OKLAHOMA
State Department
of Health

Delivery via email to: charlisa@countrysideltc.com

November 20, 2025

License Number: AL5101

Ms. Charlisa Stroman, Administrator
Countryside Memory Care Of Muskogee
3211 Chandler Road
Muskogee, OK 74403

RE: Survey Event ID: 5XU111

Dear Ms. Stroman:

On **November 6, 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 **November 6, 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: IDRCoordinator@health.ok.gov,

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

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

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

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

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Countryside Memory Care of Muskogee
Address:3211 Chandler Rd
City, State, Zip: Muskogee,OK,74403
Provider #: AL5101
Complaint #: OK00074671
Investigation Date(s):

ALLEGATION(S)
The center failed to ensure residents were not involuntarily secluded.
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 11/05/2025 at 9:30am

A sample of eight 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: Entrance into the facility is only accessible by a code, or key fob, I was greeted by the ED. Staff were observed interacting with residents, facility was clean with homelike atmosphere no foul odor detected. Upon the initial tour of the facility all doors to the salon, maintenance room, medication room were locked and only accessible by key fob. Tour of the outside facility no doors were secluded from the outside nor inside. Staff were observed knocking on residents' doors before entry was made into rooms and there was sufficient staff to meet the needs of residents. Records to review include physician orders, MARS, schedules for the past 4 weeks, medication destruction log book.

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: 11/10/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Countryside Memory Care AL
Address: 3211 Chandler Rd
City, State, Zip: Muskogee, OK, 74403
Provider #: AL5101
Complaint #: OK00083160
Investigation Date(s): 11/5/25- 11-6-25

ALLEGATION(S)
The center failed to ensure there was an administrator to ensure the day to day operations of the facility
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 11/06/2025 at 9:30 am

A sample of eight 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: Entrance into the facility is only accessible by a code, or key fob, I was greeted by the ED. Staff were observed interacting with residents, facility was clean with homelike atmosphere no foul odor detected. Upon the initial tour of the facility all doors to the salon, maintenance room, medication room were locked and only accessible by key fob. Tour of the outside facility no doors were secluded from the outside nor inside. Staff were observed knocking on residents' doors before entry was made into rooms and there was sufficient staff to meet the needs of residents. Records to review include physician orders, MARS, schedules for the past 4 weeks, medication destruction log book.

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: 11/10/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Countryside Memory Care of Muskogee
Address: 3211 Chandler Rd
City, State, Zip: Muskogee, OK, 74403
Provider #: AL5101
Complaint #: OK000833309
Investigation Date(s): 11/5/25-11/6/25

ALLEGATION(S)
enter text The facility failed to provide sufficient staff to assist the residents with their care and needs.
The facility failed to ensure staff were qualified to destroy medications.
enter text
enter text
enter text

An unannounced on-site investigation was initiated 11/06/2025 at 9:30 am

A sample of eight 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: : Entrance into the facility is only accessible by a code, or key fob, I was greeted by the ED. Staff were observed interacting with residents, facility was clean with homelike atmosphere no foul odor detected. Upon the initial tour of the facility all doors to the salon, maintenance room, medication room were locked and only accessible by key fob. Tour of the outside facility no doors were secluded from the outside nor inside. Staff were observed knocking on residents' doors before entry was made into rooms and there was sufficient staff to meet the needs of residents. Records to review include physician orders, MARS, schedules for the past 4 weeks, medication destruction log book.

