Summary," dated 12/25/24, read in part, "Your discharge diagnosis is Pelvic Fracture." An "Annual Assessment," dated 01/23/25, showed Resident #1 was partial weight bearing with limited range of motion to extremities due to a fractured hip. The resident's mobility and strength were documented as "fair" and their gait was documented as "poor." On 04/07/25 at 11:50 a.m. the DON was asked if the resident's change in mobility between assessments was caused by the pelvic fracture they sustained. They stated, "Yes." The DON was asked what the policy was for completing a significant change assessment. They stated, "Do it when a change in the resident happens." The DON was asked if a significant change assessment was completed for Resident #1. The DON stated, "No, I thought I just needed to complete the annual assessment since it was around the time it happened."	C 522		
C 543 SS=D	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.	C 543	<i>See attached Poc template. sm</i>	

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C 543	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the center failed to include a personal interview between the resident and/or the residents representative for 3 (#1, 2, and #3) of 8 residents sampled for comprehensive assessments. The DON identified 30 residents resided in the center. Findings: 1. Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sarcoillitis (inflammation of the pelvis, sacrum, and ilium), and history of falls. Resident #1's "Annual Assessment," dated 07/11/24, did not show a personal interview between the resident and/or the resident's representative. 2. Resident #2 was admitted to the center on 04/16/24. An undated "Diagnosis Sheet" showed the resident had diagnoses which included disorientation, cardiac murmur, and essential hypertension. Resident #2's "Annual Assessment," dated 01/22/25, did not show a personal interview between the resident and/or the resident's	C 543		

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C 543	Continued From page 5 representative. 3. Resident #3 was admitted to the center on 05/06/22. An undated "Diagnosis Sheet" showed the resident had diagnoses which included type 2 diabetes and Alzheimer's disease. Resident #3's "Annual Assessment," dated 01/21/25, did not show a personal interview between the resident and/or the resident's representative. On 04/07/25 at 10:30 a.m., the DON was asked if the residents or their representatives were interviewed and signed their annual assessments. The DON stated, "No."	C 543		
C 544 SS=D	310:663-5-4(d) CONDUCT OF ASSESSMENT (d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be available upon request to the following: (1) the resident; (2) the resident's personal physician; (3) the resident's representative; and (4) the Department. This Rule is not met as evidenced by: Based on record review and interview, the center failed to maintain comprehensive admission assessments for 1 (#1) of 8 residents sampled for assessments. The DON identified 30 residents resided in the	C 544	<i>See attached POC template. SW</i>	

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C 544	Continued From page 6 center. Findings: Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sarcoillitis (inflammation of the pelvis, sacrum, and ilium), and history of falls. There was not a comprehensive admission assessment for Resident #1. On 04/07/25 at 10:39 a.m., the DON was asked for the comprehensive admission assessments for resident #1. The DON stated, "I cannot find it."	C 544		
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 terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and	C1505	<i>See attached PAC template</i>	

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C1505	Continued From page 7 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 record review and interview, the center failed to follow physician orders for 2 (#1 and #2) of 8 sampled residents reviewed for physician orders. The DON identified 30 residents resided in the center. Findings: 1. Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sarcoiliitis (inflammation of the pelvis, sacrum, and ilium), and history of falls. A physician's order, dated 08/11/24, read in part, "monthly vital signs."	C1505		

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C1505	Continued From page 8 A review of Resident #1's "Weight Summary" showed the last weight obtained was 09/11/24. There were no weights recorded for October, November, or December of 2024. There were no weights recorded for January, February, or March of 2025. 2. Resident #2 was admitted to the center on 04/16/24. An undated "Diagnosis Sheet" showed the resident had diagnoses which included disorientation, cardiac murmur, and essential hypertension. A physician's order, dated 08/11/24, read in part, "monthly vital signs." A review of the Resident #2's "Weight Summary" showed the last weight obtained was 09/11/24. There were no weights recorded for October, November, or December of 2024. There were no weights recorded for January, February, or March of 2025. On 04/07/25 at 11:52 a.m., the DON was asked when the last time Residents #1 and #2 were weighed. The DON stated, "It will tell you in their chart." The DON was shown the last weights were in September of 2024 and was asked if that was the last time the residents were weighed. The DON stated, "Yes." The DON was asked if they were aware of any physicians orders to weigh the residents. The DON stated, "No, but we are supposed to weigh them monthly."	C1505		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1)	C1911	<i>See attached PAC Kuplate SW</i>	

