
Delivery via email to: thearborslife@gmail.com

December 2, 2025

License Number: AL2404

Ms. Inez McPherson, Administrator
The Arbors Assisted Living Center
4502 West Randolph
Enid, OK 73703

RE: Survey Event ID: UJ3D11

Dear Ms. McPherson:

On **October 22, 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 **October 22, 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
IDRCoordinator@health.ok.gov
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,

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- Alleged failure of the surveyor to comply with a requirement of the survey process;
 - Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
 - Alleged inadequacy or inaccuracy of the informal dispute resolution process

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

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

Respectfully,

Clorissa Nubine

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

Enclosure

INVESTIGATIVE REPORT

Facility: The Arbors Assisted Living Center-Enid
Address: 4502 W Randolph Ave
City, State, Zip: Enid, OK 73703
Provider #: AL 2404
Complaint #: OK00073572
Investigation Date(s): 10/16/25, 10/17/25, 10/20/25 - 10/22/25

ALLEGATION(S)
The center failed to ensure residents were not verbally or psychosocially abused and/or neglected.
The center failed to ensure resident's wounds were assessed, monitored and treatment provided.
The center failed to ensure the resident was not involuntarily discharged.
The center failed to ensure medication was administered as ordered.

An unannounced on-site investigation was initiated 10/16/2025 at 1:10 p.m.

A sample of 3 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:

An investigation related to abuse, wounds, discharges, staffing, assessments, care plans and medications were conducted.

At the time of the survey, medications were observed being administered. Professional interactions between staff and residents were observed.

At the time of the survey, no resident complained about the staff or about staff withholding their medication or not assisting them with activities of daily living.

At the time of the survey, staff stated residents received their medications as ordered by the physician and incontinent care was provided every two hours and as needed.

At the time of the survey, there was no deficient practice related to resident abuse or pharmaceutical services.

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: 10/28/2025

INVESTIGATIVE REPORT

Facility: The Arbors Assisted Living Center-Enid
Address: 4502 W Randolph Ave
City, State, Zip: Enid, OK 73703
Provider #: AL 2404
Complaint #: OK00079654
Investigation Date(s): 10/16/25, 10/17/25, 10/20/25 - 10/22/25

ALLEGATION(S)
The center failed to ensure medications were administered as ordered by the physician.
The center failed to ensure residents were not verbally, or psychosocially abused, and/or neglected.

An unannounced on-site investigation was initiated 10/16/2025 at 1:10 p.m.

A sample of 3 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:

An investigation related to abuse, incident reports, and medications were conducted.

At the time of the survey, staff were observed awake and alert, medications were observed being administered to residents. Professional interaction between staff and residents were observed.

At the time of the survey, no resident complained about the staff or about staff withholding their medication.

At the time of the survey, staff stated residents received their medications as ordered by the physician.

At the time of the survey, there was no deficient practice related to resident abuse or pharmaceutical services.

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: 10/28/2025

INVESTIGATIVE REPORT

Facility: The Arbors Assisted Living Center-Enid
Address: 4502 W Randolph Ave
City, State, Zip: Enid, OK 73703
Provider #: AL 2404
Complaint #: OK00086543
Investigation Date(s): 10/16/25, 10/17/25, 10/20/25 - 10/22/25

ALLEGATION(S)
The center failed to ensure residents received their medications according to physician orders as prescribed.
The facility failed to ensure the residents are allowed to choose a third party provider.

An unannounced on-site investigation was initiated 10/16/2025 at 1:10 p.m.

A sample of 3 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:

An investigation related to medications and third party providers were conducted.

At the time of the survey, medications were observed being administered to residents. Different third party providers from different agencies were observed with residents throughout the survey.

At the time of the survey, residents stated they received their medications when they needed them. Residents using a third party provider stated they chose.

At the time of the survey, staff stated residents received their medications as ordered by the physician. Staff stated residents chose their third party provider, if needed.

At the time of the survey, there was no deficient practice related to pharmaceutical services or resident rights to choose a third party provider.

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: 10/28/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2025
NAME OF PROVIDER OR SUPPLIER THE ARBORS ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4502 WEST RANDOLPH ENID, OK 73703		
(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 (#OK00073572, OK00079654, and #OK00086543) was conducted from 10/16/25 through 10/17/25 and 10/20/25 through 10/22/25. Deficiencies were cited as a result of the survey. Facility Census: 13 Listed below are abbreviations that will be used throughout this document. HWD - health and wellness director PA-C - physician assistant, certified POA - power of attorney RN - registered nurse	C 000		
C 360 SS=D	310:663-3-5(c)(1-3) INVOLUNTARY TERMINATION (c) Procedures for involuntary termination of residency for reasons other than inappropriate placement, by an assisted living center, are as follows: (1) Written notice shall be provided to the resident, the resident's representative, the person responsible for payment of charges for the resident's care, if different from any of the foregoing, and the Department, at least thirty (30) days in advance of the termination of residency date. (2) The written notice shall include: (A) A full explanation of the reasons for the termination of residency; (B) The date of the notice; (C) The date notice was given to the resident and the resident's representative; (D) The date by which the resident must leave	C 360		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2025
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C 360	Continued From page 1 the assisted living center; (E) Notice that the resident, the resident's representative or person responsible for payment of the resident's care may request a hearing with the Department; (F) Notice that the request for hearing with the Department must be filed within ten (10) Department business days of receipt of the facility notice; and (G) Notice that a written or verbal request for a hearing with the Department should be directed to the Hearing Clerk, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, OK 73117, telephone (405) 271-1269. (3) An assisted living center shall not involuntarily terminate a residency agreement for reasons other than inappropriate placement without following the procedures in this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide a written notice of termination which included all components of the discharge for 1 (#3) of 3 sampled residents reviewed for discharge. The HWD identified 13 residents resided in the center. Findings: An involuntary termination letter for Resident #3,	C 360		

