OKLAHOMA
State Department of Health

Delivery via email to: cdobbs@lyndalelife.com

November 7, 2025

License Number: AL5525

Christi Dobbs, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event ID: VNKP11

Dear Ms. Dobbs:

On **October 30, 2025**, agents from our office concluded a State Licensure survey with complaint investigations 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 **October 30, 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:

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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: LYNDALE AT EDMOND
Address: 1225 LAKESHORE DRIVE
City, State, Zip: EDMOND, OK, 73013
Provider #: AL5525
Complaint #: OK00066749
Investigation Date(s): 10/28/25 through 10/30/25

ALLEGATION(S)
The facility failed to ensure resident received medications according to physicians' orders.
The facility failed to ensure medical records were not falsified.
The facility failed to provide incontinent care in a timely manner.
The facility failed to have necessary medical equipment to safely transfer residents.
The facility failed to ensure call lights were assessable to residents.

An unannounced on-site investigation was initiated 10/28/2025 at 1:31 p.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Medication pass, incontinent care, resident transfer techniques, and call lights were observed.

Facility policy and procedures were reviewed. Nurses' notes, physician orders, resident assessments, hospital records were reviewed. Grievances and state reportable incidents were reviewed.

Residents were interviewed regarding medications, incontinent care, safe transfers using equipment, and call lights accessibility. Staff were interviewed regarding facility policy and procedure related to medication administration, falsification of records, incontinent care, safe transfers using equipment, and call lights accessibility.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/03/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **LYNDALE AT EDMOND**
Address: **1225 LAKESHORE DRIVE**
City, State, Zip: **EDMOND, OK, 73013**
Provider #: **AL5525**
Complaint #: **OK00081491**
Investigation Date(s): **10/28/25 through 10/30/25**

ALLEGATION(S)
The center failed to provide a refund in a timely manner according to the contract.
The facility failed to allow the resident to return to the facility after a hospital stay

An unannounced on-site investigation was initiated 10/28/2025 at 1:31 p.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Residents were observed.

Facility policy and procedures were reviewed. Nurses' notes, physician orders, resident assessments, hospital records were reviewed. Grievances and state reportable incidents were reviewed.

Residents were interviewed regarding discharges and billing. Staff were interviewed regarding facility policy and procedure related to discharges and billing.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/03/2025

OKLAHOMA
State Department
of Health

Facility: **LYNDALE AT EDMOND**
Address: **1225 LAKESHORE DRIVE**
City, State, Zip: **EDMOND, OK, 73013**
Provider #: **AL5525**
Complaint #: **OK00083402**
Investigation Date(s): **10/28/25 through 10/30/25**

ALLEGATION(S)
The center failed to observe the administration of medication to ensure medications were administered according to the physicians' orders.

An unannounced on-site investigation was initiated 10/28/2025 at 1:31 p.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Medication pass was observed.

Facility policy and procedures were reviewed. Nurses' notes, physician orders, resident assessments, hospital records were reviewed. Grievances and state reportable incidents were reviewed.

Residents were interviewed regarding medications administration. Staff were interviewed regarding facility policy and procedure related to medication administration.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/03/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: LYNDALE AT EDMOND
Address: 1225 LAKESHORE DRIVE
City, State, Zip: EDMOND, OK, 73013
Provider #: AL5525
Complaint #: OK00085062
Investigation Date(s): 10/28/25 through 10/30/25

ALLEGATION(S)
The center failed to provide maintenance for the air conditioning unit to ensure a safe, comfortable and homelike environment.

An unannounced on-site investigation was initiated 10/28/2025 at 1:31 p.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Temperatures in the facility and resident rooms were observed.

Facility policy and procedures were reviewed.

