
Delivery via email to: Willie@gladevenueassistedliving.com

February 25, 2026

License Number: AL5511

Ms. Willena Ferguson, Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: X37111

Dear Ms. Ferguson:

On **January 30, 2026**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance

being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement, and another plan of correction may be required.

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

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

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

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

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

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

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

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



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

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

Respectfully,

Tempal Killman

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

Enclosure

INVESTIGATIVE REPORT

Facility: Woodview Home, Inc
Address: 1630 3rd Avenue Northeast
City, State, Zip: Ardmore, OK 73401
Provider #: 375393
Complaint #: 1904253
Investigation Date(s): 02/02/26 through 02/03/26

ALLEGATION(S)

The center failed to ensure an allegation of abuse was reported to the OSDH within two hours from the time the incident occurred and/or within two hours of notifying the administrator.
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An unannounced on-site investigation was initiated 02/02/2026 at 09:30 a.m.

A sample of 4 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 Centers for Medicare and Medicaid Services (CMS) 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 throughout the investigation. Residents were observed during meals, while participating in activities, and while receiving assistance with activities of daily living. Residents were observed to interact with staff members and fellow residents. Residents were observed for being treated with dignity and respect. Staff were observed for interacting with residents in a kind and respectful manner.

Sampled clinical records, including closed records, were reviewed for progress notes, physician orders, care plans, and assessments. Incident reports were reviewed. Facsimile receipts were reviewed. Facility policies and procedures were reviewed. Resident council minutes were reviewed. Grievances were reviewed. Staff in-service training was reviewed.

Residents and staff were interviewed regarding abuse recognition and reporting.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/04/2026

INVESTIGATIVE REPORT

Facility: Woodview Home, Inc
Address: 1630 3rd Avenue Northeast
City, State, Zip: Ardmore, OK 73401
Provider #: 375393
Complaint #: 2728934
Investigation Date(s): 02/02/26 through 02/03/26

ALLEGATION(S)

The facility failed to ensure residents were free from abuse.

An unannounced on-site investigation was initiated 02/02/2026 at 09:30 a.m.

A sample of 4 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 Centers for Medicare and Medicaid Services (CMS) 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.

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Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/04/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375393		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/03/2026	
NAME OF PROVIDER OR SUPPLIER Woodview Home, Inc.				STREET ADDRESS, CITY, STATE, ZIP CODE 1630 3RD AVENUE NORTHEAST , ARDMORE, Oklahoma, 73401			
(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) COMPLETION DATE	
F0000	INITIAL COMMENTS Complaint investigations (#1904253 and #2728934) conducted on 02/02/26 through 02/03/26 resulted a finding of substantial noncompliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Facility Census: 40 Listed below are abbreviations that will be used throughout this document. BIMS-brief interview for mental status DON-director of nurses CNA-certified nurse aide OSDH-Oklahoma State Department of Health	F0000					
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a resident was free from abuse for 1 (#1) of 4 sampled residents reviewed for	F0600	"Past Noncompliance - no plan of correction required"				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0600 SS = D	Continued from page 1 abuse. The administrator identified 40 residents resided in the facility. Findings: 1. On 02/02/26 at 11:00 a.m., Resident #1 was observed being assisted to the restroom by staff. On 02/02/26 at 11:35 a.m., Resident #1 was observed sitting in the common area in front of the nurses' station smiling and waving at the surveyor. A quarterly assessment for Resident #1, dated 11/05/25, showed the resident had diagnoses which included down syndrome and cerebral infarction. The assessment showed Resident #1 had a BIMS score of 02, which indicated they were severely cognitively impaired for daily decision making and required partial to moderate assistance with all activities of daily living except eating. A late entry nursing progress note for Resident #1, dated 01/26/26 at 8:09 p.m., showed on 01/25/26 at 8:00 p.m., Resident #1 came to the nursing staff and gestured to their breast and pointed to Resident #2 saying they had grabbed their breast. An initial incident report form, dated 01/26/26, showed the charge nurse reported to the DON Resident #1 communicated their breast was touched by Resident #2. The report showed staff immediately separated the two residents and no injuries were noted for either resident. The report showed supervision was initiated for Resident #2. The report showed staff in-service regarding abuse prevention and reporting was initiated and psychiatric care referrals were initiated. 2. On 02/02/26 at 10:00 a.m., Resident #2 was observed being provided one-on-one supervision by the staff with no further incidents. A significant change assessment for Resident #2, dated 11/11/25, showed the resident had a BIMS score of 12, which indicated moderate cognitive impairment. The assessment showed diagnoses which included congestive heart failure, end stage renal disease, and diabetes mellitus. The assessment showed Resident #2 required set-up assistance for oral hygiene, toileting, showering, and partial to moderate assistance with personal hygiene. A care plan for Resident #2, dated 01/25/26, showed a	F0600					