Oklahoma State Department of Health

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C 360	Continued From page 2 dated 08/29/24, showed missing components related to involuntary discharge initiated by the center. The letter, read in part, "after reviewing recent orders with your primary care and home health provider it has been determined that the level of care needed exceeds the care that can be provided in our assisted living center, as we addressed in our in-person meeting with you yesterday. We are more than happy to assist in finding a solution that will better fit your needs. We will be as accommodating as possible during this time of transition." The missing components included: a. the date by which the resident must leave the assisted living; b. a request for a hearing with the Department; c. how many days from the receipt of the facility notice a hearing could be requested; and d. the mailing address or telephone number for written or verbal request for hearing with the Department. On 10/22/25 at 11:22 a.m., the HWD was asked how Resident #3's discharge was documented. They stated it was written in a progress note where the HWD and the administrator spoke with the resident and the POA. On 10/22/25 at 11:35 a.m., the administrator stated they had to give Resident #3 and the POA a 30 day written notice. On 10/22/25 at 1:10 p.m., the administrator and HWD were not aware of the missing components because the center's resident agreement did not contain the center initiated discharge or termination of the agreement accurately. The resident agreement showed they could terminate the agreement at any time by giving a five day notice. They stated the missing components of	C 360		

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C 360	Continued From page 3 the written notice included a full explanation of the reasons for the termination of residency, the date the notice was given to the resident and the resident's representative, the date by which the resident must leave the assisted living center, notice that the resident, the resident representative or person responsible for payment of the resident's care could request a hearing with the Department, notice that the request for hearing with the Department must be filed within 10 Department business days of receipt of the facility notice, and notice that a written or verbal request for a hearing with the Department should be directed to the hearing clerk at the Oklahoma State Department of Health.	C 360			
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to include a personal interview between the resident and/or the resident representative and the person completing the assessment form for 6 (#1, 2, 3, 4, 5, and #6) of 6 sampled residents whose assessments were reviewed.	C 543			

Oklahoma State Department of Health

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C 543	Continued From page 4 The HWD identified 13 residents resided in the center. Findings: The center's electronic health record did not contain a space/section for a resident's signature or a representative interviewed. 1. Resident #1's change in condition assessment, dated 10/16/24, showed the assessment was not signed by the resident and/or the resident's representative. 2. Resident #2's change in condition assessment, dated 03/27/25, showed the assessment was not signed by the resident and/or the resident's representative. 3. Resident #3's comprehensive assessment, dated 08/15/24, showed the assessment was not signed by the resident and/or the resident's representative. 4. Resident #4's comprehensive assessment, dated 07/31/25, showed the assessment was not signed by the resident and/or the resident's representative. 5. Resident #5's comprehensive assessment, dated 10/08/24, showed the assessment was not signed by the resident and/or the resident's representative. 6. Resident #6's comprehensive assessment, dated 09/26/25, showed the assessment was not signed by the resident and/or the resident's representative.	C 543		

Oklahoma State Department of Health

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C 543	Continued From page 5 On 10/21/25 at 3:45 p.m., the HWD stated the assessments only documented an electronic signature of the licensed practical nurse and did not include a signature of the resident and/or the resident's representative.	C 543			
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to maintain bathing hot water temperatures not to exceed 115 degrees Fahrenheit for 3 (#6, 7, and #8) of 3 sampled resident rooms tested for hot water. The HWD identified 13 residents resided in the center. Findings: On 10/22/25 at 3:42 p.m., hot water temperatures were tested by the administrator. 1. On 10/22/25 at 3:44 p.m., Resident #6's	C 701			

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C 701	Continued From page 6 bathroom hot water temperature (thermometer reading) was observed to be tested by the administrator and was between 123 and 127 degrees Fahrenheit. On 10/22/25 at 3:45 p.m., the administrator stated the hot water temperature was a little hot. 2. On 10/22/25 at 3:47 p.m., Resident #7's bathroom hot water temperature (thermometer reading) was observed to be tested by the administrator and was between 132 and 135 degrees Fahrenheit. On 10/22/25 at 3:48 p.m., the administrator stated, "It should be around 120." 3. On 10/22/25 at 3:50 p.m., Resident #8's bathroom hot water temperature (thermometer reading) was observed to be tested by the administrator and was 124 degrees Fahrenheit. On 10/22/25 at 3:51 p.m., the administrator stated the shower water temperature was getting a little too hot.	C 701		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist.	C 921		

