OKLAHOMA
State Department of Health

Delivery via email to: mmusick@homesteadofkingfisher.com

April 2, 2026

License Number: AL3701

Ms. Marcie Musick, Administrator
Homestead Of Kingfisher
1604 South 13th Street
Kingfisher, OK 73750

RE: Survey Event ID: IUVE11

Dear Ms. Musick:

On **March 3, 2026**, agents from our office concluded a State Licensure survey with complaint investigations 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 **March 3, 2026**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

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

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

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

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Homestead of Kingfisher**
Address: **1604 south 13th street**
City, State, Zip: **Kingfisher, OK, 73750**
Provider #: **AL3701**
Complaint #: **OK00086996**
Investigation Date(s): **03/02/26 through 03/03/26**

ALLEGATION(S)
The facility failed to ensure an appropriate discharge of a resident

An unannounced on-site investigation was initiated 03/01/20002/26 at 9:00 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Residents were observed for discharging or returning.

Resident records were reviewed for discharging documentation, resident behaviors, service plans and contracts were reviewed.

Staff members were interviewed regarding discharge and return process to the hospital.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/09/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Homestead of Kingfisher**
Address: **1604 south 13th street**
City, State, Zip: **Kingfisher, OK, 73750**
Provider #: **AL3701**
Complaint #: **OK00087847**
Investigation Date(s): **03/02/26 through 03/03/26**

ALLEGATION(S)
The center failed to follow abuse prevention policies and procedures.
The facility failed to ensure call lights were answered in a timely manner.
The center failed to ensure residents are offered snacks and hydration throughout the day.
The center failed to ensure residents are treated with dignity and respect.
The center failed to provide adequate supervision for dependent residents.
The center failed to follow medication administration policies and procedures.
The center failed to provide a sanitary, safe, and homelike environment.
The facility failed to ensure residents were provided activities.
The facility failed to follow medication storage policies and procedures.
The center failed to protect residents' right to access of visitation.

An unannounced on-site investigation was initiated 03/02/2026 at 9:00 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls, common areas, and resident rooms were observed for staff assistance with resident care needs. Observations made for snack and hydration, and medication administration was observed. Grievances and facility policy and procedure were reviewed.

Resident records were reviewed to include assessments, service plans and contracts, medication administration records, and physician orders were reviewed.

Staff were interviewed regarding staff assistance to care, facility cleanliness, activities, respect and dignity, abuse, and medication.

Staff was interviewed regarding staff assistance and are, activities, medication policy and procedures, and abuse.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3701	A. BUILDING: _____ B. WING _____	C 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF KINGFISHER	1604 SOUTH 13TH STREET KINGFISHER, OK 73750

(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 (#OK00086996 and #OK00087847) was conducted from 03/02/26 through 03/03/26. Deficiencies were cited as a result of the survey. Facility Census: 22 Listed below are abbreviations that will be used throughout this document. CNA - certified nurse aide	C 000		
C 328 SS=E	310:663-3-3(a)(8) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (8) planned programs for socialization, activities and exercise; and This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure scheduled activities were conducted in the memory care unit for 4 of 7 activity observations. The administrator identified six residents resided in the memory care unit. Findings: On 03/02/26 at 10:54 a.m., multiple residents were observed sitting in the memory care unit in the common area with the television on. No residents were watching the television and there was no entertainment engagement observed	C 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3701	A. BUILDING: _____ B. WING _____	C 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF KINGFISHER	1604 SOUTH 13TH STREET KINGFISHER, OK 73750

(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 328	Continued From page 1	C 328		

between residents and staff.

On 03/02/26 at 12:40 p.m., two residents were observed in the memory care unit sitting in the common area and all others were in their rooms. There was a piece of paper titled "The Daily Chronicle" on the dining room tables adjacent to the common area which was dated 03/02/26. The paper read like a new letter and showed information to read about and had questions on it for residents to answer and had announcements. There were no residents reading the paper and there were no staff members reading the paper to the residents.

On 03/02/26 at 2:58 p.m., four residents were observed in the memory care unit watching television. There were no activities or staff interaction with the residents.

On 03/03/26 at 9:50 a.m., two residents were observed in the common are in the memory unit. There were no activities in progress. Per the activity calendar there was to be exercise at 9:30 a.m. CNA #2 was observed wiping down the counter in the dining room and provided no activities to the residents.