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

OKLAHOMA
State Department
of Health

Date report completed: 11/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5101	A. BUILDING: _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEMORY CARE OF MUSKOGEE	3211 CHANDLER ROAD MUSKOGEE, OK 74403

(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 (#OK00074671, OK00083160, and #OK00083309) was conducted from 11/05/25 through 11/06/25. Deficiencies were cited as a result of the survey. Facility Census: 29 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide DON -director of nursing ED - executive director MAR - medication administration record Res - resident	C 000		
C 711 SS=D	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21.	C 711		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5101	A. BUILDING: _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEMORY CARE OF MUSKOGEE	3211 CHANDLER ROAD MUSKOGEE, OK 74403

(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 711	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow their destruction of medication policy. The executive director identified 29 residents resided in the facility. Findings: A facility policy titled "Disposal of Medications," dated 08/22/23, read in part, "Document the disposal on a Narcotic Inventory Sheet, with the date, time, amount, and method of disposal noted."..."Both employees witnessing the disposal must sign the Narcotic Inventory Sheet." On 11/06/25 at 10:50 a.m., a book titled "Destruction Log," dated 06/05/25 thru 09/19/25 was reviewed. The log showed what medication, dosage, number of quantity destroyed, name on prescription. The destruction log book did not contain initials of any staff person logging, destruction or witnessing the destruction of the medications. On 11/06/25 at 2:00 p.m., the DON was asked about the policy for destroying medications. The DON stated the nurse along with a licensed health worker could only destroy medications. They stated the pharmacist signed off on the destroyed medication when they came in for pharmacy reviews. The current destruction log sheet for dates 06-05-25 thru 09-19-25, did not show any initials for witness #1 and witness #2 in each column.	C 711		
C1920 SS=D	310:663-19-2(a) MEDICATION ADMINISTRATION	C1920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5101	A. BUILDING: _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEMORY CARE OF MUSKOGEE	3211 CHANDLER ROAD MUSKOGEE, OK 74403

(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
C1920	Continued From page 2 (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the correct dose of medications were administered for 1 of (#8) of 8 sampled residents reviewed for medication administration. The executive director identified 29 residents resided in the facility. Findings: On 11/05/25 at 12:25 p.m., CMA #1 was observed administering medication to Res #8. The CMA administered a medication from a medication bottle, dated 06/02/25. The label showed Carbidopa-Levodopa (Parkinson's medication) 25-100mg by mouth four times a day. CMA #1 also administered medication from a medication bottle, dated 09/05/25. The label showed Nateglinide 60 mg (diabetes medication) by mouth three times a day. A facility policy titled "Change of Order," dated 08/22/23, read in part, "The Resident Care Director enters the order on the Resident's medication record if applicable."..."Write the new order as prescribed in the next available space on the Resident's medication record. Be sure to include the current date, name of medication, the strength, the route, and the frequency."	C1920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5101	A. BUILDING: _____ B. WING _____	C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEMORY CARE OF MUSKOGEE	3211 CHANDLER ROAD MUSKOGEE, OK 74403

(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
C1920	Continued From page 3 An electronic MAR, order dated 03/09/25, showed Carbidopa-Levodopa 25-100mg by mouth three times a day and a electronic MAR, order dated 10/20/25, showed Nateglinide 120 mg by mouth two times a day. This resulted in 1 dose of each medication being administered incorrectly. A Electronic "Admission Record," dated 11/05/25, showed Res #8 had diagnoses which included Type 2 Diabetes and Parkinson's disease. On 11/05/25 at 2:50 p.m., CMA #1 was asked about the medication orders being different from the MAR to what the pill bottle showed. CMA #1 stated they did not know why they were different. CMA #1 was asked what the policy was for administering medication when a physician order has been changed. CMA #1 stated they did not know the policy. They stated the DON was in charge of putting in physician orders. On 11/06/25 at 8:45 a.m., the DON was asked about Res #8 MAR's. The DON stated Res #8's daughter was constantly taking them to different doctors and getting medications prescribed. The DON stated they had to wait until the doctor sent the new order for the correction could be made into their system. The DON was asked what their policy was for medication changes. They stated the nurse was responsible for putting in any physician orders.	C1920		

OKLAHOMA
State Department
of Health

Delivery via email to: charlisa@countrysideltc.com

December 18, 2025

License Number: AL5101

Ms. Charlisa Stroman, Administrator
Countryside Memory Care Of Muskogee
3211 Chandler Road
Muskogee, OK 74403

RE: Survey Event 5XU111

Dear Ms. Stroman:

On **November 6, 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 in a timely manner. **Our acceptance does not absolve the facility's responsibility for** compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **December 30, 2025**.