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C 921	Continued From page 7 This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to review monthly medications by a RN and/or pharmacist for 6 (#1, 2, 3, 4, 5, #6) of 6 sampled residents reviewed for medications. The HWD identified 13 residents resided at the center. Findings: The August, September, and October 2025 monthly physician orders, medication administration records, and treatment administration records were reviewed for Resident #1, 2, 3, 4, 5, and #6. There was no documentation Resident #1, 2, 3, 4, 5, and #6 had their medications reviewed monthly by a RN and/or pharmacist. On 10/21/25 at 3:56 p.m., the HWD stated there was no documentation the RN or pharmacist had signed that monthly medications for residents had been reviewed.	C 921		
C1505 SS=E	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	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 8 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 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 and monitor skin integrity for a resident for 1 (#3) of 1 sampled resident reviewed for radiation and chemotherapy treatments. The HWD identified 13 residents resided at the center. Findings:	C1505		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER THE ARBORS ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4502 WEST RANDOLPH ENID, OK 73703		
(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
C1505	Continued From page 9 A policy titled "Skin Integrity," dated 10/13/09, read in part, "nurse will evaluate and document the resident's skin integrity upon admission, at the annual assessment, and anytime there is a changed in skin condition"... "all findings will be documented as 'Progress Notes' in resident's chart"... "nursing staff will complete and initiate Plan of Care for treatment of skin issues"... "if resident's condition exceeds our criteria for appropriate care, we will immediately pursue a 'Plan of Accommodation' or begin the discharge process." The resident's change in condition assessment, dated 08/15/24, read in part, "skin condition"... "fair"... "radiation burns lower abdomen and perineal area." The resident's home health certification and plan of care, dated 08/22/24, read in part, "skin breakdown will be identified each visit and measures to resolve breakdown implemented promptly on day of assessment." An undated cancer institute document, read in part, "moisturize your skin often"... "obtain one of the following skin care products and apply to the skin in the treated area a minimum of two times daily"... "avoid irritating your skin in the treatment area." A wound care order, dated 08/29/24, read in part, "cleanse perineal/genital area daily with antimicrobial skin and wound cleanser. pat dry. Cleanse abdominal skin-folds"... "with antimicrobial skin and wound cleanser daily. Pat dry. Paint skin fold with betadine and pat dry. Apply triad barrier past daily and as needed to perineal and genital area. Apply skin prep to healthy skin surrounding genital and perineal	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/22/2025
NAME OF PROVIDER OR SUPPLIER THE ARBORS ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4502 WEST RANDOLPH ENID, OK 73703		
(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
C1505	Continued From page 10 wounds as well as the abdominal wound daily. Apply silvadene cream to labia and pubic area at the sites of radiation burns twice daily. Do not apply any silvadene cream to labia or genital area for at least five hours prior to radiation procedures. Apply aloe cream to bilateral groin crease areas twice daily. When patient lying in bed obtain fan and remove brief/diaper area daily for 2 hours to allow peri-genital area to air out and help prevent moisture. Elevate right heel at all times while in bed. Place pillow under lower leg to relieve pressure from heel. Monitor closely for skin breakdown." A progress note, dated 08/29/24, read in part, "communication with physician"... "late entry"... "HWD spoke with PA-C regarding wound care orders. Advised we do not have nurses in the building 24/7 and HH [home health] can only come once daily through Monday due to insurance"... "(PA-C) states it is ok to apply creams once daily. "We gotta work with what we have." HWD v/u [voiced understanding]." The census tab in the electronic health record for Resident #3, dated 09/06/24, showed the resident had discharged. On 10/22/25, a release of hospital records was requested by the surveyor. No records were provided. On 10/22/25 at 11:10 a.m., the HWD stated it would be important to monitor their skin for decline, infection, or spreading. On 10/22/25 at 11:48 a.m., the administrator stated Resident #3 had moved out completely on 09/08/24.	C1505			

Delivery via email to: thearborslife@gmail.com

December 17, 2025

License Number: AL2404

Ms. Inez McPherson, Administrator
The Arbors Assisted Living Center
4502 West Randolph
Enid, OK 73703

RE: Survey Event UJ3D11

Dear Ms. McPherson:

On **October 22, 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 **November 17, 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,

Clorissa Nubine

Clorissa Nubine, 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: 12/10/2025

Facility Name: ARBORS ASSISTED LIVING CENTER

License Number: AL2404

Survey Event ID: UJ3D11

Date Survey Completed: 10/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C360

Based on: record review and interview, the center failed to provide a written notice of termination which included all components of the discharge for 1 (#3) of 3 sampled residents reviewed for discharge. The HWD identified 13 residents resided in the center. Findings: An involuntary termination letter for Resident #3, dated 08/29/24, showed missing components related to involuntary discharge initiated by the center. The letter, read in part, "after reviewing recent orders with your primary care and homehealth provider it has been determined that the level of care needed exceeds the care that can be provided in our assisted living center, as we addressed in our in-person meeting with you yesterday. We are more than happy to assist in finding a solution that will better fit your needs. We will be as accommodating as possible during this time of transition." The missing components included: a. the date by which the resident must leave the assisted living; b. a request for a hearing with the Department; c. how many days from the receipt of the facility notice a hearing could be requested; and d. the mailing address or telephone number for written or verbal request for hearing with the Department. On 10/22/25 at 11:22 a.m., the HWD was asked how Resident #3's discharge was documented. They stated it was written in a progress note where the HWD and the administrator spoke with the resident and the POA. On 10/22/25 at 11:35 a.m., the administrator stated they had to give Resident #3 and the POA a 30 day written notice. On 10/22/25 at 1:10 p.m., the administrator and HWD were not aware of the missing components because the center's resident agreement did not contain the center initiated discharge or termination of the agreement accurately. The resident agreement showed they could terminate the agreement at any time by giving a five day notice. They stated the missing components of the written notice included a full explanation of the reasons for the termination of residency, the date the notice was given to the resident and the resident's representative, the date by which the resident must leave the assisted living center, notice that the resident, the resident representative or person responsible for payment of the resident's care could request a hearing with the Department, notice that the request for hearing with the Department must be filed within 10 Department business days of receipt of the facility notice, and notice that a written or verbal request for a hearing with the Department should be directed to the hearing clerk at the Oklahoma State Department of Health.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

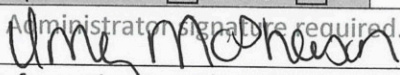
Assisted Living Center's Comments: Resident cited was discharged due to assisted living being an inappropriate placement due to required wound care orders.