A memory care activities calendar located at the nurses station, dated 03/2026, showed "The Daily chronicles" at 12:00 p.m. and "Pet Therapy" at 2:30 p.m. on 03/02/26. The activity calendar showed "Exercise" at 9:30 a.m. and "The Daily chronicles" at 12 p.m. on 03/03/26.

On 03/02/26 at 3:00 p.m., CNA #1 stated pet therapy did not occur today. They stated the only activity done so far was "The Daily Chronicle." CNA #1 stated the residents read the chronicle and the staff re-read it to them. CNA #1 stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3701	A. BUILDING: _____ B. WING _____	C 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF KINGFISHER	1604 SOUTH 13TH STREET KINGFISHER, OK 73750

(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 328	Continued From page 2 residents had magazines available. On 03/03/26 at 9:53 a.m., CNA #2 stated they forgot about the exercise activity, but had "The Daily Chronicle" they put on the table that residents did not look at. CNA #2 was asked how "The Daily Chronicle" was an activity. CNA #2 stated they did not think about that. On 03/03/26 at 10:56 a.m., the administrator and the regional resource were both present when asked how activities on the memory care unit were arranged. The administrator stated they had a calendar and the aide was to do the activity for that day. The administrator stated "The Daily Chronicle" was appropriate for the memory care residents because they could discuss and remember things that it asked.	C 328		
C 391 SS=D	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure: a. freezer #1 was kept clean and free of debris, b. refrigerator #2 was kept clean and free of debris and spills, and c. dishwasher temperature and sanitization logs were completed during 1 of 2 kitchen	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3701	A. BUILDING: _____ B. WING _____	C 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF KINGFISHER	1604 SOUTH 13TH STREET KINGFISHER, OK 73750

(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 391	Continued From page 3 observations. The administrator identified 22 residents resided in the facility. Findings: On 03/02/26 at 9:45 a.m., a tour of the kitchen was conducted. The following observations were made: a. freezer #1 had a moderate amount of brown, black, and white crumb like debris on the floor of the freezer, b. refrigerator #2 had a moderate to large amount of splatter of brown liquid on the bottom of the top shelf in the door of the refrigerator, and c. there were no temperature or sanitation logs were completed for the dishwasher at all. On 03/02/26 at 9:46 a.m., the dietary manager stated the freezer and refrigerator had not been cleaned in one month and they were supposed to be cleaned one time a month. On 03/02/26 at 9:58 a.m., the dietary manager stated they had not been checking or documenting the dishwasher temperature or sanitizer logs.	C 391		

OKLAHOMA
State Department
of Health

Delivery via email to: mmusick@homesteadofkingfisher.com

April 13, 2026

License Number: AL3701

Ms. Marcie Musick, Administrator
Homestead Of Kingfisher
1604 South 13th Street
Kingfisher, OK 73750

RE: Survey Event IUVE11

Dear Ms. Musick:

On **March 3, 2026**, a Licensure inspection with complaint investigations was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **April 10, 2026**.

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/3/2026** **Facility Name:** Homestead of Kingfisher **License Number:** AL3701 **Survey Event ID:** IUVE11 **Date Survey Completed: 3/3/2026**
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 328	Based on: Based on observation, record review, andinterview, the facility failed to ensure scheduledactivities were conducted in the memory care unitfor 4 of 7 activity observations
ASSISTED LIVING CENTER'S PLAN OF CORRECTION	
Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency	
REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The center will designate an employee(s) to perform activities daily. The Activity calendar will be updated, posted in the entry of AL and in MC as well as use of social media. The residents will be personally invited to each activity. The use of the television for activities will be to provide a visual or music aid to the activity. A log of activity attendance will be kept daily. Staff will be educated on activities and their responsibility to perform and participate These interventions will be implemented by 4/10/26
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A log of activity attendance will be kept daily to monitor for participation and interest in specific activities. The residents will be personally invited to each activity. The use of the television for activities will be to provide a visual or music aid to the activity. A log of activity attendance will be kept daily. Staff will be educated on activities and their responsibility to perform and participate These interventions will be implemented by 4/10/26
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?	An employee(s) will be designated to perform functions of the program. ED or designee will monitor activity participation log routinely. ED or designee will assure that calendar is posted as stated. ED or designee will assure that activities are being provided daily This will be ongoing
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its	Enter methods to ensure corrections are sustained:

performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	a. The interventions will be monitored through oversite from ED . Ensuring systems are in place as stated and maintained on an ongoing basis. b. As the ED monitors the activities program, areas identified to be deficient will be addressed through the QA process and discussed in the monthly QA mtg for resolution. c. The activity attendance log and activity calendar will be kept in a binder and monitored by the ED on an ongoing basis. Enter methods to incorporate into QA system: *This plan of correction is submitted as required under State and Federal law, the submission of this Plan of Corrective does not constitute an admission on the part of the Facility as to the accuracy of the surveyor `s findings or the conclusions drawn there from. The plan of correction does not constitute a deficiency or that the scope and severity regarding the deficiencies cited are correctly applied. Any changes to the Facility policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible by any third party in any civil or criminal action against the Facility or any employee, agent, officer, director, attorney or shareholder of the Facility.*
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/10/2026
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature OAC 310:663-25-4(F) M. Musick, ED	**Date** 4/8/26
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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/3/2026** **Facility Name:** Homestead of Kingfisher **License Number:** AL 3701 **Survey Event ID:** IUVE11 **Date Survey Completed: 3/3/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391	Based on: Based on observation and interview, the facilityfailed to ensure:a. freezer #1 was kept clean and free of debris,b. refrigerator #2 was kept clean and free ofdebris and spills, andc. dishwasher temperature and sanitization logswere completed during 1 of 2 kitchen observations.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	A revised cleaning list will be posted in the kitchen and staff will receive education on new list. The completed cleaning list will be submitted to the ED or designee daily. The ED or designee will inspect the kitchen daily for cleanliness, temperatures and compliance. A Revised Temperature log for dishwasher will be implemented. Dishwasher service tech will provide education on properly checking dishwasher chemical and sanitation and logs by 4/9/26
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents are affected the same as they are serviced out of one kitchen
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?	A revised cleaning list will be posted in the kitchen and staff will receive education on new list. The completed cleaning list will be submitted to the ED daily. The ED or designee will inspect the kitchen daily for cleanliness, temperatures and compliance. A Revised chemical log for dishwasher will be implemented. Dishwasher service tech will provide education on properly checking dishwasher chemical and sanitation and logs by 4/9/26 Any deficient practice or performance will be address in a timely manner
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;	Enter methods to ensure corrections are sustained: a. The ED or designee will monitor chemical logs routinely and ongoing. The cleaning lists will be reviewed daily and inspection by the ED or

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.	designee b. As the ED or designee monitors the chemical logs and cleanliness of the kitchen, areas identified to be deficient will be addressed through the QA process and discussed in the monthly QA mtg for resolution. c. The chemical and cleaning lists will be kept in a binder and monitored by the ED or designee on an ongoing basis. Enter methods to incorporate into QA system: *This plan of correction is submitted as required under State and Federal law, the submission of this Plan of Corrective does not constitute an admission on the part of the Facility as to the accuracy of the surveyor `s findings or the conclusions drawn there from. The plan of correction does not constitute a deficiency or that the scope and severity regarding the deficiencies cited are correctly applied. Any changes to the Facility policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible by any third party in any civil or criminal action against the Facility or any employee, agent, officer, director, attorney or shareholder of the Facility.*
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/10/2026
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature OAC 310:663-25-4(F) M. Musick, ED	**Date** 4/8/26
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.	
Addendum Date Enter a date of addendum.	**Submitted by** Enter name of person submitting addendum.
Items Below Are For OSDH Use Only	
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor	
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.	

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Delivery via email to: mmusick@homesteadofkingfisher.com

April 30, 2026

License Number: AL3701

Ms. Marcie Musick, Administrator
Homestead Of Kingfisher
1604 South 13th Street
Kingfisher, OK 73750

RE: Survey Event IUVE12

Dear Ms. Musick:

On **April 30, 2026,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your relicensure survey with complaints on **March 3, 2026,** have now been corrected effective **April 10, 2026.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3701	A. BUILDING: _____ B. WING _____	R-C 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF KINGFISHER	1604 SOUTH 13TH STREET KINGFISHER, OK 73750

(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 04/30/26. 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