
Delivery via email to: twright@radiancesl.com

September 12, 2025

License Number: AL5519

Ms. Tracey Wright, Administrator
Radiance Senior Living At The Village
2333 Manchester Drive
Oklahoma City, OK 73120

RE: Survey Event ID: WO6I11

Dear Ms. Wright:

On **August 28, 2025**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **August 28, 2025**.

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

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the

Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement, and another plan of correction may be required.

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

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

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

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

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to: IDRCoordinator@health.ok.gov

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

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

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

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

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

Respectfully,

Tempal Killman

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

Enclosure

INVESTIGATIVE REPORT

Facility: Radiance Senior Living At The Village
Address: 2333 Manchester Drive
City, State, Zip: Oklahoma City, OK, 73120, OK
Facility ID: AL5519
Complaint #: OK00066090
Investigation Date(s): 8-26-25 through 8-28-25

ALLEGATION(S)
The center failed to ensure residents' property was not misappropriated.
The center failed to ensure adequate supervision was provided to prevent accidents according to the plan of care and the contract.
The center failed to ensure a working call system was available for communication with the nursing staff according to the contract and failed to ensure housekeeping and laundry services were provided according to the contract.
The center failed to have and/or implement an effective pharmacy policy to ensure medications were administered according to the physicians' orders.
The center failed to ensure assistance with activities of daily living was provided according to the contract, the plan of care and the standard of care.
The center failed to ensure the right to a safe, clean and comfortable environment and failed to ensure residents' representatives had access to communication with the staff regarding residents' care.
The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 08/26/2025 at 9:45 a.m.

A sample of 9 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the center was conducted upon entrance and at other various times throughout the survey. Staff were observed for answering call lights and providing resident care, including incontinent care, feeding and other activities of daily living. Medication administration was observed. Rooms were observed for cleanliness.

Resident records were reviewed including assessments and care plans. Facility policy and procedures were reviewed. Grievance records were reviewed. Staff training and background checks were reviewed.

Residents were interviewed related to the provision of feeding care, personal hygiene and incontinent care, timeliness of call lights being answered, and medications being administered. They were asked if they felt safe



and if their care needs were being met, if any of their belongings were missing, how often their room was cleaned.

Staff members were interviewed regarding their ability to provide appropriate care in a timely manner.

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: 09/01/2025

INVESTIGATIVE REPORT

Facility: Radiance Senior Living At The Village
Address: 2333 Manchester Drive
City, State, Zip: Oklahoma City, OK, 73120, OK
Facility ID: AL5519
Complaint #: OK00066491
Investigation Date(s): 8-26-25 through 8-28-25

ALLEGATION(S)
The center failed to ensure residents were not physically, verbally or psychosocially abused.
The center failed to have and/or implement an effective policy and procedure for incidents of falls.
The center failed to ensure food was served in adequate portions according to residents' preferences.
The center failed to ensure activities were provided according to residents' preferences and failed to ensure assistance with bathing and laundry was provided according to the contract and plan of care.
The center failed to ensure adequate staff meet the needs of the residents.

An unannounced on-site investigation was initiated 08/26/2025 at 9:45 a.m.

A sample of 9 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the center was conducted upon entrance and at other various times throughout the survey. Staff were observed for answering call lights and providing resident care, including incontinent care, feeding and other activities of daily living. Medication administration was observed. Rooms were observed for cleanliness.

Resident records were reviewed including assessments and care plans. Facility policy and procedures were reviewed, including falls. Staff training including abuse, and background checks were reviewed.

Residents were interviewed related to the provision of feeding care, personal hygiene and incontinent care, timeliness of call lights being answered, and medications being administered. They were asked if they felt safe and if their care needs were being met, if any of their belongings were missing, how often their room was cleaned.

Staff members were interviewed regarding their ability to provide appropriate care in a timely manner, and if they knew what to do when made aware of abuse, as well as, what constitutes abuse.



