OKLAHOMA
State Department
of Health

Delivery via email to: roxanne@mlcconsult.com

February 11, 2026

License Number: AL2103

Ms. Roxanne Fanning, Administrator
Grandwood Assisted Living, Lc
2001 Sunrise Boulevard
Grove, OK 74344

Survey Event ID: ZY0311

Dear Ms. Fanning:

On **February 5, 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.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the 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. 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 a 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: **Grandwood Assisted Living**
Address: **2001 Sunrise Boulevard**
City, State, Zip: **Grove, OK, 74344, Delaware**
Provider #: **AL2103**
Complaint #: **OK00088378**
Investigation Date: **02/04/26 and 02/05/26**

ALLEGATION(S)
The center failed to provide adequate supervision to prevent elopements.

An unannounced on-site investigation was initiated 02/04/2026 at 9:00a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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. Resident hallways were observed for staff assistance with resident care needs and staff/resident interactions.

Incident reports, policies and procedures were reviewed. Resident records including assessments, care plans, physician orders, nursing notes, and treatment records were reviewed along with employee records.

Staff members and clients were interviewed regarding elopement.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/05/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Grandwood Assisted Living**
Address: **2001 Sunrise Boulevard**
City, State, Zip: **Grove, OK, 74344, Delaware**
Provider #: **AL2103**
Complaint #: **OK00089105**
Investigation Date: **02/04/26 and 02/05/26**

ALLEGATION
The center failed to assess, monitor and intervene in a timely manner.

An unannounced on-site investigation was initiated 02/04/2026 at 9:00a.m.

A sample of 4 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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. Resident hallways were observed for staff assistance with resident care needs and staff/resident interactions.

Incident reports, policies and procedures were reviewed. Resident records including assessments, care plans, physician orders, nursing notes, and treatment records were reviewed along with employee records.

Staff members, residents and the ombudsman were interviewed regarding staff assessments monitoring and interventions.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2103	A. BUILDING: _____ B. WING _____	C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDWOOD ASSISTED LIVING, LC	2001 SUNRISE BOULDVARD GROVE, OK 74344

(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 Complaint investigations (#OK00088378 and #OK00089105) were conducted from 02/04/26 through 02/05/26. Deficiencies were cited as a result of the survey. Facility Census: 70 Listed below are abbreviations that will be used throughout this document. CNA - certified nurse aide CMA - certified medication aide LPN - licensed practical nurse Res - resident	C 000		
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 treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 record review and interview, the center failed to assess a resident for a change in condition for 1 (#2) of 3 sampled residents reviewed for change in condition. The office manager identified 70 residents resided in the center. Findings: An incident report form, dated 01/27/26, showed CNA #2 reported to LPN #1 via radio Res #2 was having difficulty breathing. The report showed LPN #1 left the facility without notifying hospice or assessing the resident. Physician's orders, dated 01/27/26, showed Res #2 had diagnoses which included asthenia (a feeling of general weakness) and unsteady gait. The orders showed Res #2 was receiving hospice services. On 02/04/26 at 10:50 a.m., CMA #1 stated they heard a call over the radio at approximately 7:30 p.m. on 01/27/26 from CNA #2 to LPN #1 stating Res #2 was having difficulty breathing. CMA #1 reported LPN #1 stated they would notify hospice. CMA #1 stated LPN #1 left the facility around 7:45 p.m. CMA #1 stated CNA #1 reported to them LPN #1 had not assessed Res #2 before leaving. At this time CMA #1 stated they called hospice to report Res #2's condition.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2103	A. BUILDING: _____ B. WING _____	C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDWOOD ASSISTED LIVING, LC	2001 SUNRISE BOULDVARD GROVE, OK 74344

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C1505	Continued From page 2 On 02/04/26 at 12:20 p.m., the administrator stated hospice had no record of LPN #1 calling to report Res #2's condition. They stated LPN #1 should have performed an assessment on Res #2 prior to leaving for the day. On 02/05/26 at 9:31 a.m., LPN #2 stated that whenever staff reported a possible change in condition an assessment should be completed.	C1505		

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State Department of Health

Delivery via email to: roxanne@mlcconsult.com

February 23, 2026

License Number: AL2103

Ms. Roxanne Fanning, Administrator
Grandwood Assisted Living, Lc
2001 Sunrise Boulevard
Grove, OK 74344

Survey Event ID: ZY0311

Dear Ms. Fanning:

On **February 5, 2026,** a complaint investigation was conducted at your Assisted Living Center. 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 **February 13, 2026**.

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: 2/12/2026** **Facility Name:** Grandwood Assisted Living **License Number:** AL2103 **Survey Event ID:** OK00089105 **Date Survey Completed: 2/5/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Record review and interview, the center failed to assess a resident for a change in condition f 1 (#2) of 3 sampled residents reviewed for change in condition.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Please note that administration was notified immediately upon the departure of LPN and intervened, hospice was immediately called as well as another Nurse to help rectifiy the situation and provide resident with care.

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. The resident's hospice and another nurse was called and immediately assessed situation and provided orders and direction 2.The LPN was immediately supsened and terminated from her position
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Policy created and staff educated on 2/13/2026 stating that any incident where a resident is in distress a call must immediately be made to 911 and resident to be sent ot ER for eval and treated till stable and able to return.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The LPN was immediately terminated. Educated staff on 2/6/2026 of proper reporting and chain of command when emergencies occur or resident care is not provided. Policy created to educate staff of proper steps to take if this incident was to occur again.
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.	Administrator/RN will monitor daily reports and shift reports to ensure that residents are being assessed as needed. LPN's notify administration via text of any emergencies. Admin to interview staff as needed to ensure that nurses are assessing residents when they request it. Enter methods to evaluate for effectiveness: Significant changes and their declines will be monitored by administration and RN to ensure that accurate assessment is being completed, scheduled and PRN Sig Changes will be brought to QA and reviewed by QA team to ensure that appropriate actions were taken and residents were assessed in a timely manner. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		2/13/2026	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date 2/16/2026**
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

Delivery via email to: roxanne@mlcconsult.com

February 27, 2026

License Number: AL2103

Ms. Roxanne Fanning, Administrator
Grandwood Assisted Living, Lc
2001 Sunrise Boulevard
Grove, OK 74344

Survey Event ID: ZY0312

Dear Ms. Fanning:

On **February 26, 2026,** a complaint revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your survey on **February 5, 2026,** have now been corrected effective **February 13, 2025.**

If you have any questions concerning the information in this letter, please contact me at (405) 426-8201.

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
	AL2103	A. BUILDING: _____ B. WING _____	R-C 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDWOOD ASSISTED LIVING, LC	2001 SUNRISE BOULDVARD GROVE, OK 74344

(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 02/26/26. The facility was in substantial compliance.	{C 000}		

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