OKLAHOMA
State Department
of Health

Delivery via email to: SLee@homesteadofweatherford.com

March 20, 2026

License Number: AL2003

Ms. Stacy Lee, Administrator
Homestead Of Weatherford
3601 East Main
Weatherford, OK 73096

Survey Event ID: 5CO911

Dear Ms. Lee:

On **February 27, 2026**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality

assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement, and another plan of correction may be required.

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

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

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

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

or mail 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: **Homestead of Weatherford**
Address: **3601 East Main**
City, State, Zip: **Weatherford, OK.,**
Provider #: **AL2003**
Complaint #: **OK00088494**
Investigation Date(s): **02/25/26 through 02/27/26**

ALLEGATION(S)
1.The facility failed to ensure call lights were answered in a timely manner
2.The facility failed to ensure residents were treated with dignity and respect.

An unannounced on-site investigation was initiated 02/25/2026 at 9:45 a.m.

A sample of 9 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 at other various times throughout the survey.

Residents call pendants were observed being worn by residents. Staff response times to call pendants were observed. Residents' rooms and persons were observed for good hygiene and sanitary care. Call pendant reports were reviewed. Resident records were reviewed including assessments, physician orders, nursing notes, treatment records, and contracts. Residents and family representatives were interviewed about facility policy, care practices and procedures involving response times to calls and care concerns. Staff were interviewed regarding call pendants responses and concerns related to dignity.

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: 03/08/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Homestead of Weatherford**
Address: **3601 East Main**
City, State, Zip: **Weatherford, OK.,**
Provider #: **AL2003**
Complaint #: **OK00089576**
Investigation Date(s): **02/25/26 through 02/27/26**

ALLEGATION(S)
1.The facility failed to ensure adequate staff supervision.

An unannounced on-site investigation was initiated 02/25/2026 at 9:45 a.m.

A sample of 9 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 at other various times throughout the survey.

Residents call pendants were observed being worn by residents. Staff response times to call pendants were observed. Egress doors and alarms were observed. Residents' rooms and persons were observed for good supervision and staffing. Call pendant reports were reviewed. Resident records were reviewed including assessments, physician orders, nursing notes, treatment records, employee disciplinary reports, facility policies, and contracts. Residents and family representatives were interviewed about facility policy, care practices and procedures involving response times to calls and care concerns. Staff were interviewed regarding call pendants responses and concerns related to supervision.

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: 03/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2003	A. BUILDING: _____ B. WING _____	C 02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF WEATHERFORD	3601 EAST MAIN 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 with complaints (#OK00088494 and #OK00089576) was conducted from 02/25/26 through 02/27/26. Deficiencies were cited as a result of the survey. Facility Census: 45 Listed below are abbreviations that will be used throughout this document. ACMA -advanced certified medication aide CNA - certified nursing assistant IV - intravenous RCC- resident care coordinator	C 000		
C1505 SS=G	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 treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully	C1505		

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C1505	Continued From page 1 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: a. locate a resident during safety check rounds; b. follow the center's policy and procedures for an elopement and an exit seeking resident; and c. ensure a resident did not eloped from the center for 1 (#1) of 9 sampled residents reviewed for elopement. The executive director identified 45 residents resided in the center. Findings: On 02/25/26 at 9:45 a.m., upon entrance to the facility, the building was observed to be located on a busy interstate and a two lane heavily traveled access road. There were portable buildings for sale and a hotel located next door to the facility. On 02/25/26 at 10:00 a.m., Resident #1 was observed sitting in a recliner on the memory care unit in their room. Resident #1 was heard yelling "Help." Direct care staff was observed responding to Resident #1. Resident #1 was heard requesting a cup of ice and water. On 02/26/26 at 10:15 a.m., exits doors were observed on the assisted living side of the center.	C1505		