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

Resident found to be affected is no longer residing at the center. Moving forward the center has developed and put in place a template to use for involuntary termination of residency, other than inappropriate placement, to ensure all components required per state regulations are included.

OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The center has developed and put in place a template to use for involuntary discharges to ensure all components required by state regulations are included for any involuntary terminations, other than inappropriate placement, of the residency agreement moving forward.		
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 center has developed a template to use for involuntary discharges, other than inappropriate placement, that has all components required per state regulations. This template will be used for all involuntary discharges, other than inappropriate placement, moving forward. (See template on page following)		
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.	Enter methods to ensure corrections are sustained: a. The center will evaluate for effectiveness by utilizing the involuntary discharge, other than inappropriate placement, template. The center will evaluate each discharge notice to ensure all components are included prior to presenting the notice to the resident and responsible parties. b. The center will review any discharges during quarterly quality assurance meetings. c. Records of quality assurance meeting will be kept and on file. All copies of involuntary discharge letters will be kept in resident files to evidence the correction.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	11/1/2025		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)  Date 12/10/2025			
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.			

Arbors Assisted Living Center

4502 W. Randolph
Enid, OK 73703
(580) 242-4500

Date of Notice: _____

To:

Resident Name: _____
Resident Room/Unit Number: _____
Resident Representative (if applicable): _____

RE: Involuntary Termination of Residency Agreement

(For Reasons Other Than Inappropriate Placement)

Dear _____,

This letter serves as formal written notice that Arbors Assisted Living Center is initiating an involuntary termination of residency for the above-named resident, in accordance with Oklahoma Administrative Code OAC 310:663 and facility policy.

1. Explanation of Reasons for Termination (Required Item A)

2. Date of This Notice (Required Item B)

The date of this written notice is: _____

3. Date Notice Was Given to Resident and Resident's Representative (Required Item C)

Resident: _____ on ____ / ____ / ____
Resident's Representative: _____ on ____ / ____ / ____

4. Date by Which Resident Must Vacate (Required Item D) The resident must vacate no later than: ____ / ____ / ____**5. Right to Request a Hearing (Required Item E)**

The resident, representative, or payer may request a hearing with the Oklahoma State Department of Health.

6. Deadline to Request a Hearing (Required Item F)

A request must be filed within ten (10) Department business days of receipt of this notice.

7. How to Request a Hearing (Required Item G)

Hearing Clerk
Oklahoma State Department of Health
1000 NE Tenth Street

Oklahoma City, OK 73117
Phone: (405) 271-1269

8. Discharge Planning and Transition Assistance

We will assist with locating alternative housing and transferring records.

Acknowledgment of Receipt

Resident Signature: _____ Date: _____
Representative Signature: _____ Date: _____
Administrator Signature: _____ Date: _____



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/10/2025

Facility Name: ARBORS ASSISTED LIVING CENTER

License Number: AL2404

Survey Event ID: UJ3D11

Date Survey Completed: 10/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C543

Based on: record review and interview, the center failed to include a personal interview between the resident and/or the resident representative and the person completing the assessment form for 6(#1, 2, 3, 4, 5, and #6) of 6 sampled residents whose assessments were reviewed. The HWD identified 13 residents resided in the center. Findings: The center's electronic health record did not contain a space/section for a resident's signature or a representative interviewed. 1. Resident #1's change in condition assessment, dated 10/16/24, showed the assessment was not signed by the resident and/or the resident's representative. 2. Resident #2's change in condition assessment, dated 03/27/25, showed the assessment was not signed by the resident and/or the resident's representative. 3. Resident #3's comprehensive assessment, dated 08/15/24, showed the assessment was not signed by the resident and/or the resident's representative. 4. Resident #4's comprehensive assessment, dated 07/31/25, showed the assessment was not signed by the resident and/or the resident's representative. 5. Resident #5's comprehensive assessment, dated 10/08/24, showed the assessment was not signed by the resident and/or the resident's representative. 6. Resident #6's comprehensive assessment, dated 09/26/25, showed the assessment was not signed by the resident and/or the resident's representative. On 10/21/25 at 3:45 p.m., the HWD stated the assessments only documented an electronic signature of the licensed practical nurse and did not include a signature of the resident and/or the resident's representative.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The center does ensure that each comprehensive assessment includes a personal interview with the resident and/or their responsible party. The center did not have the resident and/or responsible party sign the assessment form as residents and/or responsible parties do not have access to the electronic system (PointClickCare) to sign.

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?

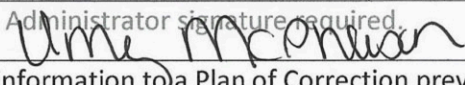
ASSISTED LIVING CENTER'S PLAN ELEMENTS

Center will continue to ensure that each comprehensive assessment includes a personal interview between the resident and/or the responsible party and the person completing the form. Moving forward the center will print the assessment form and have the resident and/or responsible party sign the assessment form to document their involvement in the comprehensive assessment. The signed assessment form will be scanned into the resident's electronic chart.