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F0600 SS = D	Continued from page 2 problem of behavioral symptoms with a history of socially inappropriate and/or disruptive behavior. The goal was the resident was to remain free from exhibiting socially inappropriate and/or disruptive behaviors with some of the following approaches listed: administer medications as prescribed, allow distance in seating other residents, allow resident to have control over situations, and if possible, assess whether the behavior endangers the resident and/or others. Intervene to ensure all residents feel safe as necessary. Physician orders for Resident #2, dated 01/26/26, showed the resident was newly prescribed Provera (hormonal medication) 10 mg once a day and Paxil (an antidepressant) 30 mg once a day. A "RE 1 on 1 sitting schedule" form, dated 01/26/26 through 02/02/26, showed Resident #2 was provided on-on-one supervision each shift. A quality assurance form, dated 01/26/26, showed facility department heads, corporate staff, physician, and nurse practitioner had met to develop a plan to ensure the abuse would not happen again. The form showed safe surveys were done, psychiatric consults were completed, trauma informed care observations were initiated, progress notes were written, staff interviews were conducted, full body assessments were done, care plans were updated, and in-service of staff was completed. An "in-service" form reviewed, dated 01/26/26, showed all staff had been in-serviced on abuse by them signing the form. "Safe Surveys" reviewed, dated 01/26/26, showed residents were interviewed regarding abuse. The surveys showed residents were not abused. A final incident report form, received by OSDH on 01/30/26 at 8:28 p.m., showed the facility cameras were reviewed and the footage showed Resident #2 pulling their wheelchair beside Resident #1, lifting Resident #1's blanket and putting their hand on Resident #1's breast. The report showed the physician, law enforcement, and family were immediately notified. The report showed other residents were interviewed and not found to have experienced any abuse. The report showed Resident #2 continued to be supervised and was seen by a psychiatrist and medications adjustments were made. The report showed Resident #1 had no residual effects from the incident. The report showed Resident #2 had referrals sent to multiple inpatient psychiatric	F0600					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375393		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/03/2026	
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F0600 SS = D	Continued from page 3 facilities but had been denied. The report showed Resident #2 would continue to be supervised, psychiatric consultations as needed, and provided additional interventions as needed. On 02/02/26 at 10:00 a.m., the DON was interviewed and reported other facilities had been sought out to transfer Resident #2 to. The DON stated due to Resident #2 having dialysis three times weekly, all the facilities that had been contacted had refused Resident #2. The DON stated Resident #2 had no behaviors before or since the incident with Resident #1. The DON stated Resident #2 remained on one-on-one with staff. On 02/03/26 at 9:40 a.m., CNA #3 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:43 a.m., licensed practical nurse #1 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:45 a.m., registered nurse #1 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:50 a.m., housekeeper #1 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:52 a.m., CNA #4 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:55 a.m., CNA #5 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 9:59 a.m., CNA #6 stated they would report abuse to the abuse coordinator and knew all signs of abuse. On 02/03/26 at 11:15 a.m., the administrator stated Resident #1 and Resident #2 were immediately separated after the incident on 01/25/26 and an investigation began. They stated Resident #2 was placed on one-on-one with staff.	F0600					
F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F0609					

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F0609 SS = E	Continued from page 4 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to report allegations of abuse to OSDH within two hours for 2 (#1 and #3) of 4 sampled residents reviewed for abuse. The administrator identified 40 residents resided in the facility. Findings: An "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating" policy, dated September 2022, read in part, "Reporting Allegations to the Administrator and Authorities"... "3. 'immediately' is defined as: a. within two hours of an allegation involving abuse." 1. An initial incident report form, dated 06/11/25, showed Resident #3 had a diagnosis of severe dementia and they ambulated independently. The report, read in part, "This morning [CNA #1] reported to the DON that they had observed [CNA #2] scream at [Resident #3] in the dining room yesterday evening." The facsimile	F0609					