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C1505	Continued From page 2 All egress to the outside were unlocked and had door sensors that alerted the direct care staff when they were opened. The doors had audible alarms that were observed to make a loud high pitched noise when opened. An undated center document titled "Assisted Living Sentinel Event Procedure," read in part, "This procedure outlines the steps to take in the event of a resident or visitor incident described below:"..."Elopement or elopement attempts;"..."If any of the above incidents occur, follow these procedures:"..."2. Notify the Executive Director and /or RCC will then notify the Regional Vice president. If necessary, the RVP [regional vice president] will notify the the Senior VP [vice president] for consulting: 3. Document the medical record or incident report with objective facts only." An undated facility document titled " Elopement Procedures," read in part, "Immediate actions 1. Check last known location. 2. Secure the area. 3. Review security footage. 4. Call emergency services if necessary. 5. Notify on-call nurse, RCC, ED [executive director], Family. 6. Reports: State Report, APS [adult protective services], Police." An admission assessment for Resident #1, dated 10/14/25, showed the resident had diagnoses which included respiratory failure with hypoxia, Alzheimer's, and type 2 diabetes. The assessment showed Resident #1 was confused and forgetful often. The assessment showed Resident #1 had full range of motion, fair physical functional status, and used a wheelchair to ambulate long distances.	C1505		

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C1505	Continued From page 3 A physician's order for Resident #1, dated 10/16/25, read in part, "Oxygen per Nasal Cannula every shift 2 l/m [liters per minute] as needed to keep O2 [oxygen] stats [saturation] above 90 percent." A facility reported final incident report for Resident #1, dated 2/21/26, showed the resident was last seen during rounds on 2/21/26 at 5:00 a.m. The report showed ACMA #1 was leaving work around 6:10 a.m. and heard an unidentified resident yelling "Help." The report showed ACMA #1 called the police and left the property. The report showed the police responded and found Resident #1, 100 yards away from the facility's Southwest exit. The report showed Resident #1 was evaluated at the hospital, diagnosed with altered mental status and hypothermia, was returned to the facility, and placed on the memory care unit. The report showed the center conducted an investigation of the elopement and found the following: a. ACMA#1 did not follow resident safety responsibilities on 02/21/26, b. a door alarm activated at 5:13 a.m. was not acknowledged or investigated, c. during rounds on 02/21/26, ACMA #1 failed to make visual contact with Resident #1, and d. failed to respond to a resident needs who was yelling for help. A hospital record for Resident #1, dated 02/21/26 at 8:06 a.m., showed the resident was shivering with a temperature on 97.1 Fahrenheit, oxygen saturation was 85 %. The hospital record showed Resident #1 received warm IV fluids, blankets, oxygen, and was diagnosed with altered mental status and hypothermia.	C1505		

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C1505	Continued From page 4 The national weather service showed the temperature on 2/21/26 at 5:15 a.m. was 28 degrees Fahrenheit. A center door sensor report, dated 02/21/26, showed an alert on the Southwest exit door sensor on 02/21/26 at 5:13 a.m. A center document titled "Employee Disciplinary Action Record," dated 02/21/26, showed ACMA #1 was suspended on 02/21/26 and terminated on 02/23/26. The report, read in part, "This reflects a serious lapse in resident care, supervision, and adherence to established protocols. These actions (and inactions) constitute a significant violation of resident safety standards and place residents at risk of harm." A center document titled "[ACMA #1] -2/21/26 Statement," showed ACMA #1 reported after the incident, Resident #1 was wandering the night before looking for their deceased spouse. The statement showed ACMA #1 reported to the oncoming shift during rounds at 6:00 a.m., Resident #1 was not located. The statement showed ACMA #1 told the oncoming staff, Resident #1 was wandering all night and was probably somewhere in the building. The statement showed ACMA #1 heard someone yelling for help near a hotel next door to the facility, they called the police, and did not follow up to see if it was a resident in distress. A center document titled "Employee Disciplinary Action Record," dated 02/21/26, showed ACMA #2 who was coming on shift received a written disciplinary action for not following proper protocol and notifying the executive director, the resident care coordinator, following the facilty's policy regarding sentinel events.	C1505		