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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 09/01/2025

INVESTIGATIVE REPORT

Facility: Radiance Senior Living At The Village
Address: 2333 Manchester Drive
City, State, Zip: Oklahoma City, OK, 73120, OK
Facility ID: AL5519
Complaint #: OK00080542
Investigation Date(s): 8-26-25 through 8-28-25

ALLEGATION(S)
The center failed to ensure the residents were free from abuse.
The center failed to ensure care was provided for residents who were dependent on staff to complete their ADL's.

An unannounced on-site investigation was initiated 08/26/2025 at 9:45 a.m.

A sample of 9 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the center was conducted upon entrance and at other various times throughout the survey. Staff were observed for answering call lights and providing resident care, including incontinent care, feeding and other activities of daily living. Medication administration was observed. Rooms were observed for cleanliness.

Resident records were reviewed including assessments and care plans. Facility policy and procedures were reviewed. Grievance records were reviewed. Staff training and background checks were reviewed.

Residents were interviewed related to the provision of feeding care, personal hygiene and incontinent care, timeliness of call lights being answered, and medications being administered. They were asked if they felt safe and if their care needs were being met, if any of their belongings were missing, and how often their room was cleaned.

Staff members were interviewed regarding their ability to provide appropriate care in a timely manner.

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: 09/01/2025

INVESTIGATIVE REPORT

Facility: Radiance Senior Living At The Village
Address: 2333 Manchester Drive
City, State, Zip: Oklahoma City, OK, 73120, OK
Facility ID: AL5519
Complaint #: OK00080937
Investigation Date(s): 8-26-25 through 8-28-25

ALLEGATION(S)
The center failed to ensure residents were free from abuse
The center failed to maintain a clean, homelike environment.
The center failed to ensure care was provided for residents who were dependent on staff to complete their ADL's.

An unannounced on-site investigation was initiated 08/26/2025 at 9:45 a.m.

A sample of 9 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the center was conducted upon entrance and at other various times throughout the survey. Staff were observed for answering call lights and providing resident care, including incontinent care, feeding and other activities of daily living. Medication administration was observed. Rooms were observed for cleanliness.

Resident records were reviewed including assessments and care plans. Facility policy and procedures were reviewed. Grievance records were reviewed. Staff training and background checks were reviewed.

Residents were interviewed related to the provision of feeding care, personal hygiene and incontinent care, timeliness of call lights being answered, and medications being administered. They were asked if they felt safe and if their care needs were being met, if any of their belongings were missing, and how often their room was cleaned.

Staff members were interviewed regarding their ability to provide appropriate care in a timely manner.

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: 09/02/2025

INVESTIGATIVE REPORT

Facility: Radiance Senior Living at the Village
Address: 2333 Manchester Drive
City, State, Zip: Oklahoma City, OK, 73120, OK
Facility ID: AL5519
Complaint #: OK00081023
Investigation Date(s): 8-26-25 through 8-28-25

ALLEGATION(S)
The center failed to ensure residents were free from abuse.

An unannounced on-site investigation was initiated 08/26/2025 at 9:45 a.m.

A sample of 9 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 tour of the center was conducted upon entrance and at other various times throughout the survey. Staff were observed for answering call lights, providing resident care, and interacting with residents.

Resident records were reviewed including assessments and care plans. Facility policy and procedures were reviewed.. Staff training including abuse and neglect, and background checks were reviewed.

Residents were interviewed related to the provision of assistance with activities of daily living. They were asked if they felt safe, if they felt respected, and if their care needs were being met,

Staff members were interviewed regarding their ability to provide appropriate care in a timely manner, and what constitutes abuse and neglect, and their responsibilities if they were made aware of abuse.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 09/02/2025

INVESTIGATIVE REPORT

Facility: Radiance Senior Living at the Village
Address: 2333 Manchester Drive
City, State, Zip: Oklahoma City, OK, 73120, OK
Facility ID: AL5519
Complaint #: OK00085332
Investigation Date(s): 8-26-25 through 8-28-25

ALLEGATION(S)
The center failed to provide wound care that is consistent with community standards to prevent the development and worsening of wounds.
The center failed to protect residents from involuntary seclusion.