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0609 SS = E	Continued from page 5 receipt showed OSDH received the incident report on 06/12/25 at 4:41 p.m. 2. A late entry nursing progress note for Resident #1, dated 01/26/26 at 8:09 p.m., showed on 01/25/26 at 8:00 p.m., Resident #1 came to the nursing staff and gestured to their breast and pointed to Resident #2 saying they had grabbed their breast. The note showed Resident #1 gestured they slapped the hand of Resident #2. The note did not show the allegation had been reported to the abuse coordinator. An initial incident report form, dated 01/25/26, showed the charge nurse reported to the DON and administrator Resident #1 communicated that their breast was touched by Resident #2. The facsimile received by OSDH was dated 01/26/26 at 2:55 p.m. On 02/03/26 at 11:30 a.m., the administrator nodded and was in agreement the allegations of abuse were not reported to OSDH timely.	F0609					

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH1008		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/03/2026	
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LL000	Initial Comments Complaint investigations (#1904253 and #2728934) were conducted on 02/02/26 through 02/03/26. Facility Census: 40			LL000			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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Delivery via email to: Willie@gladeavenueassistedliving.com

February 25, 2026

License Number: AL5511

Ms. Willena Ferguson, Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: X37111

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123 Robert S. Kerr Ave, Ste.1702
Oklahoma City, OK 73102-6406

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- 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

INVESTIGATIVE REPORT

Facility: Glade Avenue Assisted Living
Address: 2500 North Glade
City, State, Zip: Bethany, Okla. 73008
Provider #: AL5511
Complaint #: OK00087035
Investigation Dates: 01/13/26, 01/14/26, 01/16/26, 01/20/26, 01/21/26, 01/27/26, and 01/30/26

ALLEGATION(S)
The facility failed to ensure fall interventions were implemented.
The facility failed to ensure care was provided for dependent residents.
The facility failed to ensure adequate staff to meet the needs (call lights) of the residents.

An unannounced on-site investigation was initiated 01/13/2026 at 12:46 p.m.

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

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:

Residents' environment was observed for fall interventions, staff were observed during care of the residents. Residents were observed throughout the survey, call lights were observed to ensure they were answered timely.

Resident records, service plan, contracts, activities of daily living sheets, shower sheets, grievances, resident council minutes, incident reports, and policies and procedures were reviewed during the survey.

Staff were interviewed about resident care needs, fall interventions, and call lights. Residents and families were interviewed about the care provided to the residents.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/10/2026

INVESTIGATIVE REPORT

Facility: Glade Avenue Assisted Living
Address: 2500 North Glade
City, State, Zip: Bethany, Okla. 73008
Provider #: AL5511
Complaint #: OK00087046
Investigation Dates: 01/13/26, 01/14/26, 01/16/26, 01/20/26, 01/21/26, 01/27/26, and 01/30/26

ALLEGATION(S)
The facility failed to ensure residents were free from abuse.
The center failed to assess monitor and intervene in a timely manner for a fall.
The center failed to ensure incontinent care was provided according to the plan of care.
The center failed to ensure rehab services were provided according to the physician orders.
The center failed to have and/or implement an effective infection control program.

An unannounced on-site investigation was initiated 01/13/2026 at 12:46 p.m.

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

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:

Staff were observed during the care of residents. The residents were observed for bruising, injuries, and/or signs of abuse. The residents were observed for falls and fall interventions. Residents were observed during incontinent care for proper care and infection control. Staff and resident interactions were observed throughout the survey.

Resident records, contracts, service plans, physician's orders, activities of daily living sheets, shower sheets, grievances, resident council minutes, incident reports, and policies and procedures were reviewed during the survey.

Staff and residents were interviewed about abuse. Residents were interviewed about care provided, call lights, falls, incontinent checks, and showers. Staff were interviewed about falls, incontinent care, outside providers-home health and hospice, and infection control.



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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/12/2026

INVESTIGATIVE REPORT

Facility: Glade Avenue Assisted Living
Address: 2500 North Glade
City, State, Zip: Bethany, Okla. 73008
Provider #: AL5511
Complaint #: OK00087184
Investigation Dates: 01/13/26, 01/14/26, 01/16/26, 01/20/26, 01/21/26, 01/27/26, and 01/30/26

ALLEGATION(S)

The facility failed to ensure care and services were provided according to the contract.
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An unannounced on-site investigation was initiated 01/13/2026 at 12:46 p.m.