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C1505	Continued From page 5 A center document titled "[ACMA #2] -2/21/26 Statement," showed ACMA #2 who was just coming on shift was notified on 02/21/26 at 6:30 a.m., by the police, Resident #1 was found outside the facility by them. The statement showed ACMA #2 stated it was 22 degrees Fahrenheit outside and the police called for an ambulance to evaluate Resident #1. A center document titled "Employee Disciplinary Action Record," dated 02/21/26, showed CNA #3 received written disciplinary action. The document, read in part, "The employee did not visually confirm the resident's location, as required. As a result of this failure, the resident exited the building unsupervised (elopement), creating a serious safety risk." A center document titled "[CNA #3] -2/21/26 Statement," showed CNA #3 did not locate resident #1 during rounds. The statement showed CNA #3 stated they were told by ACMA #1, Resident #1 was somewhere in the facilty so they did not look for Resident #1 because they assumed Resident #1 was in the bathroom or somewhere else in the facility. The statement showed on 02/21/26 at 6:28 a.m., the police arrived at the center and notified them Resident #1 was outside the center. The statement showed Resident #1 was transported to the hospital for evaluation. A facility document titled "Employee Disciplinary Action Record," dated 02/21/26, showed licensed practical nurse #1 who worked the night shift received a written disciplinary action. The document, read in part, "Failure to login in to the system resulted in missed alerts, including those related to door activity and resident movement,	C1505		

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C1505	Continued From page 6 which contributed to the delay in response during a critical incident. This failure represents a significant breach of established protocols and expectations for resident monitoring, supervision, and safety." A managed risk agreement for Resident #1, dated 02/23/26, showed they were a potential risk for elopement due to impaired decision making and decreased safety awareness. On 02/25/26 at 11:35 a.m., Resident #1 stated they did not recall the elopement and wanted to know if they were in trouble for something. On 02/25/26 at 3:26 p.m., resident representative #1 stated the facility was not aware Resident #1 was missing. They stated Resident #1 was not allowed to leave the facility unsupervised. Resident Representative #1 stated Resident #1 received warm IV fluids at the hospital due to the cold. On 02/26/26 at 8:13 a.m., the RCC discussed the results of the investigation they conducted regarding Resident #1 eloping from the center on 02/21/26 at 5:13 a.m. The RCC stated the following events occurred on 02/20/26 through 02/21/26: a. Resident #1 was up the night before wandering and searching for their deceased spouse, b. on 02/21/26 at 6:00 a.m. shift change, Resident #1 was not visually located by on coming staff during their rounds, c. ACMA #1 working the night shift, reported to oncoming staff, Resident #1 was inside the facility wandering, e. ACMA #1 exited the facility around 6:00 a.m., heard an unidentified resident yelling for help, called the police, and left the center property,	C1505		

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C1505	Continued From page 7 f. police found Resident #1 outside the facility and called an ambulance to evaluate Resident #1, g. police notified the center Resident #1 was found 100 yards away from the facility, they called an ambulance, h. the center was not aware Resident #1 had eloped from the center, i. Resident #1 was sent to the hospital and diagnosed with hypothermia and altered mental status, and j. the center had several breakdowns in their procedures and the elopement could have been prevented On 02/26/26 at 9:00 a.m., CNA #1 stated they started rounding on the the residents on 02/21/26 at 5:55 a.m. They stated they failed to locate Resident #1 during rounds, was notified by the police at 6:30 a.m., Resident #1 was found outside by the hotel and was cold, and they were not aware Resident #1 eloped from the center. CNA #1 stated when Resident #1 was not located, they should have started the missing resident procedure and notified the on call nurse. They stated Resident #1 had never eloped and night shift told them they were in the center somewhere, so they should have verified by finding the resident. CNA #1 stated they were aware of the procedures and did not follow the missing resident procedure. On 02/26/26 at 9:12 a.m., ACMA #3 stated Resident #1 wandered the center looking for their deceased spouse. They stated when they started a shift, it was the center policy to always visually identify the location of each resident for safety reasons. On 02/26/26 at 9:21 a.m., CNA #2 stated Resdient #1 would wander the center on the 2:00	C1505		