An unannounced on-site investigation was initiated 08/26/2025 at 9:45 a.m.

A sample of 9 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the center was conducted upon entrance and at other various times throughout the survey. Staff were observed for answering call lights and providing resident care, including incontinent care, feeding and other activities of daily living. Medication administration was observed. Rooms were observed for cleanliness.

Resident records were reviewed including assessments, care plans, and wound care documentation. Facility policy and procedures were reviewed. Staff training including abuse and neglect, and background checks were reviewed.

Residents were interviewed related to the provision of feeding care, personal hygiene and incontinent care, timeliness of call lights being answered, and medications being administered. They were asked if they felt safe and if their care needs were being met, if any of their belongings were missing, how often their room was cleaned.

Staff members were interviewed regarding their ability to provide appropriate care in a timely manner. Administration was asked about coordination of care and how they monitor wound progression. Staff were also asked about the locks on the doors and they stated they have keys to enter on the off chance that the residents were to lock their door.

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: 09/02/2025

INVESTIGATIVE REPORT

Facility: Radiance Senior Living at the Village
Address: 2333 Manchester Drive
City, State, Zip: Oklahoma City, OK, 73120, OK
Facility ID: AL5519
Complaint #: OK00085333
Investigation Date(s): 8-26-25 through 8-28-25
The

ALLEGATION(S)
The center failed to ensure residents were free from abuse.
The center failed to ensure the residents right for dignity and respect.

An unannounced on-site investigation was initiated 08/26/2025 at 9:45 a.m.

A sample of 9 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the center was conducted upon entrance and at other various times throughout the survey. Staff were observed for answering call lights, providing resident care, and interacting with residents. Medication administration was observed. Rooms were observed for cleanliness.

Resident records were reviewed including assessments and care plans. Facility policy and procedures were reviewed.. Staff training and background checks were reviewed.

Residents were interviewed related to the provision of assistance with activities of daily living. They were asked if they felt safe, if they felt respected, and if their care needs were being met,

Staff members were interviewed regarding their ability to provide appropriate care in a timely manner, and what constitutes abuse and neglect and their responsibilities were they made aware of it.

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: 09/02/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER RADIANCE SENIOR LIVING AT THE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey with complaints (#OK00012345, OK00012346, OK00012347, OK00012348, and #OK00012349) was conducted from 08/26/25 through 08/28/25. Deficiencies were cited as a result of the survey. Facility Census: 50 Listed below are abbreviations that will be used throughout this document. ACMA -advanced certified medication aide CDM - certified dietary manager CMA - certified medication aide CNA - certified nurse aide DON - director of nursing LPN - licensed practical nurse RN - registered nurse	C 000		
C 521 SS=E	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an admission assessment was	C 521		