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

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

A Summary of Complaint Investigation:

Residents and resident rooms were observed for cleanliness, staff were observed for care of the residents, and cleaning of the resident rooms and common areas.

Resident contracts, service plans, grievances, resident council, physician orders, assessments, activities of daily living sheets, shower sheets, policies and procedures were reviewed during the survey.

Staff were interviewed about the care residents required, residents were interviewed about care provided by the facility staff. Staff were interviewed about contracts and service plans.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/12/2026

INVESTIGATIVE REPORT

Facility: Glade Avenue Assisted Living
Address: 2500 North Glade
City, State, Zip: Bethany, Okla. 73008
Provider #: AL5511
Complaint #: OK00088731
Investigation Dates: 01/13/26, 01/14/26, 01/16/26, 01/20/26, 01/21/26, 01/27/26, and 01/30/26

ALLEGATION(S)
The facility failed to ensure residents were not verbally, mentally or physically abused.

An unannounced on-site investigation was initiated 01/13/2026 at 12:46 p.m.

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

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:

Staff were observed interacting with the residents. Residents were observed for bruising, injuries, and/or signs they were afraid of the staff.

Resident records, physician's orders, service plans, contracts, grievances, resident council, incident reports, and policies and procedures were reviewed during the survey.

Staff was interviewed about abuse policies and procedures and abuse allegations. Residents were asked about abuse and if they felt safe.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/10/2026

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/30/2026
NAME OF PROVIDER OR SUPPLIER GLADE AVENUE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaints (#OK00087035, OK00087046, OK00087184, and #OK00088731) were investigated on 01/13/26 through 01/14/26, 01/16/26, 01/20/26 through 01/21/26, 01/27/26, and 01/30/26. Facility Census: 73 Listed below are abbreviations that will be used throughout this document. ADL - activities of daily living CMA - certified medication aide CNA- certified nursing assistant DON - director of nursing IJ - immediate jeopardy LPN - licensed practical nurse OSDH - Oklahoma State Department of Health PT- physical therapy PTA - physical therapy assistant QA - quality assurance RN - registered nurse	C 000		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure: a. common areas were clean and/or in good repair for 4 (#100, 200, 300, and #400) of 4 halls observed; and	C1304		