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/20/2025** **Facility Name:** Countryside Senior Living **License Number:** AL5101 **Survey Event ID:** 5XU111 **Date Survey Completed: 11/6/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C711	Based on: The facility failed to follow their destruction of medication policy.

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?	Destruction log was reviewed and signed off by Nurse and CMA on 11/15/2025. Medication logs were reviewed for any additional discrepancies.
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 medications that has been refused, expired, or discontinued will be destroyed by CMA and Nurse, Pharmacist or employee designated by the Administrator and ensure signatures are in place.
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?	Staff education for all cma's on the policy and procedures for medication destruction. The medication policy will be reviewed by the pharmacy consultant and DON to ensure clear, step by step language regarding destruction.
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.	DON will conduct weekly log audits for 8 weeks of all medications and destructon log entries. DON and Administator to check weekly for 8 weeks for signatures, then monthly to ensure continued compliance with policy. Compliance with the medication destruction policy will be integrated into quarterly QAPI review process. Any trends indication non-compliance will trigger immediate retraining. Destruction log will be kept in medication room and reviewed weekly for 8 weeks and then monthly.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/30/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.
Marissa Hinman	11/24/25

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

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/20/2025

Facility Name: Countryside Senior Living

License Number: AL5101

Survey Event ID: 5XU111

Date Survey Completed: 11/6/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1920	Based on: The facility failed to to ensure the correct dose of medications were administered for 1 of 8 sampled residents reviewed for medication administration.

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 nurse placed a change of order sticker on the medication bottle in question 11/6/25.
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 medications will be checked by CMA's and DON to ensure order matches the bottle or prescription package before administering.
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?	Mandatory "five rights" competency training will be completed by all medication aides to ensure compliance.
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.	The DON will conduct medication audits weekly for 8 weeks and then monthly for 3 months. The DON will conduct a weekly audit of a minimum of 10 active resident MAR's to ensure they align with physician orders, focusing on dosage strength and frequency. All medication error reports will be aggregated monthly and reviewed by QAPI committee. Trends related to dosing errors will trigger targeted retraining interventions.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/30/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Charlotte Stroman **Date** Enter a date of Signature. 11/24/25

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.

Today

5 rights of medication administration

The 5 rights of medication administration are: right patient, right drug, right dose, right route, and right time GoodRx +2 .

Detailed Explanation of the 5 Rights

- **Right Patient**
  - Always confirm the identity of the patient before giving medication.
  - Use at least two identifiers (e.g., name and date of birth) to avoid mix-ups.
- **Right Drug**
  - Verify the medication against the doctor's order.
  - Double-check labels and watch for look-alike or sound-alike drugs.
- **Right Dose**
  - Ensure the prescribed dose matches what is being administered.
  - Be cautious with calculations, especially for pediatric or elderly patients.
- **Right Route**
  - Confirm the correct method of administration (oral, intravenous, intramuscular, topical, etc.).
  - Using the wrong route can make the drug ineffective or harmful.
- **Right Time**
  - Administer medication at the correct time and frequency as prescribed.
  - Timing affects drug effectiveness (e.g., antibiotics must be spaced evenly).

Why These Rights Matter

- They **reduce medication errors**, which can cause serious harm.
- Nurses and caregivers act as the **final safety check** before a drug reaches the patient.
- Following these rights ensures **safe, effective, and ethical care.**

COUNTRYSIDE MEMORY CARE

In-Service Attendance Record

IN-SERVICE TITLE: 5 rights of medication administration

DATE: 12.2.25 TIME: ______

IN-SERVICE PRESENTER(S): Rob Daniel LPN | DSN

TYPE: LECTURE ✓ WEBINAR ______ AUDIO ______ VIDEO ______

EVACUATION DRILL ____ OTHER ______

BRIEF SUMMARY OF CONTENTS: ______

PRINT NAME	SIGNATURE
1.Adair, Thomasina	Thomasina Adair
2.Grayson, Latonda	Latonda Grayson
3.Hunter, Roxanne	Roxanne Hunter
4.Radebaugh, Christin	Christin Radebaugh
5.Wright, Kaila	Kaila Wright
6.Ashley Ruffin	Ashley Ruffin
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24.	
25.	