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: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER RADIANCE SENIOR LIVING AT THE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120		
(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 521	Continued From page 1 completed within 30 days before or at the time of admission for 3 (#3, 4, and #6) of 9 sampled residents reviewed for admission assessments. The administrator identified 50 residents resided in the center. Findings: An undated policy "Time Frames For Completing The Assessments," read in part, "The community shall complete the Admission Assessment within 30 days before, or at the time of admission." On 08/26/24, the administrator and DON were unable to provide an admission assessment for Resident #3, #4, or #6. On 08/26/25 at 3:42 p.m., the administrator stated "I'm going to be honest, we can't find them. We do not know where the prior person put them. I have only been here since the beginning of the year, and the current DON has been here about a month." The administrator stated they will start keeping their own copy in a separate binder in the future.	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition.	C 522		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER RADIANCE SENIOR LIVING AT THE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120		
(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 522	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure a comprehensive assessment was completed once every 12 months and promptly after a significant change in the resident's condition for 5 (#1, 3, 4, 8, and #9) of 9 sampled residents reviewed for admission assessments. The administrator identified 50 residents resided in the center. Findings: An undated policy "Time Frames For Completing The Assessments," read in part, "The community shall complete the comprehensive assessment within 14 days after admission of the resident, and then once every 12 months thereafter; promptly after a significant change in the resident's condition." On 08/26/24, the administrator and DON were unable to provide current comprehensive assessments for Resident #1, #3, #4, #8, or #9. On 08/26/25 at 3:42 p.m., the administrator stated, "I'm going to be honest, we can't find them. We do not know where the prior person put them. I have only been here since the beginning of the year, and the current DON has been here about a month. They stated they will start keeping their own copy in a separate binder in the future.	C 522		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER RADIANCE SENIOR LIVING AT THE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120		
(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 703	Continued From page 3	C 703		
C 703 SS=E	Hot Water - Laundry - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot water at a temperature of 160 degree Fahrenheit shall be available for use in the laundry at all times. The required temperature of 160 degrees shall be that measured in the washing machine and shall be supplied so that this temperature may be maintained over the entire wash and rinse period. This Rule is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure hot water was available for use in the assisted living laundry at all times. The administrator identified 50 residents resided in the center. Findings: On 08/26/25 at 12:42 p.m., the maintenance director was observed checking the temperature of the washing machine on the hot cycle four times, with the highest reading being 106 degrees Fahrenheit. On 08/28/25 at 8:45 a.m., the maintenance director observed this surveyor check the washing machine temperature on the hot cycle with their thermometer. The thermometer read	C 703		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER RADIANCE SENIOR LIVING AT THE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120		
(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 703	Continued From page 4 109 degrees Fahrenheit. An undated policy "Hot Water Use and Temperature, read in part, "Required temperature of 160 [degrees Fahrenheit] in the laundry area is that measured in the washing machine and shall be supplied so that temperature may be maintained over the entire wash and rinse period. Attention is called to the fact that control of bacteria in laundry processing is dependent upon a number of inter-related factors such as detergent, bleach, number of rinses and temperature. In most instances, maximum overall economies with acceptable results can be achieved with the use of 160 [degrees Fahrenheit] water. Lesser temperature may require excessive bleaching or other chemical treatment that would be damaging to fabrics." On 08/26/25 at 12:44 p.m., the maintenance director stated the water temperature controls the sink in the laundry room as well as the washing machines and they did not want the water to burn the staff. On 08/28/25 at 8:50 a.m., the maintenance director stated they thought the temperature should reach 120 degrees on the hot cycle. On 08/28/25 at 9:15 a.m., the DON stated they did not know what the washing machine temperature should be, but they would locate the policy.	C 703		
C 940 SS=E	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the	C 940		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER RADIANCE SENIOR LIVING AT THE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120		
(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 940	Continued From page 5 assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure food prepared for 2 of 2 meal observations were consistent with a written and planned menu prepared by a dietary consultant. The administrator identified 50 residents resided in the center. Findings: On 08/27/25 at 11:25 a.m., foods served were observed to be scallop potatoes, meatloaf, rolls, and peach cobbler. The Wednesday 08/27/25 menu showed lunch: ravioli bake, roasted fresh cauliflower, breadstick with butter or margarine, vanilla butter cake. On 08/28/25 at 7:30 a.m., the posted two-week menus observable to the residents were of week 2 and week 5. However, the dietary manager stated they were on week 1's rotation. On 08/28/25 at 7:30 a.m., observed the featured selection menu for "Wednesday August 27th dinner: Fresh garden salad, sweet and sour chicken tenders, fried rice, stir fry vegetables, fresh bread sticks, chefs choice." The planned menu showed Wednesday 08/27/25 dinner: chicken tenders, dipping sauce, steak fries, creamy cucumber salad, and apple brown betty. On 08/28/25 at 7:33 a.m., observed pancakes,	C 940		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER RADIANCE SENIOR LIVING AT THE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER DRIVE OKLAHOMA CITY, OK 73120		
(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 940	Continued From page 6 sausage, bacon, biscuits, and scrambled eggs with ham waiting to be served. The menu showed Thursday breakfast: western omelet toast seasonal fruit, and hot or cold cereal. The week at a glance menu for the week of 08/24/25 through 08/30/25 showed: Tuesday 08/26/25 lunch brown sugar baked ham, corn bread dressing, green bean casserole, bread or roll with butter, and cherry cobbler. On 08/27/25 at 2:32 p.m., dietary aide #1 stated the meal served gets changed from the menu about twice a week. Dietary Aide #1 stated they did not have ham on Tuesday, and they had meatloaf today instead of beef tips that were scheduled for Thursday. On 08/28/25 at 7:34 a.m., cook #1 stated the dietary manager does not usually arrive until 8:00 a.m., so they just make what there was and does not necessarily follow the printed menu. On 08/28/25 at 9:00 a.m., the CDM stated they made sure they provided a protein, starch, and a vegetable, but did not necessarily follow the menu. They stated the dietician stated it was fine to adjust the menu. The CDM stated they were unaware of the regulation there should be few substitutions to the approved menu. On 08/28/25 at 9:35 a.m., the DON stated the posted two week menus the residents were able to view, were not that of the current menu. The residents would not be able to know what the next meal was going to be until the featured meal got posted right before the next meal to be served. The DON stated they were unable to find a policy in regards to posting menus for two weeks prior.	C 940		