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: AL5511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/30/2026
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C1304	Continued From page 1 b. residents were provided assistance with ADL care and/or housekeeping/maintenance for 4 (#10, 11, 12, and #16) of 5 sampled residents reviewed for contracted services. The administrator identified 73 residents resided in the facility. Findings: 1. On 01/13/26 at 1:50 p.m., large and small black stains were observed in multiple areas on the carpet on hall 300. On 01/13/26 at 2:00 p.m., black stains were observed on the carpet and the carpet was frayed on hall 400. On 01/13/26 at 2:10 p.m., black and large white stains were observed on the carpet and the carpet was frayed on hall 200. On 01/16/26 at 8:54 a.m., a strong urine odor was observed on hall 100. On 01/20/26 at 8:51 a.m., a strong urine odor was observed on hall 100. On 01/21/26 at 10:38 a.m., a strong urine odor was observed on hall 100. On 01/20/26 at 9:10 a.m., the handrails were observed to having missing paint and wood showing through in the main hall in front of the dining room leading to hall 100. An undated facility "Residence and Care Agreement" policy showed the residents could be charged a community fee upon admission to the	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/30/2026
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C1304	Continued From page 2 facility. The policy showed the community fee covered maintaining the comfort and beauty of the public and common areas. An undated facility "Cleaning of Common Areas" policy showed all staff were responsible for seeing that the common areas were clean and neat, and if any area was found dirty it would be cleaned even if it was not the specific day for cleaning. An undated facility "Internal Environmental Services" policy showed the facility would be kept clean and well maintained through a regular cleaning schedule and preventative maintenance program to ensure the facility remained a pleasant place to live. The policy showed the facility would repair or enhance existing structures, systems, or fixtures. An undated facility "Preventive Maintenance" policy showed all areas of the building would be inspected monthly for preventative maintenance needs, including checks of hand rails, main areas, etc. The policy showed any maintenance needed would be performed immediately. On 01/13/26 at 1:32 p.m., Resident #3 stated the facility had been working on replacing the floors. Resident #3 stated the facility needed to replace the carpet on hall 200, 300, and 400. On 01/13/26 at 2:52 p.m., the administrator stated the owner had got the bids and they would have to check with the owner about the signed contract to replace the flooring. On 01/13/26 at 4:17 p.m., the administrator was asked for the signed contract for the replacement of the carpet for hall 200, 300, and 400. The	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 3 signed contract was not provided. On 01/27/26 at 4:06 p.m., the maintenance director stated they were working on repairing the handrails and replacing the flooring on the halls. 2. An undated facility "Personal Hygiene" policy showed the amount of hygiene provided to the residents would be discussed with the resident and included in the resident's plan of care and this would be reviewed at regular intervals. An undated face sheet for Resident #10 showed they were admitted to the facility on 12/31/24 with diagnoses which included hypertension, congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, and arthritis. An undated facility "ADL Quick Reference Hall 100" policy showed Resident #10 required assistance with incontinent care. An initial assessment for Resident #10, dated 01/11/25, showed the resident required assistance with grooming, required two staff assistance with transfers, and was incontinent of bowel and bladder. The assessment showed the resident had weekly housekeeping services, daily bed making, and safety checks due to high fall risk. A home health therapy note for Resident #10, dated 09/08/25, showed the resident was dependent on staff for bathing and toileting. A home health therapy note for Resident #10, dated 09/09/25, showed the resident was maximum assistance with transfers, dressing, sponge baths, and was unable to get to the toilet	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/30/2026
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C1304	Continued From page 4 due to poor sitting balance. Home health visit notes for Resident #10, dated 09/2025 through 10/2025, showed the resident was observed soiled with feces and/or urine upon arrival of the home health provider: a. on 09/11/25, the resident was found in bed soaked in urine and feces soaking through the mattress and several pads; b. on 09/15/25, the resident was sitting on the edge of the bed fully soiled in urine with the bed completely covered in urine; c. on 09/17/25, the resident was in bed soiled in urine and feces; d. on 09/23/25, the resident was lying in bed soiled in urine; e. on 10/03/25, the resident was soiled with urine and the PTA had to wait over 40 minutes for staff assistance; and f. on 10/07/25, the resident was in bed "Heavily soiled with urine and feces." The note, read in part, "[Resident #10] has been pushing [their] button for assistance for hours and no one is coming." On 01/13/26 at 2:36 p.m., the PTA stated Resident #10 was wearing multiple incontinent briefs and they were soaked through to the mattress with urine when they had gone to the facility to provide PT. The PTA stated the staff were not changing out the resident's bedding when it was soaked with urine through to the mattress.	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 5 On 01/20/26 at 3:00 p.m., the DON stated a home health PTA on one occasion reported the resident needed help getting out of bed and changed. The DON was asked for the "Outside Provider Report Sheet." They stated the resident was discharged from the facility and they did not know where the "Outside Provider Report Sheets" were located. On 01/27/26 at 1:34 p.m., the DON stated Resident #10 would refuse care. 3. On 01/14/26 at 9:43 a.m., a strong odor of urine was observed in Resident #11's room. There were multiple baskets with items in them on the floor. The room was cluttered with boxes and chairs. Towels and trash was on the floor. There were holes in the wall and missing sheetrock from the corner of the wall, a broken shelf was up against the wall, and the cabinet doors under the sink were missing. On 01/16/26 at 8:54 a.m., a stale musky foul odor was observed in Resident #11's room. On 01/16/26 at 10:38 a.m., the administrator was observed telling Resident #11 they needed to let the housekeeper clean their room. Resident #11 agreed to let the staff clean their room. An undated facility "Housekeeping/Internal Environmental" policy showed the facility would establish standards of cleanliness and consistency from apartments and common areas. The policy showed the resident's rooms would be cleaned per the resident's plan of care and residents who consistently needed daily support with tidying, making beds, etc. would need to be assessed for level of care change.	