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C1505	Continued From page 8 p.m. - 10:00 p.m. shift looking for their deceased spouse or push their pendent every 10 minutes asking about their deceased spouse prior to the elopement. On 02/26/26 at 3:33 p.m., CNA #3 stated when they arrived to work on 02/21/26 at 6:00 a.m., ACMA #1 from night shift told them Resident #1 was up walking the facility. They stated at 6:20 a.m., the police arrived and told them Resident #1 was outside. They stated it was 22 degrees outside and Resident #1 went to the hospital. CNA #3 stated they did not put eyes on Resident #1 during their morning safety check rounds and that was their mistake. On 02/26/26 at 10:13 a.m., the RCC stated Resident #1 had no history of wondering reported and had some confusion and forgetfulness. They stated Resident #1 used a power chair to ambulate and got short of breath while ambulating without their power chair. On 02/26/26 at 11:51 a.m., the executive director stated there was breakdown in the processes and the situation was not handled appropriately. They stated the center did not have a policy involving door alarms responses. On 02/26/26 at 11:52 a.m., corporate nurse #1 stated the center did not have a policy for rounding on residents.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: SLee@homesteadofweatherford.com;
lbeadles@homesteadofweatherford.com

March 24, 2026

License Number: AL2003

Ms. Stacey Lee, Administrator
Homestead Of Weatherford
3601 East Main
Weatherford, OK 73096

RE: Survey Event 5CO911

Dear Ms. Lee:

On **February 27, 2026**, a Licensure inspection with a complaint investigation 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 **April 6, 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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
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: 3/23/2026** **Facility Name:** Homestead of Weatherford **License Number:** AL2003 **Survey Event ID:** SC0911 **Date Survey Completed: 2/27/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Based on observation, record review, and interview, the center failed to:a. locate a resident during safety check rounds;b. follow the center's policy and procedures for an elopement and an exit seeking resident; and c. ensure a resident did not elope from the center for 1 (#1) of 9 sampled residents reviewedfor elopement.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

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?	Education regarding elopement P&P, how to address exit seeking residents, review of how to perform routine checks on residents and actions to be taken will be given to staff by 04/06/26. Record of the education will be kept on file at the center.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Routine assessment for elopement, wandering and exit seeking behavior will be completed routinely and prn. This will be implemented by 04/06/26 and record of the assessments will be in the resident chart in EMR. This will be an ongoing practice.
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?	Routine audits will be conducted of resident charts and behavior reports made by staff will be followed up on and addressed as appropriate to the resident. Routine checks will be monitored for completion routinely and implemented by 04/06/26.
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.	a. The documentation of routine checks, completion of elopement, wandering and exit seeking behavior assessments will be monitored routinely and any deficient practice will be reported to leadership and addressed as appropriate and ongoing with implementation on 03.27.26 b. Routine quarterly audits will be completed by regional nurses and/or RCC and identified concerns will be addressed and corrected as appropriate and ongoing with implementation by 04/06/26. This will be documented in the quarterly QA notes. c. All QA documentation will be kept in the QA binder at the center by 04/06/26 Enter methods to keep monitoring records:

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		4/6/2026	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Stacey Lee, E.D.** OAC 310:663-25-4(F)			**Date 3/24/2026**
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

FINAL DETERMINATION NOTICE
USPS Tracking #9589 0710 5270 2318 8398 29

Delivery via email to: SLee@homesteadofweatherford.com

April 14, 2026

License Number: AL2003

Ms. Stacey Lee, Administrator
Homestead Of Weatherford
3601 East Main
Weatherford, OK 73096

Survey Event ID: 5CO912

Dear Ms. Lee:

A revisit conducted **April 9, 2026**, revealed that your facility corrected deficiencies effective **April 6, 2026**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me at (405) 426-8200.

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

Respectfully,

Lisa Calvin

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2003	A. BUILDING: _____ B. WING _____	R-C 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF WEATHERFORD	3601 EAST MAIN 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 revisit was conducted on 04/09/26. All deficiencies from the 02/27/26 survey were cleared. The administrator identified 45 residents resided at the facility.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE