OKLAHOMA
State Department
of Health

Delivery via email to: Skye@gladeavenueassistedliving.com

July 23, 2025

License Number: AL5511
Survey Event ID: RX9X11

Ms. Skye Statum, Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Dear Ms. Statum:

On **July 14, 2025**, agents from our office concluded a State Licensure survey with a complaint investigation 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 **July 14, 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: Glade Avenue Assisted Living
Address: 2500 N Glade Avenue
City, State, Zip: Bethany, OK
Provider #: AL5511
Complaint #: OK00084409
Investigation Date(s): 07/10/25, 07/11/25, 07/14/25

ALLEGATION(S)
Facility failed to ensure residents are free from abuse.

An unannounced on-site investigation was initiated 07/10/2025 at 2:30 p.m.

A sample of three 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 into the center. Residents were observed for abuse and neglect concerns. Staff were observed interacting with residents, as well as residents interacting with other residents. Records reviewed included: Residents health records, facility reported incidents, and grievances. Residents and staff were asked questions regarding abuse and abuse training.

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: 07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5511	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING	2500 NORTH GLADE AVENUE BETHANY, OK 73008

(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 complaint (#OK00084409) was conducted from 07/10/25 through 07/11/25, and 07/14/25. Deficiencies were cited as a result of the survey. Facility Census: 62 Listed below are abbreviations that will be used throughout this document. DON - Director of Nursing	C 000		
C 391 SS=E	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, record review, and interview, the facility failed to ensure food items were labeled, stored, prepared, and served safely, and in sanitary conditions. for 2 of 2 observations conducted. The DON stated 62 residents resided in the facility. Findings: On 07/10/25 at 3:00 p.m., a tour of the kitchen was conducted, and the following was observed: a. the dishwasher was observed to be holding	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5511	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING	2500 NORTH GLADE AVENUE BETHANY, OK 73008

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C 391	Continued From page 1 dirty water with food particles, and not draining, b. a broken electrical cover plate was lying on the floor below the outlet, exposing wires on the electrical outlet, c. the ice machine was observed to have dust build up on the vent, and dust and dirt on top of the machine, d. a cabinet in the serving area had broken hinges on the door and an unlevel shelf with dirt and grime build up, e. the walls and floors under dishwasher and stove, in the kitchen observed to have dirt build up and food splatter, and f. clean glass bowls were observed to be stacked upright while wet. On 07/14/25 at 11:00 a.m., the refrigerator and freezer were observed to have to following: a. an open, undated, 1/4 gallon of milk, b. an open, undated, package of shredded cheese, and c. an open, undated, gallon of ice cream observed in the freezer. On 07/14/25 at 11:45 a.m., the dietary manage and DON were asked about cleaning logs and food storage policies. The dietary manager stated, "Anything that's opened, requires a date." The DON or dietary manager were not able to produce a cleaning log or documentation where maintenance was notified of needed repairs to shelf, doors and the electrical outlet.	C 391		
C 711 SS=E	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title	C 711		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5511	A. BUILDING: _____ B. WING _____	C 07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING	2500 NORTH GLADE AVENUE BETHANY, OK 73008

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C 711	Continued From page 2 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an annual fire marshal inspection was conducted. The DON reported 62 residents resided in the facility. Findings: A report titled, "Fire & Life Safety Inspection," dated 12/04/23, and a report dated, 07/09/25, was provided by facility for review. On 07/14/25 at 1:00 p.m., the administrator stated they missed being scheduled for an inspection in 2024.	C 711		

OKLAHOMA
State Department
of Health

Delivery via email to: Skye@gladeavenueassistedliving.com

August 12, 2025
License Number: AL5511

Ms. Skye Statum, Executive Director
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

RE: Survey Event RX9X11

Dear Ms. Statum:

On **July 14, 2025**, a Licensure inspection with a complaint investigation was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and 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 **September 8, 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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/8/2025** **Facility Name:** Glade Assisted Living **License Number:** AL5511 North Building **Survey Event ID:** RX9X11 **Date Survey Completed: 7/14/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 Food Storage, Preparation AND Service	Based on: Observation, record review, and interview center failed to maintain a steam table in good repair and hold temperature for hot hold food at 135 degrees Fahrenheit or above for hall trays.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Assisted Living Center's Comments: Submission of this response and plan of correction is NOT legal admission that a deficiency exists or, that this statement of deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or plan of correction. In addition, the preparation and submission of this plan of correction does NOT constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	1. Executive Director will train the Dining room Director on Chapter 257 on food stored, prepared, and served. Training will be added to the QA monthly minutes. 2. Dining Director and Kitchen Staff will be trained on Food Safety and Food Storage regulations. Training will be added to the QA monthly minutes. 3. Dining Director and Kitchen staff will be trained on proper temperatures for serving residents. Training added to the QA monthly minutes. 4. Dining Director and Kitchen staff will be trained on proper cleaning and documentation of cleaning. Cleaning logs will be maintained weekly and signed off on by Dietary manager weekly and Executive Director monthly. 5. Dining Room Director will perform weekly audits on kitchen steam table, ice machine, and microwave to ensure it is properly working and being cleaned. And weekly audits on food temperatures and cleaning logs to ensure are being completed. 6. Executive Director will make walking rounds weekly and document findings to ensure Food Storage and preparation and service is being followed. 7. Audits will be turned into Executive Director weekly and reviewed by Administrator monthly and added to the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding. Executive Directtor will

	train the Dining Director and Kitchen staff on Chapter 257 food storage, prepared, and proper temperatures.
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?	1. Dining Room Director will maintain weekly audits on food tempartures, cleaning logs, and monitor dates on food and properly storage. 2. The Audits will be be reviewed in the monthly QA by the Administrator.
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.	ED and/or Dining Room Director will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits will be reviewed by Executive Director and added to the monthly QA meeting. Montoring of audits will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/8/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Skye Statum OAC 310:663-25-4(F)	**Date 8/8/2025**

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.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/8/2025** **Facility Name:** Glade Assisted Living **License Number:** AL5511 NORTH Building **Survey Event ID:** RX9X11 **Date Survey Completed: 7/14/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 711 General Requirements	Based on: Observation, record review, and interview center failed to ensure a fire marshal inspection was conducted

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Assisted Living Center's Comments: Submission of this response and plan of correction is NOT legal admission that a deficiency exists or, that this statement of deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or plan of correction. In addition, the preparation and submission of this plan of correction does NOT constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	1. Administrator will train Maintenance Director on State Regulations 310:663-7-1 (a) General Requirements. Training will be added to the QA monthly meeting minutes. 2. Administrator had notifed the Bethany Fire Marshal and had community inspected as of 7/9/25. Report will be added to the QA monthly meeting minutes. 3. Facility Maintenance Director will have all corrected items on Fire Marshal report from 7/9/25 corrected and have a clear Fire Marshal report added to QA monthly meeting minutes. Reported verified by Administrator. 4. Administrator will add yearly schedule Due Date on QA notes to prevent reoccurrence.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	1. Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding.
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?	1. Both Maintenance Director and Administrator will add next schedule Fire Marshal inspection due date to yearly calendar and alert Fire Marshal office 60 days before inspection is due. The date of next inspection will be added to the Monthly QA meeting notes.
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.	ED and/or Maintenance Director will be responsible for sustained compliance. ED will add training to the QA meeting and binder will be kept in Administrators office. Enter methods to incorporate into QA system: Montoring of audits will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/8/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye Statum** OAC 310:663-25-4(F)	**Date 8/8/2025**

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.

OKLAHOMA
State Department of Health

Delivery via email to: Skye@gladeavenueassistedliving.com

September 10, 2025

License Number: AL5511

Ms. Skye Statum, Executive Director
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

RE: Survey Event RX9X12

Dear Ms. Statum:

On **September 9, 2025,** an off-site paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **July 14, 2025,** have now been corrected effective **September 8, 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
	AL5511	A. BUILDING: _____ B. WING _____	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING	2500 NORTH GLADE AVENUE BETHANY, OK 73008

(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 09/09/25. 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