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 6 An undated facility "Assistance with Bathing" policy showed bathing would be encouraged and monitored and if there was a problem with odor the resident would be counseled as to the frequency and type of bathing completed. A "Residence and Care Agreement" for Resident #11, dated 12/19/24, showed the facility would perform all necessary maintenance and repairs at the expense of the facility and housekeeping services would be provided weekly. The agreement showed personal assistance and care with ADLs would be provided in accordance with the resident's plan of care. A service plan for Resident #11, dated 03/30/25, showed the resident struggled with hygiene and needed verbal cues and reminders for bathing as well as physical assistance with bathing. The service plan showed housekeeping would be provided daily due to worsening ataxia and poor hygiene. A service plan for behaviors for Resident #11, dated 10/04/25, showed the resident often refused assistance with showers, personal hygiene care, housekeeping services, and continued to clutter room despite redirection. The service plan showed interventions included the community would provide assistance to manage behaviors in a supportive environment. The refusal of care forms for Resident #11, date 10/2025 through 12/2025, read in part, "Showers refused must be reported to the nurse and the nurse must sign off that they are aware of the refusal and have spoke to the resident about the importance of receiving their showers. More than 1 refusal in a week must be noted in the resident's chart by the nurse and a plan of action	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/30/2026
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C1304	Continued From page 7 completed if refusals continue." The refusal of care forms for Resident #11, showed the resident refused showers on the following dates: 10/01/25, 10/03/25, 10/08/25, 10/10/25, 10/31/25, 11/14/25, 11/19/25, 11/21/25, 11/24/25, 11/26/25, 12/01/25, 12/03/25, and 12/31/25. A "Service Checkoff List" for Resident #11, dated 01/01/26 through 01/16/26, showed staff did not initial they provided daily housekeeping on 01/01/26 through 01/03/26, 01/05/26 through 01/09/26, and 01/11/26 through 01/16/26. The checkoff list showed Resident #11 was scheduled to be assisted with showers on Mondays and Thursdays and staff had not initialed they provided the resident with shower assistance. A "Refusal of Services" document for Resident #11, dated 01/14/26, showed the resident refused their shower due to being sick. On 01/14/26 at 9:48 a.m., housekeeper #1 stated they were not sure who changed Resident #11's sheets. They stated they had not changed them. Housekeeper #1 stated they smelled the urine odor in Resident #11's room. On 01/14/26 at 9:43 a.m., Resident #11 stated staff did not change their bed linens. On 01/16/26 at 10:38 a.m., the administrator stated Resident #11 had been in the hospital and did not want them to clean their room. On 01/21/26 at 9:27 a.m., the DON stated the residents were charged for services according to their service plan unless they were on the advantage program. They stated residents who were on advantage program were not charged based on services provided. The DON stated	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/30/2026
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C1304	Continued From page 8 they did not have documentation related to Resident #11 refusing showers. On 01/27/26 at 4:06 p.m., the maintenance director stated Resident #11 ran into the walls with their electric wheelchair and caused the holes in the walls. 4. On 01/14/26 at 10:44 a.m., a strong urine odor was observed in Resident #12's room. On 01/16/26 at 9:02 a.m., a strong urine odor was observed in Resident #12's room. On 01/20/26 at 9:05 a.m., a strong urine odor was observed in Resident #12's room. On 01/21/26 at 9:34 a.m., a strong urine odor was observed in Resident #12's room. On 01/14/26 at 10:44 a.m., CNA #1 was observed asking Resident #12 if they were okay. The resident stated yes, and the CNA exited the room without offering assistance with incontinent care. A sign was observed on Resident #12's door frame. The sign showed to please check on the resident every two hours because they were needing more assistance than usual. On 01/14/26 at 10:46 a.m., CNA #1 was observed assisting Resident #12 to the bathroom. The resident's incontinent brief was saturated with urine. The resident was observed to sit on the toilet and urinate. An undated facility document titled "Quick Reference Hall ADL 400," showed Resident #12 required assistance with incontinent care. A "Service Plan" for Resident #12, dated	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/30/2026
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C1304	Continued From page 9 03/30/24, showed the resident had diagnoses which included tremors, malaise and fatigue, hypertension, transient cerebral ischemic attack, cerebral infarction, and low back pain. The service plan showed staff were to "deep clean weekly" and weekly housekeeping was included in basic housekeeping package. The service plan showed the resident required assistance during toileting and/or incontinence care and to assist the resident with toileting as tolerated and as necessary. A "Residence and Care Agreement" for Resident #12, dated 05/08/24, showed housekeeping services would be provided weekly. The agreement showed personal assistance and care with ADLs would be provided in accordance with the resident's plan of care. An annual assessment for Resident #12, dated 09/20/25, showed the resident required frequent assistance with incontinent care, staff assistance for toileting, and was incontinent of urine. A "Service Checkoff List" for Resident #12, dated 01/01/26 through 01/16/26, showed staff had not initialed the form to show incontinent care was provided on 01/01/26, 01/06/26, 01/07/26, 01/13/26, 01/15/26, and 01/16/26. On 01/14/26 at 10:45 a.m., CNA #1 stated they smelled the urine odor in Resident #12's room. CNA #1 stated the resident was incontinent of urine. CNA #1 stated they did not check the resident to see if they were incontinent. On 01/16/26 at 10:17 a.m., the administrator stated they were not sure how long Resident #12's room smelled like urine or where the smell was coming from. The administrator stated they	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/30/2026
NAME OF PROVIDER OR SUPPLIER GLADE AVENUE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH GLADE AVENUE BETHANY, OK 73008		
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C1304	Continued From page 10 did not think any room should smell like urine. On 01/27/26 at 1:34 p.m., the DON stated the resident's service plan determined how often to provide ADL care. The DON was asked about the sign on Resident #12's door which showed to check on the resident more often. They stated that sign was not from management and they did not know anything about the sign or what it meant. The DON was asked if the CNA #1 should have asked the resident if they needed assistance with incontinent care while they were in the room checking on Resident #10. The DON stated they believed that was what was on the resident's service plan but the resident refused at times. The DON stated the staff documented on the "Service Checkoff List" to indicate they provided the resident incontinent care throughout the shift each day. 5. On at 01/21/26 at 9:23 a.m., Resident #16's room was observed. The cabinet doors below and above the sink and counter were missing. There was a stain on the resident's couch and the room had a urine odor. A "Service Plan" for Resident #16, dated 05/22/24, showed the resident was forgetful and needed frequent orientation to time and place. A "Residence and Care Agreement" for Resident #16, dated 04/11/25, showed the facility would perform all necessary maintenance and repairs at the expense of the facility and housekeeping services would be provided weekly. The agreement showed personal assistance and care with ADLs would be provided in accordance with the resident's plan of care. On 01/27/26 at 4:06 p.m., the maintenance	C1304		