OSDH Response: Element accepted Yes ☐ No ☐

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

Center will continue to ensure that each comprehensive assessment includes a personal interview between the resident and/or the responsible party and the person completing the form. Moving forward the center will print the assessment form and have the resident and/or

	responsible party sign the assessment form to document their involvement in the comprehensive assessment. The signed assessment form will be scanned into the resident's electronic chart.		
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?	Center will continue to ensure that each comprehensive assessment includes a personal interview between the resident and/or the responsible party and the person completing the form. Moving forward the center will print the assessment form and have the resident and/or responsible party sign the assessment form to document their involvement in the comprehensive assessment. The signed assessment form will be scanned into the resident's electronic chart. Annual assessments will be reviewed by their due date to ensure signatures are in place to reflect personal interview compliance for each comprehensive assessment. Any change of condition assessments will be reviewed at the time of change of condition to ensure compliance of personal interview and signature.		
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.	Enter methods to ensure corrections are sustained: a. Center will review completed assessments in PointClickCare to ensure signatures of the resident and/or responsible party are in place on each comprehensive assessment moving forward. b. Center will review assessments during quality assurance meetings to ensure compliance. c. Records will be kept in resident charts and will include signatures by the resident and/or responsible party to reflect the personal interview is included in the comprehensive assessment.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	11/10/2025		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 		Date 12/10/2025	
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.			

Assisted Living Resident Assessment Form

Oral / Nutritional Status:

Diet Order: Reg Height: 60.0 Weight: 81.8 Weight Changes (loss or gain) _____

Abnormalities: Swallowing Problems ☐ Yes ☒ No Nausea / Vomiting (describe) _____

Ability to Eat: Independent / Meal Set Up & Cueing / Assistance to Use Utensils / Supervision / Must be Fed ☐ ☐ ☐ ☐ ☐

Oral Status: Own Teeth / Partial Teeth / Dentures / No Teeth / Condition of Teeth (describe) _____

Tube Feeding: Gastrostomy / Nasogastric (describe) _____

Toileting Ability/Elimination:

Bladder: Continent / Incontinent / Incontinent at times (describe) / Urinary Catheter - Indwelling / Other ☐ ☐ ☐ ☐

Bowel: Continent / Incontinent / Incontinent at times (describe) _____

Toileting Ability: Independent / Assist / Total Assist / Adult Briefs / B&B Restoration / Toileting Schedule ☐ ☐ ☐ ☐ ☐

Customary Routine (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Sleep habits: G / F / P How Many Hours in 24? varies Sleep Problems (describe) difficulty falling asleep and staying

Meals: In Dining Room / In Room / Other Location / Eats Out (describe frequency) _____

Bathing: Prefers bath / Prefers shower / Preferred schedule (describe) m-w-f morning

Usual time to rise 0600 or earlier Usual bedtime varies Naps during day? no

Psychosocial Status: (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Ability to communicate: G / F / P Interviewable: Yes / No. If No describe: memory impaired

Usual Mood: Calm / Fearful / Agitated / Anxious energetic anxious at times

History of Mood Disorder / Depression: NA

History of Abnormal Behaviors: Agitation / Anger Outburst / Crying / Aggressive / Combative / Elopement Risk ☐ ☐ ☐ ☐ ☐

Family / Friends Involvement: Yes / No (describe) Resident has a lot of friends in the community

Skin Condition (G=Good, F=Fair, P=Poor, if fair or poor, describe):

General Condition: G / F / P Turgor: G / F / P ☐ ☐ ☐

Describe Color, Texture and Appearance: WNL

Describe Abnormalities: NA

Wounds (Describe All: location, size, color, drainage, treatment): NA

Special Treatments and Procedures (i.e. wound care, respiratory therapy, physical therapy, restorative, etc.):

HH with ST

Sensory and Physical Impairments (i.e. vision, hearing, etc.):

acuity impaired

Sue Schmittman
Signature of Resident or Representative Interviewed
Charles Allen 11-10-2025

*Signature (R.N. or Physician), Title Date

Joy Naylor LPN/HWD
Participating Health Professional 11/06/2025
Date

Participating Health Professional Date



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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/10/2025

Facility Name: ARBORS ASSISTED LIVING CENTER

License Number: AL2404

Survey Event ID: UJ3D11

Date Survey Completed: 10/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C701

Based on: observation, record review, and interview, the center failed to maintain bathing hotwater temperatures not to exceed 115 degrees Fahrenheit for 3 (#6, 7, and #8) of 3 sampled resident rooms tested for hot water. The HWD identified 13 residents resided in the center. Findings: On 10/22/25 at 3:42 p.m., hot water temperatures were tested by the administrator. 1. On 10/22/25 at 3:44 p.m., Resident #6's bathroom hot water temperature (thermometer reading) was observed to be tested by the administrator and was between 123 and 127 degrees Fahrenheit. On 10/22/25 at 3:45 p.m., the administrator stated the hot water temperature was a little hot. 2. On 10/22/25 at 3:47 p.m., Resident #7's bathroom hot water temperature (thermometer reading) was observed to be tested by the administrator and was between 132 and 135 degrees Fahrenheit. On 10/22/25 at 3:48 p.m., the administrator stated, "It should be around 120." 3. On 10/22/25 at 3:50 p.m., Resident #8's bathroom hot water temperature (thermometer reading) was observed to be tested by the administrator and was 124 degrees Fahrenheit. On 10/22/25 at 3:51 p.m., the administrator stated the shower water temperature was getting a little too hot.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Center contacted their plumbing company for them to assess and adjust temperatures of the water heaters. Adjustments were made. Center will continue to monitor temperatures to ensure temperatures do not exceed 120 degrees Fahrenheit and make adjustments as needed to keep temperatures below 120 degrees Fahrenheit.

