OKLAHOMA
State Department
of Health

Delivery via email to: Willie@gladeavenueassistedliving.com

February 4, 2026

License Number: AL5512

Ms. Willena Ferguson, Administrator
Glade Avenue Assisted Living South
2480 North Glade Avenue
Bethany, OK 73008

Survey Event ID: ISLY11

Dear Ms. Ferguson:

On **January 16, 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.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the 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 a 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

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Glade Avenue Assisted Living South**
Address: **2480 North Glade Avenue**
City, State, Zip: **Bethany, Oklahoma 73008**
Provider #: **AL5512**
Complaint #: **OK00088546**
Investigation Date(s): **01/13/26 through 01/16/26**

ALLEGATION(S)
The facility failed to ensure adequate supervision to prevent elopements.

An unannounced on-site investigation was initiated 01/13/2026 at 08:06 a.m.

A sample of three 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:

A brief initial tour was completed upon entrance. Staff were interacting with residents. Residents were observed for any wandering or exit seeking behaviors. Exit doors were observed and tested for functioning alarms.

Interviews were conducted with residents, resident representatives, direct care staff, maintenance and administration.

Resident records were reviewed to include physician orders, assessments, and service plans. Policies and procedures, and incident reports were reviewed.

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: 01/22/2026

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INVESTIGATIVE REPORT

Facility: **Glade Avenue Assisted Living South**
Address: **2480 North Glade Avenue**
City, State, Zip: **Bethany, Oklahoma 73008**
Provider #: **AL5512**
Complaint #: **OK00088509**
Investigation Dates: **01/13/26 through 01/16/26**

ALLEGATION(S)
The facility failed to ensure adequate staffing to meet the needs of the residents.
The facility failed to ensure services in the contract were provided.

An unannounced on-site investigation was initiated on 08/13/26 at 8:03 a.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:

A brief initial tour was completed upon entrance. Staff were interacting and assisting residents with activities of daily living. Residents were observed for any wounds.

Interviews were conducted with residents, resident representatives, direct care staff, and administration

Resident records were reviewed to include contracts, physician orders, assessments, service plans, ADL sheets, and staffing schedules. Policies and procedures were reviewed.

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

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Facility: **Glade Avenue Assisted Living South**
Address: **2480 North Glade Avenue**
City, State, Zip: **Bethany, Oklahoma 73008**
Provider #: **AL5512**
Complaint #: **OK00088786**
Investigation Dates: **01/13/26 through 01/16/26**

ALLEGATION(S)
The facility failed to ensure adequate staffing to meet the needs of the residents.
The facility failed to ensure services in the contract were provided.

An unannounced on-site investigation was initiated on 08/13/26 at 8:03 a.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:

A brief initial tour was completed upon entrance. Staff were interacting and assisting residents with activities of daily living. Residents were observed for any wounds.

Interviews were conducted with residents, resident representatives, direct care staff, and administration

Resident records were reviewed to include contracts, physician orders, assessments, service plans, ADL sheets, and staffing schedules. Policies and procedures were reviewed.

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

Thank you for bringing your concerns to our attention.

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Date report completed: 01/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5512	A. BUILDING: _____ B. WING _____	C 01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING SOUTH	2480 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 Complaint investigations (#OK00077353, #OK000885646, #OK00088786, and #OK00088509) were conducted on 01/13/26 through 01/16/26. Deficiencies were cited as a result of the survey. Facility Census: 32 Listed below are abbreviations that will be used throughout this survey. ADLs-Activities of Daily Living CMA-certified medication aide CNA-certified nursing assistant DON-Director of Nursing RCC-resident care coordinator	C 000		
C1304 SS=F	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. the walls, ceilings, and carpets were clean and in good repair for 2 halls (500 and 600) of 2 halls observed; and b. resident rooms were maintained in good repair for 1 (#3) of 3 sampled resident rooms observed. The DON identified 32 residents resided in the facility.	C1304		