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C1304	Continued From page 11 director stated housekeeping was provided one day a week for the residents' rooms. The maintenance director stated the maintenance of the rooms and common areas was included in the rental fee that was charged to the residents.	C1304		
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 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 observation, record review, and interview, the facility failed to ensure:	C1505		

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C1505	Continued From page 12 a. staff performed hand hygiene between residents during different tasks for 4 (#7, 18, 19, and #20) of 5 sampled residents observed during provision of care; and b. a resident was assessed and the physician was notified after a fall for 1 (#10) of 3 sampled residents reviewed for falls. The administrator identified 73 residents resided in the facility. Findings: 1. On 01/14/26 at 10:17 a.m., CNA #1 was observed to don a pair of gloves, and assist Resident #7 with moving their legs in the bed. CNA #1 removed their gloves and did not wash their hands or use hand sanitizer. On 01/14/26 at 10:19 a.m., CNA #1 was observed to don a pair of gloves without washing or sanitizing their hands, pick up trash, and food containers off of Resident #19's floor. CNA #1 put their hands in their pockets then touched the resident's shirt that was laying on the bed and picked up some papers and put them in the drawer. CNA #1 was observed to remove their gloves and leave the resident's room without washing their hands or using hand sanitizer. On 01/14/26 at 10:20 a.m., CNA #1 was observed to enter Resident #20's room and don a pair of gloves without washing their hands or using hand sanitizer. CNA #1 was observed to pick up trash in the room, empty the resident's urinal, remove their gloves, touch the resident's call pendant, and then wash their hands. CNA #1 was not observed to wash or sanitize their hands after	C1505		