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C1911	Continued From page 9 Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the center failed to submit an incident report to the Department within 1 business day of the incident's discovery for 2 (#2 and #3) of 8 residents sampled for incident reports. The DON identified 30 residents resided in the center. Findings:	C1911		

Oklahoma State Department of Health

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C1911	Continued From page 10 1. Resident #2 was admitted to the center on 04/16/24. An undated "Diagnosis Sheet" showed the resident had diagnoses which included disorientation, cardiac murmur, and essential hypertension. An "Incident Report Form," dated 10/31/24, read in part, "Fell in bathroom resulting in laceration to left eyebrow and black eye. Resulted in stitches to left eyebrow." The Department did not receive the incident report form until 11/05/24. 2. Resident #3 was admitted to the center on 05/06/22. An undated "Diagnosis Sheet" showed the resident had diagnoses which included type 2 diabetes and Alzheimer's disease. An "Incident Report Form," dated 10/31/24, read in part, "Fell"... "hit back of head. Has approximately 2 cm [centimeter] laceration to back of head." A nurse's note, dated 11/01/24, read in part, "Resident arrived back to facility"... "received 3 staples to the back of head." The Department did not receive the incident report form until 11/05/24. On 04/07/25 at 4:00 p.m. the administrator was asked what the policy was on notifying the Department of reportable incidents. They stated, "One day. I did not know the reports had not been sent until I saw them on November 5th and I sent them in immediately."	C1911		

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C1912	Continued From page 11	C1912	<i>See attached PCR template. SW</i>	
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement.	C1912		

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NAME OF PROVIDER OR SUPPLIER OXFORD SPRINGS WEATHERFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 800 GARTRELL PLACE WEATHERFORD, OK 73096		
(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
C1912	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to submit an incident report to the Oklahoma State Department of Health for 1 (#1) of 8 sampled residents reviewed for incident reports. The DON identified 30 residents resided in the center. Findings: Resident #1 was admitted to the center on 06/27/24. A "Diagnosis Sheet," dated 06/28/24, showed the resident had diagnoses which included low back pain, muscle weakness, sacroiliitis (inflammation of the pelvis, sacrum, and ilium), and history of falls. A hospital "After Visit Summary," dated 12/25/24, read in part, "Your discharge diagnosis is Pelvic Fracture." A review of the center's incident reports did not show an incident report was initiated. On 04/07/25 at 10:55 a.m. the administrator was asked for the incident report involving Resident #1's pelvic fracture. On 04/07/25 at 4:15 p.m. the administrator was asked again for the incident report involving Resident #1's pelvic fracture. The administrator	C1912		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/07/2025
NAME OF PROVIDER OR SUPPLIER OXFORD SPRINGS WEATHERFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 800 GARTRELL PLACE WEATHERFORD, OK 73096		
(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	
C1912	Continued From page 13 stated, "I cannot find it."	C1912			



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/27/2025

Facility Name: Oxford Springs of Weatherford

License Number: AL 2001-2001

Survey Event ID: DNMS11

Date Survey Completed: 4/7/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C371

Based on: Based on observation, record review, and interview, the center failed to advise a resident and the resident's representative of the risks associated with the use of a bed rail for 1 (#1) of 8 sampled residents reviewed for risk management.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: None.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. Negotiated Risk Agreement Completed with Resident and all current residents in community audited for Negotiated Risk for use of rail.
2. Inservice completed with all staff regarding proper use of rail, notification to RCD/ED regarding new rail use.
3. ED Inservice with RCD regarding rail use, notification of risk to family/residents, community policy on rail use, and completion of Negotiated Risk Agreements.
4. ED/Maintenance will complete weekly walk through of community to audit for use of rails to ensure community management is aware of all rail use and will evaluate rails for safety and proper attachment.
5. QA completed to include safe use of rails, Negotiated Risk Agreements and will follow up at each QA meeting for continued compliance.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

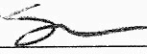
ED/Maintenance will complete weekly walk through of community to audit for use of rails to ensure community management is aware of all rail use and will evaluate rails for safety and proper attachment.