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C1304	Continued From page 1 Findings: On 01/13/26 at 8:22 a.m., a tour of the facility was conducted. The following observations were made: a. the carpet on hall 600 had dark discolored stains, b. on hall 500 the carpet was pulling up and frayed at the seam, and c. the ceiling on hall 500 was peeling and stained with brown discoloration. On 01/14/26 at 7:52 a.m., an air vent cover on hall 500 was observed missing with exposed air duct visible on the ceiling. On 01/14/26 at 3:48 p.m., the carpet on hall 600 was observed and had discolored stains and was frayed. On 01/15/26 at 8:29 a.m., Resident #3's room was observed and did not have baseboards on the walls. An undated facility policy titled "Internal Environmental Services," showed the facility would be kept clean and well maintained and would be accomplished through regular cleaning, preventative maintenance, and repair of existing structures, systems, and fixtures. On 01/14/26 at 7:52 a.m., maintenance technician #2 was asked about the dark stained areas on the carpet on hall 500. They stated they had been trying to keep the carpets clean and had been steam cleaning them approximately every six weeks. They were asked about the missing air vent cover located on the ceiling on hall 500 with the air duct visible. Maintenance	C1304		

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C1304	Continued From page 2 Technician #2 stated they had to repair the ceiling around the area due to a sprinkler busting in the ceiling and leaking water. They stated the repair started about a month after the leak happened, and they had started the repair about three weeks ago, but had not been able to finish. Maintenance Technician #2 stated the carpet had been frayed and missing on hall 500 since approximately July 2025. On 01/14/26 at 3:55 p.m., CMA #1 stated the carpet had been stained and frayed for at least three months. On 01/15/26 at 8:15 a.m., Resident #3's family member stated the resident did not have baseboards in their room. The family member stated they asked facility staff to replace them. On 01/15/26 at 8:29 a.m., CNA #2 stated Resident #3's room had not had baseboards for at least two months. On 01/15/26 at 8:40 a.m., the maintenance director stated they were responsible for the maintenance in the building. The maintenance director stated the carpets were cleaned every two weeks and they trimmed the frayed edges as necessary. The maintenance director stated they did not know how long Resident #3's room did not have base boards. The maintenance director stated the maintenance of the building was included in the rental fee charged to the residents. The maintenance director was asked for the maintenance log of repair requests. They stated they did not know how to access the logs. On 01/15/26 at 10:52 a.m., the executive director stated the facility had flooded and was not sure when the flood had occurred. The administrator	C1304		

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C1304	Continued From page 3 stated Resident #3 should have baseboards in their room. They stated it was maintenance's responsibility to make the repairs.	C1304		
C1512 SS=E	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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 Statues, 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,	C1512		

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C1512	Continued From page 4 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 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: Based on observation, record review, and interview, the facility failed to ensure adequate supervision to prevent elopement for 2 (#1 and #4) of 3 sampled residents reviewed for elopement. The DON identified 32 resided in the facility. Findings: On 01/13/26 at 3:12 p.m., all four doors on the two resident halls (hall 500 and hall 600), the courtyard door, and the back door were observed with maintenance technician #2. The additional alarms located at the top of the egress doors were tested along with the egress alarms. One of the additional alarms on the Northeast exit door (hall 600) did not produce an audible alarm sound when tested. One of the additional alarms on the	C1512		

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C1512	Continued From page 5 Northwest exit door (hall 500) did not sound when tested. On 01/14/26 at 7:46 a.m., the two additional alarms on the resident halls (hall 500 and hall 600) that were not working on 01/13/26, were checked to see if they were functioning. Maintenance Technician #2 was observed opening the Northeast door on hall 600. This surveyor stood at the nurse's desk in the common area and was able to faintly hear the egress door alarm. The additional alarm was not working at this time. On 01/14/26 at 7:56 a.m., maintenance technician #2 tested the Northwest egress door on hall 500. The egress alarm sounded, but the additional alarm did not produce an audible alarm. On 01/14/26 at 8:13 a.m., Resident #1 was observed in common area. On 01/14/26 at 8:23 a.m., Resident #1 was observed walking in the common area near the nurse's desk. On 01/15/26 at 11:45 a.m., the Northeast door alarms on hall 600 were checked by the executive director. The additional alarm was not working. On 01/15/26 at 11:51 a.m., the Northwest door alarms on hall 500 were checked by the executive director. The additional alarm did not sound when the door was opened. The executive director attempted to press the alarm buttons to recode, but the alarm failed to sound. On 01/15/26 at 12:05 p.m., the maintenance	C1512		