Delivery via email to: twright@radiancesl.com

October 8, 2025

Survey Event ID: **WO6111**

Ms. Tracey Wright, Executive Director
Radiance Senior Living At The Village
2333 Manchester Drive
Oklahoma City, OK 73120

Dear Ms. Wright:

On **August 28, 2025**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **November 10, 2025**.

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

Respectfully,

Tempal Killman

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

Enclosure



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/19/2025

Facility Name: Radiance Senior Living at the Village

License Number: AL5519

Survey Event ID: W06I11

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 521

Based on: Record review and interview, the center failed to ensure an admission assessment was completed within 30 days before or at the time of admission for 3 (#3, #4, and #6) of 9 sampled residents reviewed for admission assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a 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, preparation and submission of the Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The Licensed Practical Nurse will complete an admission assessment within 30 days before or at the time of admission. Executive Director will verify completion.

A checklist will be put into place. Checklist will be done to verify admission assessment were done within 30 days, or on the day of move in. We will also keep a separate binder of all completed assessments.

The Executive Director has educated the Director of Wellness regarding the requirements and importance of admission assessments. A checklist will be put into place to verify all assessments have been completed.

Director of Wellness and/or designee will audit 6 charts weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month. The results of the audits will be discussed in the monthly QA meeting. Executive Director to verify completion.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

11/10/2025

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.
Tracy Wright

Date Enter a date of signature.

9/22/25

10012013



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/19/2025

Facility Name: Radiance Senior Living at the Village

License Number: AL5519

Survey Event ID: W06I11

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522

Based on: Record, review and interview, the center failed to ensure a comprehensive assessment was completed once every 12 months and promptly after a significant change in the resident's condition for 5 (#1, #3, #4, #8, and #9) of 9 sampled residents reviewed for admission assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a 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, preparation and submission of the Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness 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?

The Licensed Practical Nurse will complete a comprehensive assessment on residents #1, #3, #4, #8, and #9. Executive Director will verify completion.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

A checklist will be put into place. Checklist will be done to verify comprehensive assessments were done within 14 days of new resident move in, a significant change, and every 12 months by the Director of Wellness and Executive Director. We will also keep a separate binder of all completed assessments.

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?

The Executive Director has educated the Director of Wellness regarding the requirements of pre admission, admission and change of condition assessments. A checklist will be put into place to verify completion.