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C1505	Continued From page 13 emptying the urinal prior to touching the call pendant. On 01/14/26 at 10:23 a.m., CNA #1 was observed to enter Resident #20's room, make the resident's bed, and exit the resident's room without washing their hands or using hand sanitizer. On 01/14/26 at 10:30 a.m., CNA #1 was observed to enter Resident #18's room and don a pair of gloves without washing their hands or using hand sanitizer. CNA #1 was observed to assist the resident with emptying their catheter bag in the bathroom. CNA #1 removed their gloves and did not wash their hands or use hand sanitizer. CNA #1 obtained a supplement drink from the resident's refrigerator, picked up the resident's inhaler, assisted the resident with removing their shoes and socks and touched the supplement drink container again without washing their hands or using hand sanitizer. CNA #1 was observed to leave the room without washing their hands or using hand sanitizer. On 01/14/26 at 11:13 a.m., CNA #1 stated they were supposed to wash their hands or use hand sanitizer every time they were finished helping a resident or when they left the resident's room. CNA #1 stated they forgot to wash their hands. An in-service training document, dated 07/02/25, showed staff were in-serviced on the following facility universal precautions. The document showed universal precautions were safety precautions used with every resident and handwashing was the single most effective means of preventing the transfer of infection. The document showed to wash hands before and after each resident contact, before and after using gloves, and after touching contaminated	C1505		

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C1505	Continued From page 14 surfaces. On 01/16/26 at 10:14 a.m. RN #1 stated staff were supposed to wash their hands or use hand sanitizer before and after the care of each resident, and before and after donning gloves. 2. An undated face sheet for Resident #10 showed they were admitted to the facility on 12/31/24 with diagnoses which included hypertension, congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, and arthritis. An initial assessment for Resident #10, dated 01/11/25, showed the resident required assistance with grooming, required the assistance of two staff with transfers, and was incontinent of bowel and bladder. The assessment showed the resident had weekly housekeeping services, daily bed making, and safety checks due to high fall risk. A home health therapy note for Resident #10, dated 10/14/25 at 1:27 p.m., showed the PTA arrived at the facility and found the resident sitting on the floor. The note showed the resident reported to the PTA they had been on the floor for 30 minutes and the call light was pressed. The note showed the PTA ensured the resident was without injury and felt safe, and left the room to find staff to help the resident. The note showed once the PTA arrived back to Resident #10's room with a CNA and a CMA, staff were observed lifting the resident without using a gait belt and without the nurse assessing the resident. The note showed the PTA notified the resident's family. Resident #10's clinical record did not contain any	C1505		

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C1505	Continued From page 15 documentation about the fall on 10/14/25. Internal incident reports were reviewed for 10/2025. There was no incident report for Resident #10 related to the fall on 10/14/25. There was no documentation in Resident #10's record at the facility about the fall documented in the home health therapy notes on 10/14/25. There was no documentation provided to indicate the physician was notified of the fall. On 01/13/26 at 2:36 p.m., the PTA stated they arrived at the facility and found Resident #10 on the floor. The PTA stated the nurse did not assess the resident for injuries after the fall. On 01/16/26 at 11:17 a.m., Resident #10's family member stated the PTA reported to them the resident had fallen. Resident #10's family member stated they had a camera in the resident's room when the resident lived there and they did not see the DON or a nurse from the facility assess the resident after they fell. On 01/20/26 at 3:00 p.m., the DON stated they documented in the resident's record if they had a fall. On 01/21/26 at 10:45 a.m., CMA #1 stated they did not remember if Resident #10 had fallen. On 01/27/26 at 1:34 p.m., the DON stated they thought Resident #10 may have fallen once but they were not sure when.	C1505		
C1512 SS=J	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect	C1512		

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C1512	Continued From page 16 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable	C1512		

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C1512	Continued From page 17 adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: On 01/21/26, an immediate jeopardy situation was determined to exist when the facility failed to ensure adequate supervision to prevent an elopement. Resident #16 left out the front door of the facility unattended and sustained a fall which resulted in a head injury. Resident #16 was found by a staff member in the parking area, who was passing by in their vehicle. The resident had fallen and was unable to get up without assistance. Direct care staff was unaware Resident #16 was outside. On 01/21/26 at 4:10 p.m., the OSDH was notified and verified the existence of immediate jeopardy related to Resident #16's elopement. On 01/21/26 at 4:22 p.m., the administrator and DON were notified of the IJ situation related to Resident #16's elopement. The IJ template was provided to the administrator. On 01/27/26 at 4:43 p.m., an acceptable plan of removal was approved by the OSDH. The plan of removal, read in part, "Due to a recent fall outside the community and	C1512		