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C1512	Continued From page 6 director stated maintenance technician #2 checked the alarms every morning, but was unsure when the last time they were checked. On 01/15/26 at 12:10 a.m., the maintenance director was observed testing the Northwest door alarm on hall 500. An undated "Elopement Prevention and Response Policy," read in part, "the resident's care plan will be updated and may include frequent safety checks, one-on-one supervision, environmental modifications, or other interventions up to including discharge if safety cannot be maintained." Resident #1's fourteen day "Recommended Assisted Living Resident Assessment Form," dated 03/06/25, showed Resident #1 had diagnoses which included dementia, traumatic brain injury, and anxiety. An "Elopement Policy and Procedure Update," dated 11/01/25, read in part, "A resident will be considered missing when the staff are unable to locate the resident during required checks"..."Administration will complete an investigation and submit all the required reports to the state regulatory agency"..."The residents care plan will be reviewed and updated, including increased supervision, frequent checks, one on one monitoring if necessary, or discharge planning when safety cannot be maintained" An Oklahoma State Department of Health incident report, dated 12/11/25, read in part, "[Resident #1] was found at [approximately 3:30 p.m.] at [name of store withheld] at the corner of [street address withheld] which is approximately two miles from the facility. Resident verbalized	C1512		

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C1512	Continued From page 7	C1512		

that [they] went in the enclosed back area and climbed over the fence to get off the property walked to [name of store withheld] and called [family member]"..."Resident remained on hourly checks for 3 days, not [sic] further elopements attempted."

Resident #1's service plan, updated 12/11/25, showed the resident had eloped and to monitor the resident's whereabouts at all times. The service plan showed to notify the DON or executive director if the resident attempted to leave the facility and to provide assistance to manage their behavior.

A late entry nursing progress note, dated 12/19/25 at 2:06 p.m., read in part, "12/11/2025"..."the resident was found at [name of store withheld]"..."When assessed [Resident #1] was noted to be confused and not at [their] baseline of orientation"..."Staff interviewed and stated that resident was last seen in common area around [2:45 p.m.]. Resident placed on hourly checks, and staff notified that resident cannot be outside unsupervised. The resident did not have any injuries noted."

An undated document titled "1 Hour Checks" showed Resident #1 was observed at the following times prior to their elopement on 12/22/25:
a. on 12/22/25 the resident was observed at 9:00 a.m. for the 9:00 a.m. and 10:00 a.m. checks,
b. on 12/22/25 the resident was observed at 10:19 a.m. for the 11:00 a.m. check,
c. on 12/22/25 the resident was observed at 11:16 a.m. for the 12:00 p.m. check,
d. on 12/22/25 the resident was observed at 12:24 p.m. for the 1:00 p.m. check,
e. on 12/22/25 the resident was observed at 1:10

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GLADE AVENUE ASSISTED LIVING SOUTH	2480 NORTH GLADE AVENUE BETHANY, OK 73008

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C1512	Continued From page 8 p.m. for the 2:00 p.m. check, f. on 12/22/25 the resident was observed at 9:30 p.m. for the 3:00 p.m. check, g. on 12/22/25 the resident was observed at 9:30 p.m. for the 4:00 p.m. check, h. on 12/22/25 the resident was observed at 9:30 p.m. for the 5:00 p.m. check, i. on 12/22/25 the resident was observed at 9:30 p.m. for the 6:00 p.m. check, j. on 12/22/25 the resident was observed at 9:30 p.m. for the 7:00 p.m. check, k. on 12/22/25 the resident was observed at 9:30 p.m. for the 8:00 p.m. check, l. on 12/22/25 the resident was observed at 9:29 p.m. for the 9:00 p.m. check, and m. on 12/22/25 the resident was observed at at 9:30 p.m. for the 10:00 p.m. check. The one hour checks from 3:00 p.m. until 10:00 p.m. showed the resident was observed at 9:29 p.m. and 9:30 p.m. The visual one hour safety checks were not signed off at the time they were scheduled to be completed. An OSDH incident report, dated 12/22/25, read in part, "Staff noted [Resident #1] was missing from the facility at approx. [approximately] 3:30pm [3:30 p.m.]. Resident was last seen by staff at approximately 3pm [3:00 p.m.]. Staff immediately started elopement drill procedure"..."Resident verbalized they were at [name of street withheld] after receiving a phone call from [family member]"..."Independent with ADL's dx [diagnoses] traumatic brain injury and anxiety"..."Resident continues to remain on safety checks. Staff continues to be aware of resident elopement precautions. Additional door alarms placed at North and South emergency exits by residents room"..."Resident to have supervision when going outside."	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5512	A. BUILDING: _____ B. WING _____	C 01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING SOUTH	2480 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
C1512	Continued From page 9 Resident #1's service plan, updated 12/22/25, showed the resident was at risk to wander and displayed wandering and/or exit seeking behaviors. The service plan showed the resident was to be provided assistance to manage behaviors. A "Progress Note," dated 01/14/26 at 9:24 a.m., showed Resident #1 was missing from the facility on 12/22/25 at approximately 3:30 p.m. The progress note showed the family was notified and the resident's family notified the police and the facility of the resident's location. The note showed the police escorted Resident #1 back to the facility. Resident #1's "Elopement Risk Assessment," dated 01/14/26, showed the resident's risk for elopement score was 13 which placed the resident at risk for elopement. On 01/13/26 at 2:53 p.m., CNA #1 was asked how the resident had left the facility on 12/11/25. They stated the resident had left out of the courtyard area. They stated the code to the courtyard door was changed at that time. CNA #1 was asked how the resident had left on 12/22/25. They stated the resident went out one of the exit doors on the resident hall. On 01/14/26 at 7:46 a.m., maintenance technician #2 was not sure why the additional alarm on the Northeast resident hall was not working and thought the maintenance director had checked the alarms yesterday afternoon. Maintenance Technician #2 was asked how often the alarms were checked to ensure they were working. They stated every week, but they did not keep a log of the checks.	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5512	A. BUILDING: _____ B. WING _____	C 01/16/2026

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GLADE AVENUE ASSISTED LIVING SOUTH	2480 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
C1512	Continued From page 10 On 01/14/26 at 10:02 a.m., Resident #1's family member stated the resident "ran away" from the facility twice. Resident #1's family member stated the resident could be lucid at times, but had short term memory loss. They stated when Resident #1 ran away from the facility the resident was trying to go home. Resident #1's family member stated the facility was supposed to be a locked facility and they were not sure how the resident got out of the facility. On 01/14/26 at 10:36 a.m., the DON was asked what interventions had been put into place after Resident #1 had eloped on 12/22/25. They stated they provided one on one supervision for six days then the resident was placed on one hour checks and additional alarms were placed at the exit doors on the resident halls. The DON stated the resident was alert and oriented at times with some confusion and forgetfulness and was started on medication to reduce their anxiety after they eloped on 12/22/25. They stated staff were to visually check on the resident every hour then had to sign off for the hour safety checks. On 01/14/26 at 2:16 p.m., the DON was asked if an elopement assessment had been completed for Resident #1 after 12/22/25. They stated it had not been completed until today. On 01/14/26 at 3:26 p.m., CMA #1 was asked about the one hour checks on 12/22/25. They stated they did not document on the "1 Hour Checks" sheet at the time the resident was checked, they completed the documentation at the end of their shift. On 01/15/26 at 8:29 a.m., the RCC was asked to review their written statement from 12/22/25.	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5512	A. BUILDING: _____ B. WING _____	C 01/16/2026

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GLADE AVENUE ASSISTED LIVING SOUTH	2480 NORTH GLADE AVENUE BETHANY, OK 73008