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?

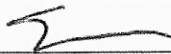
1. ED/Maintenance will complete weekly walk through of community to audit for use of rails to ensure community management is aware of all rail use and will evaluate rails for safety and proper attachment.
2. Inservice completed with all staff regarding proper use of rail, notification to RCD/ED regarding new rail use.
3. QA team will continue ongoing monitoring in QA meetings.

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.	ED/Maintenance will complete ongoing weekly audits to ensure community management is aware of all rail use and ED or assigned representative will audit negotiated risk agreements to ensure all residents with rail use have negotiated risk in place. Any discrepancy found in weekly audit will be immediately reviewed by QA team and additional measures implemented to ensure further compliance. Monitoring form will be added to current QA forms and will be reviewed at each QA meeting by QA team. All audit/monitoring records will be maintained in POC binder and reviewed at each QA meeting.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	5/20/2025		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Stephanie M. Warner, LNHA  OAC 310:663-25-4(F)	Date 5/5/2025		
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.			

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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 4/27/2025	
	Facility Name: Oxford Springs of Weatherford	
	License Number: AL 2001-2001	
	Survey Event ID: DNMS11	
Date Survey Completed: 4/7/2025		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C522	Based on: Based on record review and interview, the facility failed to ensure a significant change assessment was completed for 1 (#1) of 8 residents sampled for assessments.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: None.		
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?		1. RCD inserviced over proper completion and timeframes of assessments. 2. All staff inserviced on proper notifications to be made to ED and/or RCD when a resident goes to ER, returns from hospital, or has a change in condition. 3. ED will monitor assessment completions on residents with change of condition reported by staff.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		ED will monitor assessment completions and need for assessments on all residents with reported change in condition.
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?		1. ED will monitor assessment completions and need for assessments on all residents with reported change in condition. 2. Inservice completed with all staff regarding proper reporting of change of resident condition. 3. QA team will continue ongoing monitoring in QA meetings.
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.		ED will monitor assessment completions and need for assessment on all residents with reported change of condition. ED will complete ongoing audits and report to QA committee immediately any concerns of noncompliance in order to quickly remediate any potential noncompliance. Any discrepancy found in audit will be immediately reviewed by QA team and additional measures implemented to ensure further compliance. Monitoring form will be added to current QA forms and will be reviewed at each QA meeting by QA team.

		All audit/monitoring records will be maintained in POC binder and reviewed at each QA meeting.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/20/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Stephanie M. Warner, LNHA  OAC 310:663-25-4(F)		Date 5/5/2025	
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			
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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.			

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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 4/27/2025	
	Facility Name: Oxford Springs of Weatherford	
	License Number: AL 2001-2001	
	Survey Event ID: DNMS11	
Date Survey Completed: 4/7/2025		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C543	Based on: Based on record review and interview, the center failed to include a personal interview between the resident and/or the residents representative for 3(#1, 2, and #3) of 8 residents sampled for comprehensive assessments.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: None.		
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?	1. RCD inserviced over proper completion of assessments. 2. ED and/or RN will audit each assessment for completion and compliance. 3. All current resident assessments will be reviewed and any not fully complete and in compliance will be rectified immediately. 4. QA team will at each QA meeting review ED findings and randomly choose 3-4 resident assessments to pull to audit for compliance, if any are found to be in non-compliance all resident assessments will be audited for compliance immediately.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	ED and QA team will monitor assessment completions and complete random audits of resident assessments at each QA meeting.	
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?	ED and/or RN will audit each assessment for completion and full compliance. ED and QA team will monitor assessment completions and complete random audits of resident assessments at each QA meeting.	
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.	ED and/or RN will monitor/audit assessment completions for full compliance. ED will complete ongoing audits and report to QA committee immediately any concerns of noncompliance in order to quickly remediate any potential noncompliance. Any discrepancy found in audit will be immediately reviewed by QA team and additional measures implemented to ensure further compliance.	

		Monitoring form will be added to current QA forms and will be reviewed at each QA meeting by QA team.	
		All audit/monitoring records will be maintained in POC binder and reviewed at each QA meeting.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/20/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Stephanie M. Warner, LNHA  OAC 310:663-25-4(F)		Date 5/5/2025	
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.
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