Center contacted their plumbing company for them to assess and adjust temperatures of the water heaters and mixing valves. Adjustments were made. Center will continue to monitor temperatures to ensure temperatures do not exceed 120 degrees Fahrenheit.

Center will continue testing water temperatures and make adjustments as needed and will have the plumbing company make adjustments to heaters and/or mixing valves as needed.

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. Center will evaluate by performing monthly temperatures of the hot water in resident apartments. b. Center will incorporate a review of monthly water temperature checks in our quality assurance meetings. c. Center will maintain records of the monthly water temperatures in a binder specifically for these checks.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/24/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Ume McNeen</i> OAC 310:663-25-4(F)		Date 12/10/2025	
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.			

JONES PLUMBING LLC
5818 S. 16TH STREET
ENID, OK 73701
580.747.5083



Invoice #

9190

10/24/2025

Bill To
ARBORS
4502 W RANDOLPH
ENID, OK, 73703

Description:	Amount:
REPAIR LEAKS, ADD SHUT OFF VALVE, REPLACE FILL VALVE, 2 FLAPPERS, AND 1 SUPPLY LINE. ADJUST WATER HEATER/MIXING VALVE TEMPERATURES TO ACHIEVE 120 DEGREES	
AMOUNT DUE	\$367.50

Amount Paid: \$0.00

Amount Due: \$367.50

Sub Total: \$367.50

Total: \$367.50



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/10/2025

Facility Name: ARBORS ASSISTED LIVING CENTER

License Number: AL2404

Survey Event ID: UJ3D11

Date Survey Completed: 10/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921

Based on: record review and interview, the center failed to review monthly medications by a RN and/or pharmacist for 6 (#1, 2, 3, 4, 5, #6) of 6 sampled residents reviewed for medications. The HWD identified 13 residents resided at the center. Findings: The August, September, and October 2025 monthly physician orders, medication administration records, and treatment administration records were reviewed for Resident #1, 2, 3, 4, 5, and #6. There was no documentation Resident #1, 2, 3, 4, 5, and #6 had their medications reviewed monthly by a RN and/or pharmacist. On 10/21/25 at 3:56 p.m., the HWD stated there was no documentation the RN or pharmacist had signed that monthly medications for residents had been reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

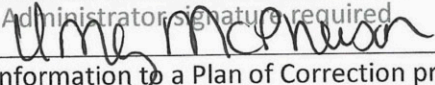
ASSISTED LIVING CENTER'S PLAN ELEMENTS

Moving forward the center will have monthly medication reviews completed for each resident showing the review was completed and signed by the RNCM, Health and Wellness Director, and PCP.

Moving forward the center will have monthly medication reviews completed for each resident showing the review was completed and signed by the RNCM, Health and Wellness Director, and PCP.

Center added signature lines to monthly order reviews to be reviewed and signed by RNCM, HWD, and PCP to ensure compliance. (see attached form)

- Center will review completed medication reviews in PointClickCare to ensure reviews have been completed and signed by the RNCM, HWD, and PCP.
- Center will incorporate into quality assurance meetings reviewing monthly medication reviews to monitor and ensure signatures are in place showing RNCM, HWD, and PCP have reviewed each month.

		c. Records will be kept in resident chart in PointClickCare.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		11/3/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required 		Date 12/10/2025	
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.			

Community #: ---
Date: Nov 3, 2025
Time: 09:11:53 CT

Arbors Assisted Living Center
Medication Review Report

Community Code: ---
User: Joy Naylor

Resident: All Unit: All Floor: All Status: Current On or After Date: 11/03/2025

Resident:

Location:

Move in:

Order
Summary

Order Summary	Communication Method	Order Status	Order Date	Start Date
Venlafaxine HCl Oral Tablet 75 MG (Venlafaxine HCl) Give 1 tablet by mouth in the morning for mood	Phone	Active	08/04/2025	08/05/2025
Vitamin B12 Oral Tablet 1000 MCG (Cyanocobalamin) Give 1 tablet by mouth in the morning for supplement	Prescriber Written	Active	08/04/2025	08/05/2025
Vitamin C Oral Tablet Chewable 500 MG (Ascorbic Acid) Give 1 tablet by mouth in the morning for supplement	Prescriber Written	Active	08/15/2025	08/16/2025
Vitamin D3 Oral Tablet 50 MCG (2000 IU) (Cholecalciferol) Give 1 tablet by mouth in the morning for supplement	Prescriber Written	Active	09/18/2025	09/19/2025

I have approved these orders for ~~11/03/2025~~ 11/18/25. Total pages 5.