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C1512	Continued From page 11 They stated when they entered the front door and came around the nurses desk they heard the alarm sounding down hall 600. They stated CMA #1 was in the medication room, CNA #5 was coming from hall 500, and they were not sure if they saw CNA #6 at that time. The RCC stated they had an inservice about the elopement and the resident was placed on one on one supervision then was put on hourly checks. On 01/15/26 at 9:10 a.m., CNA #2 was asked if they had observed Resident #1 on 12/22/25. They stated they had observed the resident about 2:30 p.m. on hall 600 prior to them leaving their shift at three. They were asked how they documented the one hour checks for Resident 1. They stated they were not told they had to document the checks. On 01/15/26 at 9:15 a.m., CMA #2 was asked who was responsible to complete the one hour checks on Resident #1. They stated, "My staff and me, I walk down the hall and glance." They stated the way the documentation was set up, for example, an 8 o'clock check could "pop" up early at 7 o'clock. CMA #2 stated the one hour checks were set up on the computer the medication aides had access to and the CNAs did not have access to document their observations of the resident. On 01/15/26 at 9:40 a.m., the DON stated Resident #1 was admitted to the facility because the resident required more care than what family members could provide. The DON stated Resident #1 was not safe to be outside in the public alone. The DON stated Resident #1 left the facility on 12/22/25 through the Northeast door. The DON stated Resident #1 was sent to the hospital for evaluation and when they returned,	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5512	A. BUILDING: _____ B. WING _____	C 01/16/2026

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C1512	Continued From page 12 they were placed on one on one supervision and additional alarms were placed on the doors to make them louder. The DON stated the maintenance department should be checking to ensure the door alarms were working. The DON stated they were not made aware the door alarms were not working. On 01/15/26 at 9:46 a.m., the DON was asked who was responsible for documenting the one hour checks. They stated the medication aides documented the checks, but all staff could report the one hour checks for the medication aide to document. The "1 Hour Checks" for Resident #1 were reviewed with the DON. The DON was asked if the documentation on 12/22/25 at one and two o'clock were documented correctly. They stated the time was documented early. They were asked with the way the documentation had been completed was the resident checked on every hour. They stated it did not match the times that it had been scheduled. No other response was given. On 01/15/26 at 10:45 a.m., CMA #1 was asked to describe the incident on 12/22/25 involving Resident #1. They stated they came in and started to count the medication cart and about thirty minutes later they heard the "alarms going off." CMA #1 stated they observed the resident in the common area when they had come into start their shift. CMA #1 was asked if they were able to hear the alarm. They stated it was "not easily heard with everyone up there and the radio going." They were asked who was responsible to complete the one hour checks. They stated, "All of us there." They stated the hourly checks "come up on the MAR [medication administration record]" then you document the time.	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1512	Continued From page 13 On 01/15/26 at 10:59 a.m., the executive director was asked what they did after Resident #1 eloped on 12/22/25. They stated they got additional alarms due to the door alarms were hard for staff to hear. On 01/15/26 at 11:45 a.m., the executive director stated the alarm located on the Northeast exit door on hall 600 was not working and there was not a red light on the alarm. On 01/15/26 at 12:10 p.m., the maintenance director was asked who all knew how to reset the alarm. They stated no one had been trained to reset the alarms. They stated if there was an issue that staff should call them. On 01/15/26 at 5:26 p.m., the police officer stated they responded to the call for the missing resident on 12/22/25. The police officer stated Resident #1 was found approximately four miles from the facility, walking down the street on 12/22/25 at 4:23 p.m. The police officer stated Resident #1 willingly got in the police car and they took them back to the facility. On 01/16/26 at 8:07 a.m., maintenance #1 was asked if the alarms had been checked. They stated "No." 2. Resident #4 had diagnoses which included psychosis, dementia, and neurocognitive disorder. Resident #4's "Elopement Risk," dated 10/13/25, showed Resident #4's risk for elopement score was a 10 which placed the resident at risk for elopement. Resident #4's service plan, updated 10/27/25,	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1512	Continued From page 14 showed the resident was forgetful and required "frequent orientation to time and place." The service plan did not show Resident #4 was at risk for elopement. An undated document titled "ADL Quick Reference 500 Hall" showed Resident #4 was not identifed to be at risk for elopement. On 01/15/26 at 9:46 a.m., the DON was asked to review Resident #4's elopement risk, dated 10/13/25, which identified the resident was at risk for elopement. They were then asked to review the ADL sheets (used by care staff) which did not identify the resident at risk for elopement for staff to monitor. They stated the resident had not been added to the ADL sheet. They were asked if Resident #4's service plan, dated 10/27/25, showed the resident had been identified as at risk for elopement. They stated it had not been updated.	C1512		

OKLAHOMA
State Department of Health

Delivery via email to: Willie@gladeavenueassistedliving.com

February 20, 2026

License Number: AL5512

Ms. Willena Ferguson, Administrator
Glade Avenue Assisted Living South
2480 North Glade Avenue
Bethany, OK 73008

Survey Event ID: ISLY11

Dear Ms. Ferguson:

On **January 16, 2026,** a complaint investigation was conducted at your Assisted Living Center. 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 **April 3, 2026**.