C1920

Medications packages should match the physician orders or have a change of order on the medication.

The Five Rights
of Drug Administration

Use these questions to make sure you are providing proper drug dosage to the individual you serve.

1 | Right Drug

Are you certain that this is the right drug for this individual?

2 | Right Dose

Are you sure that this is the right amount of that drug for this individual?

3 | Right Route

Are you sure this is the right place or way to administer this drug for this individual?

4 | Right Time

Are you sure that this is the right time to provide this drug to this individual?

5 | Right Patient

Are you certain that you are giving this drug to the right patient?

Protect Your Patients.

DISPOSAL OF MEDICATIONS

POLICY: Medications shall be disposed of according to state and federal regulations and established procedure, with appropriate documentation made.

PROCEDURES:

1. Medication must be disposed of when it is refused by a Resident, becomes outdated (i.e., expired), or is discontinued by the Resident's physician. Depending upon the situation, destroy the medication at the Community.

2. Check expiration dates for all medications (prescription and over-the-counter) on a regular basis to ensure that all medications are current.

3. Dispose of a single dose of medication (e.g., a medication that was refused by a Resident) by placing the medication in a medication disposal container. These should be inventoried & locked until the Preferred Pharmacy comes to the Community for destruction.

4. When a representative from the pharmacy arrives at the Community to destroy the medications, he/she should sign the Medication Destruction Record in the "Signature of Witness" column. He/she should also write the name of the pharmacy in this space. Give a copy of the Medication Destruction Record to the pharmacy representative if requested, with the original form maintained in the medication destruction log.

5. Controlled medications cannot be returned to the pharmacy. Thus, when these medications need to be destroyed, they must be placed in a separate medication disposal container, with those procedures outlined in #3 and above followed.

6. Document the disposal on a Narcotic Inventory Sheet, with the date, time, amount and method of disposal noted. Both employees witnessing the disposal must sign the Narcotic Inventory Sheet (i.e., the Resident Care Director and Administrator or another employee designated by the Administrator).

COUNTRYSIDE MEMORY CARE

In-Service Attendance Record

IN-SERVICE TITLE: Disposal of medications

DATE: 12.2.25 TIME: _____

IN-SERVICE PRESENTER(S): Deb Daniel WEX/DSK

TYPE: LECTURE ✓ WEBINAR _____ AUDIO _____ VIDEO _____

EVACUATION DRILL ____ OTHER _____

BRIEF SUMMARY OF CONTENTS: _____

PRINT NAME	SIGNATURE
1.Adair, Thomasina	Thomasina Adair
2.Grayson, Latonda	Latonda Grayson
3.Hunter, Roxanne	Roxanne Hunter
4.Radebaugh, Christin	Christin Radebaugh
5.Wright, Kaila	Kaila Wright
6.Ashley Ruffin	Ashley Ruffin
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Medications should be logged and destroyed with two signatures. CMA and Nurse, Pharmacist, or employee designated by the Administrator.

OKLAHOMA
State Department of Health

Delivery via email to: charlisa@countrysideltc.com

January 6, 2026

License Number: AL5101

Ms. Charlisa Stroman, Administrator
Countryside Memory Care of Muskogee
3211 Chandler Road
Muskogee, OK 74403

RE: Survey Event 5XU112

Dear Ms. Stroman:

On **January 5, 2026,** a revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your survey on **November 6, 2025,** have now been corrected effective **December 30, 2025.**

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5101	A. BUILDING: _____ B. WING _____	R-C 01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MEMORY CARE OF MUSKOGEE	3211 CHANDLER ROAD MUSKOGEE, OK 74403

(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 01/05/26. 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