Physician:

Name:

Name:

Robert Chertberg

Nikki Kuesant
Joy Naylor LPN

Signature:

Signature:

Signature:

Date:

Date:

Date:

11/18/25

11/3/25

11/8/25

Resident: All Unit: All Floor: All Status: Current On or After Date: 12/01/2025

Resident: [REDACTED] Location: [REDACTED] Move In: [REDACTED]

Order Summary	Communication Method	Order Status	Order Date	Start Date
Latanoprost Ophthalmic Solution 0.005 % (Latanoprost) Instill 1 drop in both eyes at bedtime for glaucoma. Notify nurse of burning or discomfort- wait 5 minutes between medicated eye drops	Phone	Active	04/15/2025	04/15/2025
Miralax Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350) Give 1 scoop by mouth every 24 hours as needed for constipation mix in 4-6 oz liquid of choice	Verbal	Active	01/15/2025	01/15/2025
Nasacort Allergy 24HR Nasal Aerosol 55 MCG/ACT (Triamcinolone Acetonide (Nasal)) 1 spray in both nostrils two times a day for allergies	Phone	Active	10/30/2024	10/30/2024
Systeme Balance Ophthalmic Solution 0.6 % (Propylene Glycol (Ophth)) Instill 1 drop in both eyes at bedtime for lubricant use 10 minutes after	Prescriber Written	Active	08/20/2024	08/20/2024
Latanoprost eye drops				
Vibegron Oral Tablet 75 MG (Vibegron) Give 1 tablet by mouth in the morning for over active bladder	Prescriber Written	Active	08/09/2024	08/16/2024
Vitamin D Oral Tablet 50 MCG (2000 UT) (Cholecalciferol) Give 1 tablet by mouth one time a day for supplement	Verbal	Active	12/23/2024	12/24/2024

I have approved these orders for [REDACTED] Total pages 3.

Physician: [REDACTED]

Name: [REDACTED]

Name: [REDACTED]

Signature: [REDACTED]

Signature: [REDACTED]

Signature: [REDACTED]

Date: [REDACTED]

Date: [REDACTED]

Date: [REDACTED]

Example:



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/10/2025

Facility Name: ARBORS ASSISTED LIVING CENTER

License Number: AL2404

Survey Event ID: UJ3D11

Date Survey Completed: 10/22/2025

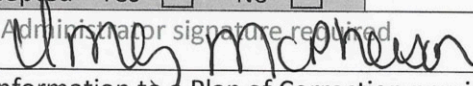
SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: record review and interview, the center failed to assess and monitor skin integrity for a resident for 1 (#3) of 1 sampled resident reviewed for radiation and chemotherapy treatments. The HWD identified 13 residents resided at the center. Findings: A policy titled "Skin Integrity," dated 10/13/09, read in part, "nurse will evaluate and document the resident's skin integrity upon admission, at the annual assessment, and anytime there is a change in skin condition" ... "all findings will be documented as 'Progress Notes' in resident's chart" ... "nursing staff will complete and initiate Plan of Care for treatment of skin issues" ... "if resident's condition exceeds our criteria for appropriate care, we will immediately pursue a 'Plan of Accommodation' or begin the discharge process." The resident's change in condition assessment, dated 08/15/24, read in part, "skin condition" ... "fair" ... "radiation burns lower abdomen and perineal area." The resident's home health certification and plan of care, dated 08/22/24, read in part, "skin breakdown will be identified each visit and measures to resolve breakdown implemented promptly on day of assessment." An undated cancer institute document, read in part, "moisturize your skin often" ... "obtain one of the following skin care products and apply to the skin in the treated area a minimum of two times daily" ... "avoid irritating your skin in the treatment area." A wound care order, dated 08/29/24, read in part, "cleanse perineal/genital area daily with antimicrobial skin and wound cleanser. pat dry. Cleanse abdominal skin-folds" ... "with antimicrobial skin and wound cleanser daily. Pat dry. Paint skin fold with betadine and pat dry. Apply triad barrier past daily and as needed to perineal and genital area. Apply skin prep to healthy skin surrounding genital and perineal wounds as well as the abdominal wound daily. Apply silvadene cream to labia and pubic area at the sites of radiation burns twice daily. Do not apply any silvadene cream to labia or genital area for at least five hours prior to radiation procedures. Apply aloe cream to bilateral groin crease areas twice daily. When patient lying in bed obtain fan and remove brief/diaper area daily for 2 hours to allow peri-genital area to air out and help prevent moisture. Elevate right heel at all times while in bed. Place pillow under lower leg to relieve pressure from heel. Monitor closely for skin breakdown." A progress note, dated 08/29/24, read in part, "communication with physician" ... "late entry" ... "HWD spoke with PA-C regarding wound care orders. Advised we do not have nurses in the building 24/7 and HH [home health] can only come once daily through Monday due to insurance" ... "(PA-C) states it is ok to apply creams once daily. 'We gotta work with what we have.' HWD v/u [voiced understanding]." The census tab in the electronic health record for Resident #3, dated 09/06/24, showed the resident had discharged. On 10/22/25, a release of hospital records was requested by the surveyor. No records were provided. On 10/22/25 at 11:10 a.m., the HWD stated it would be important to monitor their skin for decline, infection, or spreading. On 10/22/25 at 11:48 a.m., the administrator stated Resident #3 had moved out completely on 09/08/24.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS	
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		The resident identified as affected no longer resides at the center. Moving forward HWD will evaluate and document all residents skin integrity upon admission, at the annual assessment, and anytime there is a change in skin condition. All findings will be documented as "Progress Notes" in resident's chart.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Moving forward HWD will evaluate and document all residents skin integrity upon admission, at the annual assessment, and anytime there is a change in skin condition. All findings will be documented as "Progress Notes" in resident's chart.	
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?		HWD will evaluate and document all residents skin integrity upon admission, at the annual assessment, and anytime there is a change in skin condition. All findings will be documented as "Progress Notes" in resident's chart. Management will review at quality assurance meetings to ensure deficient practice will not recur.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		a. Center will evaluate by reviewing documentation in resident charts in PointClickCare to ensure effectiveness. b. Center will review wounds/skin integrity during quality assurance meetings. c. Records will be kept in resident charts in PointClickCare under "Progress Notes".	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		11/17/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required OAC 310:663-25-4(F) 		Date 12/10/2025	
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.			