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

Director of Wellness and/or designee will audit 6 charts weekly for 4 week, bi-weekly for 4 week and monthly for 1 month. Executive Director to verify completion. The results will be discussed in our monthly Q and A meetings.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

11/10/2025

OSDH Response: Element accepted Yes ☐ No ☐

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.
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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.](#)

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature.	
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.
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OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/19/2025

Facility Name: Radiance Senior Living at the Village

License Number: AL5519

Survey Event ID: W06I11

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 703

Based on: observation and interview, it was determined the center failed to ensure hot water was available for use in the assisted living laundry at all times.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a 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, preparation and submission of the Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The center has partnered with Able Medical and Janitorial. Center has implemented effective sanitation with low water washing chemicals safe for all fabric types. *Our laundry machines are not able to provide the required 160-degree temperature due to the fact it is the same system used for resident bathing. This temperature is unsafe and would scald a resident. Due to this fact, we will be using the option as outlined in Title 63-1-890 et seq Appendix A. How Water Use that allows for chemical treatments to control bacteria in the laundry process. "*

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

Monthly audit will be put into place to verify low water sanitation chemicals are used and maintained at all washing machines. Maintenance Director will provide checklist to Executive Director for verification.

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?

The Executive Director has educated the Maintenance Director on the importance and requirements of sanitation with laundry. All of old chemicals will be removed and replaced with low water sanitation approved chemicals.

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;

Maintenance Director and/or designee will do weekly chemical checks for adequate product for 4 week, bi-weekly for 4 week and monthly for 1 month. The results will be discussed in our monthly Q and A meetings.

Enter methods to evaluate 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.		Enter methods to incorporate into QA system: Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		11/10/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature.	
<i>Tracy Wright</i>		9/22/25	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/19/2025

Facility Name: Radiance Senior Living at the Village

License Number: AL5519

Survey Event ID: W06111

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 940

Based on: observation, record review, and interview, the center failed to ensure food prepared for 2 of 2 meal observations were consistent with a written and planned menu prepared by a dietary consultant.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a 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, preparation and submission of the Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The center has partnered with Grove Menus by Aline to incorporate monthly menus written and planned by a dietary consultant.

Executive director will audit menu planning and receive monthly menu. Executive director will audit menu/and confirm that planning is being followed.

The Executive Director has educated the Dining Director on the importance and requirements of menu planning and a dietician. The center has partnered with Grove Menus by Aline to incorporate monthly menus written and planned by a dietary consultant.

Dining Director and/or designee will do weekly menu checks for consistency and planning for 4 weeks, bi-weekly for 4 weeks and monthly for 1 month. The results will be discussed in our monthly Q and A meetings.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.

Jacey Wright

Date Enter a date of signature.

9/22/25

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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Facility in Compliance by: [Click here to enter a date.](#)



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/19/2025

Facility Name: Radiance Senior Living at the Village

License Number: AL5519

Survey Event ID: W06I11

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 521

Based on: Record review and interview, the center failed to ensure an admission assessment was completed within 30 days before or at the time of admission for 3 (#3, #4, and #6) of 9 sampled residents reviewed for admission assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a 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, preparation and submission of the Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The Licensed Practical Nurse will complete an admission assessment within 30 days before or at the time of admission. Executive Director will verify completion.

A checklist will be put into place. Checklist will be done to verify admission assessment were done within 30 days, or on the day of move in. We will also keep a separate binder of all completed assessments.

The Executive Director has educated the Director of Wellness regarding the requirements and importance of admission assessments. A checklist will be put into place to verify all assessments have been completed.

Director of Wellness and/or designee will audit 6 charts weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month. The results of the audits will be discussed in the monthly QA meeting. Executive Director to verify completion.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

11/10/2025

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required

Sharon Wright

Date Enter a date of signature.