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: 2/10/2026** **Facility Name:** GLADE AVENUE ASSISTED LIVING **License Number:** AL5512 **Survey Event ID:** ISLY11 **Date Survey Completed: 1/16/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1304	Based on: Observation, record review, and interview, the facility failed to insure: a. the walls, ceilings, and carpets were clean and in good repair for 2 halls (500 and 600) of 2 halls observed: and b. resident rooms were maintained in good repair for 1 (#3) of 3 sampled resident rooms observed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and plan of correction is NOT legal admission that a deficieny 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 constitiute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections or 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?	Resident #3's room will have new baseboards placed. The ceiling on hall 500 where there was a water leak due to defective sprinkler will have the repairs completed and the ceiling textured and repainted for continuity and color. The air vent on hall 500 will be replaced. Carpets on both the 500 and 600 halls with dark discolored stains will be treated professionally for removal as necessary. For resident safety, frayed carpet; pulling up at the seams will be trimmed and sections replaced where applicable.
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 apartments will be checked for baseboards and/or carpet repair, with a report of apartments checked and needing repair become part of the quarterly QA minutes with a repair schedule created to insure timely maintenance updates as needed.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	A maintenance log will be put in place for weekly, monthly and annual schedule for both in-house and professional carpet cleaning and/or replacement. A timeline for replacing the carpet with tile in both 500 and 600 halls will be added to the Capital Expenditure (CapX) budget.
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	At each QA held with leadership managers the ongoing maintenance requests/completion of tasks will be reviewed: a. Documented weekly walk-through of both 500 and 600 halls:

c. How monitoring records will be kept to evidence the correction.	b. Ongoing updates at the QA meetings regarding progress of cleanliness, repairs and/or replacement of carpet; and c. Maintain maintenance logs with completion updates.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/3/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Willena Ferguson** OAC 310:663-25-4(F)	**Date 2/11/2026**

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: 2/10/2026** **Facility Name:** Glade Assisted Living **License Number:** AL5512 **Survey Event ID:** ISLY11 **Date Survey Completed: 1/16/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1512 Resident Rights - Abuse/Neglect	Based on: Observation, record review, and interview center failed to ensure adequate supervision to prevent elopement for 2 (#1 and #4) of 3 sampled residents reviewed for elopement.

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. Resident #1 was discharged to higher level of care 1/31/26. 2. Nursing DON/ADON will reassess all residents using the Elopement tool in order to identify residents that are high risk for elopement. 3. Nursing DON/ADON will update ADL Quick Reference list of the residents that are At Risk for Elopement. Staff will be trained on the list. 4. DON/ADON or ED will train Employees on the Elopement Drill. 5. DON/ADON, or ED will train the Nursing employees on "How to document 1hr checks" on any resident that is placed on 1hr checks for previous elopement. 6. Employees will be trained on how to reset door alarms. 7. Maintenance will check the all door alarms daily and medication tech on weekends. This check is to ensure alarms are working properly and the alarms are sounding. This daily check will be recorded on a weekly log and turned into Executive Director. Executive Director will ensure the log is being completed weekly. 8. Staff will be trained on Residents Rights & Abuse & Neglect. All Training will be added to the QA notes.
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. Nursing staff will reassess all residents using the Elopement Tool in order to identify which residents are high risk for elopement. Staff will be trained on the High Risk for Elopement list. Training will be added to the Quartely QA meetings.

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. Door alarms will be checked daily and recorded on a log. 2. Elopement Risk will be reviewed and updated every month and staff trained on any changes. 3. Audits and training will be added to the Quarterly QA and verified by the DON and or ED>
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/DON/ADON 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. Ongoing montoring of audits, logs, and trainings will completed weekly by Executive Director and added to the quarterly 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?	4/3/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Willie Ferguson** OAC 310:663-25-4(F)	**Date 2/17/2026**

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.