Quality Assurance Quarterly Report

Attendees and Title:

1. _____ 2. _____
3. _____ 4. _____

Incidents and trends:

* Wounds/TX: _____
Falls: _____

Resident Satisfaction:

Dietary needs and Preferences: _____

Weight Loss/Gain: _____

New Business/New move ins and discharges* (discharge template in use)

* Water Temp review: _____

Old Business:

Home Health/Hospice POC: _____

MAR Audits: _____

Assessment Reviews (sig changes, upcoming/signatures:*) _____

Plans of Accommodations: _____

3 Highest Acuity:

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2025
NAME OF PROVIDER OR SUPPLIER THE ARBORS ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4502 WEST RANDOLPH ENID, OK 73703		
(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 (#OK00073572, OK00079654, and #OK00086543) was conducted from 10/16/25 through 10/17/25 and 10/20/25 through 10/22/25. Deficiencies were cited as a result of the survey. Facility Census: 13 Listed below are abbreviations that will be used throughout this document. HWD - health and wellness director PA-C - physician assistant, certified POA - power of attorney RN - registered nurse	C 000	Plan of correction is being submitted using the optional template.	
C 360 SS=D	310:663-3-5(c)(1-3) INVOLUNTARY TERMINATION (c) Procedures for involuntary termination of residency for reasons other than inappropriate placement, by an assisted living center, are as follows: (1) Written notice shall be provided to the resident, the resident's representative, the person responsible for payment of charges for the resident's care, if different from any of the foregoing, and the Department, at least thirty (30) days in advance of the termination of residency date. (2) The written notice shall include: (A) A full explanation of the reasons for the termination of residency; (B) The date of the notice; (C) The date notice was given to the resident and the resident's representative; (D) The date by which the resident must leave	C 360		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/22/2025
NAME OF PROVIDER OR SUPPLIER THE ARBORS ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4502 WEST RANDOLPH ENID, OK 73703		
(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 360	Continued From page 1 the assisted living center; (E) Notice that the resident, the resident's representative or person responsible for payment of the resident's care may request a hearing with the Department; (F) Notice that the request for hearing with the Department must be filed within ten (10) Department business days of receipt of the facility notice; and (G) Notice that a written or verbal request for a hearing with the Department should be directed to the Hearing Clerk, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, OK 73117, telephone (405) 271-1269. (3) An assisted living center shall not involuntarily terminate a residency agreement for reasons other than inappropriate placement without following the procedures in this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide a written notice of termination which included all components of the discharge for 1 (#3) of 3 sampled residents reviewed for discharge. The HWD identified 13 residents resided in the center. Findings: An involuntary termination letter for Resident #3,	C 360			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/22/2025
NAME OF PROVIDER OR SUPPLIER THE ARBORS ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4502 WEST RANDOLPH ENID, OK 73703		
(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 360	Continued From page 2 dated 08/29/24, showed missing components related to involuntary discharge initiated by the center. The letter, read in part, "after reviewing recent orders with your primary care and home health provider it has been determined that the level of care needed exceeds the care that can be provided in our assisted living center, as we addressed in our in-person meeting with you yesterday. We are more than happy to assist in finding a solution that will better fit your needs. We will be as accommodating as possible during this time of transition." The missing components included: a. the date by which the resident must leave the assisted living; b. a request for a hearing with the Department; c. how many days from the receipt of the facility notice a hearing could be requested; and d. the mailing address or telephone number for written or verbal request for hearing with the Department. On 10/22/25 at 11:22 a.m., the HWD was asked how Resident #3's discharge was documented. They stated it was written in a progress note where the HWD and the administrator spoke with the resident and the POA. On 10/22/25 at 11:35 a.m., the administrator stated they had to give Resident #3 and the POA a 30 day written notice. On 10/22/25 at 1:10 p.m., the administrator and HWD were not aware of the missing components because the center's resident agreement did not contain the center initiated discharge or termination of the agreement accurately. The resident agreement showed they could terminate the agreement at any time by giving a five day notice. They stated the missing components of	C 360			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/22/2025
NAME OF PROVIDER OR SUPPLIER THE ARBORS ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4502 WEST RANDOLPH ENID, OK 73703		
(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 360	Continued From page 3 the written notice included a full explanation of the reasons for the termination of residency, the date the notice was given to the resident and the resident's representative, the date by which the resident must leave the assisted living center, notice that the resident, the resident representative or person responsible for payment of the resident's care could request a hearing with the Department, notice that the request for hearing with the Department must be filed within 10 Department business days of receipt of the facility notice, and notice that a written or verbal request for a hearing with the Department should be directed to the hearing clerk at the Oklahoma State Department of Health.	C 360		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to include a personal interview between the resident and/or the resident representative and the person completing the assessment form for 6 (#1, 2, 3, 4, 5, and #6) of 6 sampled residents whose assessments were reviewed.	C 543		