10/3/25

10012013

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.
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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: [Click here to enter text.](#)

Facility in Compliance by: [Click here to enter a date.](#)



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/19/2025

Facility Name: Radiance Senior Living at the Village

License Number: AL5519

Survey Event ID: W06I11

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522

Based on: Record, review and interview, the center failed to ensure a comprehensive assessment was completed once every 12 months and promptly after a significant change in the resident's condition for 5 (#1, #3, #4, #8, and #9) of 9 sampled residents reviewed for admission assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a 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, preparation and submission of the Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness 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?

The Licensed Practical Nurse will complete a comprehensive assessment on residents #1, #3, #4, #8, and #9. Executive Director will verify completion.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

A checklist will be put into place. Checklist will be done to verify comprehensive assessments were done within 14 days of new resident move in, a significant change, and every 12 months by the Director of Wellness and Executive Director. We will also keep a separate binder of all completed assessments.

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?

The Executive Director has educated the Director of Wellness regarding the requirements of pre admission, admission and change of condition assessments. A checklist will be put into place to verify completion.

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

Director of Wellness and/or designee will audit 6 charts weekly for 4 week, bi-weekly for 4 week and monthly for 1 month. Executive Director to verify completion. The results will be discussed in our monthly Q and A meetings.

- 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.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

11/10/2025

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Administrator signature required OAC 310:663-25-4(F)		Date Enter a date of signature. 10/3/25	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 9/19/2025	
	Facility Name: Radiance Senior Living at the Village	
	License Number: AL5519	
	Survey Event ID: W06I11	
Date Survey Completed: 8/28/2025		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 703	Based on: observation and interview, it was determined the center failed to ensure hot water was available for use in the assisted living laundry at all times.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a 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, preparation and submission of the Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness 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?		The center has purchase industrial tankless hot water tanks for each laundry room. They will specifically heat the water for our washing machines to the current regulation temperature of 160 degrees. This will ensure proper sanitation of all laundry being washed.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Monthly audit will be put into place to verify temperature meets regulation of 160 degrees. Maintenance Director will provide checkoff to Executive Director for verification.
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?		The Executive Director has educated the Maintenance Director on the importance and requirements of sanitation with laundry. Maintenance Director will temp water in washers to verify 160 degrees. Industrial tankless hot water tanks installed to ensure proper temperature is reached.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Maintenance Director and/or designee will do weekly water temperature checks for adequate temperature for 4 week, bi-weekly for 4 week and monthly for 1 month. The results will be discussed in our monthly Q and A meetings.
a. How the correction will be evaluated for effectiveness;		Enter methods to evaluate for effectiveness:
b. How the correction will be incorporated into the center's quality assurance system; and		Enter methods to incorporate into QA system:
c. How monitoring records will be kept to evidence the correction.		Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		11/10/2025
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature	Administrator signature required <i>Tracey Wright</i>	Date Enter a date of signature. 10/13/25

OAC 310:663-25-4(F)			
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	10/2/2025	Submitted by	Tracey Wright, Executive Director
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/19/2025

Facility Name: Radiance Senior Living at the Village

License Number: AL5519

Survey Event ID: W06I11

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 940

Based on: observation, record review, and interview, the center failed to ensure food prepared for 2 of 2 meal observations were consistent with a written and planned menu prepared by a dietary consultant.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a 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, preparation and submission of the Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The center has partnered with Grove Menus by Aline to incorporate monthly menus written and planned by a dietary consultant.

Executive director will audit menu planning and receive monthly menu. Executive director will audit menu/and confirm that planning is being followed.

The Executive Director has educated the Dining Director on the importance and requirements of menu planning and a dietician. The center has partnered with Grove Menus by Aline to incorporate monthly menus written and planned by a dietary consultant.

Dining Director and/or designee will do weekly menu checks for consistency and planning for 4 weeks, bi-weekly for 4 weeks and monthly for 1 month. The results will be discussed in our monthly Q and A meetings.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.

Jacqui Wright

Date Enter a date of signature.

10/3/25

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: Surveyor

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Facility in Compliance by: [Click here to enter a date.](#)