Residents were interviewed regarding facility temperatures. Staff were interviewed regarding facility policy and procedure related to facility temperatures.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A. BUILDING: _____ B. WING _____	C 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

(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 (#OK00066749, OK00081491, OK00083402, and #OK00085062) was conducted from 10/28/25 through 10/30/25. Deficiencies were cited as a result. Facility Census: 36	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure used food items were: a. labeled with opened/used date; and b. properly secured for 2 of 2 kitchens observed. The administrator identified 36 residents received services from the kitchen. Findings: The policy "Culinary Standard Operating Procedures," revised 11/07/19, read in part, "The food should also be stored in a way that the food is completely covered to prevent cross-contamination." On 10/28/25 at 2:10 p.m., a tour of the	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A. BUILDING: _____ B. WING _____	C 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

(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 391	Continued From page 1 independent kitchen was completed. The following was observed in the refrigerator: a. four open bottles of salad dressings with no open date, b. an open bottle of mayonnaise with no open date, and c. an open bag of parmesan cheese with no open date. On 10/28/25 at 2:28 p.m., a tour of the assisted living kitchen was completed. The following was observed in the refrigerator and freezer: a. two open bottles of salad dressings were observed with no open date, and b. an open, unsealed bag of onion rings with no open date. The policy "Culinary Standard Operating Procedures," revised 11/07/19, read in part, "The food should also be stored in a way that the food is completely covered to prevent cross-contamination." On 10/28/25 at 2:33 p.m., the culinary director stated open food items should be dated with open date and sealed properly.	C 391		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A. BUILDING: _____ B. WING _____	C 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

(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 543	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the center failed to include a personal interview between the resident and/or the resident representative for 1(#6) of 8 sampled residents reviewed for comprehensive assessments. The administrator identified 36 residents resided in the center. Findings: Resident #6's annual assessment, dated 08/09/25, showed the resident was admitted on 06/18/23 with diagnoses which included hypertension and chronic kidney disease. The assessment showed Resident #6 had orientation impairment and was oriented to self and place. The assessment was not signed by the resident and/or resident representative. On 10/30/25 at 1:00 p.m., the resident services director stated they usually call resident representatives and set up resident conferences after completion of the resident's assessment. They stated they sent the resident's representative an email on 10/29/25. On 10/30/25 at 1:48 p.m., the resident services director stated they were not sure what an acceptable time frame was for resident representative signatures.	C 543		

OKLAHOMA
State Department of Health

Delivery via email to: cdobbs@lyndalelife.com

November 14, 2025

License Number: AL5525

Christi Dobbs, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event VNKP11

Dear Ms. Dobbs:

On **October 30, 2025,** agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C391:** The plan of correction does not state how often the random audits will be completed.
- **C543:** The plan of correction does not state how often the RSD will audit assessments.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/11/2025** **Facility Name:** Lyndale Edmond **License Number:** AL5525 **Survey Event ID:** VNKP11 **Date Survey Completed: 10/30/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 391	Based on: Observation, record review and interview, the center failed to endure used food items were: A. Labeled with opened/used date; B. Properly secured for 2 of 2 kitchens observed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All 36 residents who receive meals from the kitchen will receive meals prepared only with properly labeled and sealed food items. The Culinary Director immediately conducted a comprehensive clean- out of all refrigerators and freezers, discarding any unlabeled or improperly stored items and replaced them with correctly labeled, sealed products.
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 residents have the potential to be affected.
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 "Culinary Standard Operating Procedures" have been reviewed to include a mandatory "Open-Date Labeling" for all perishable items. All kitchen staff received an in-service training on proper labeling, covering, and storage of opened foods
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Culinary Director performs a random visual audit of the perishable food items and records findings on the "Kitchen Checklist." The Administrator and Culinary Director will review audit results monthly, noting any deviations and corrective actions taken Monitoring audits are reviewed at each QA meeting to ensure sustained compliance. Monitoring records are maintained at each QA meeting to ensure sustained compliance.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	12/15/2025		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required	**Date 11/13/2025**	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/11/2025
Facility Name: Lyndale Edmond
License Number: AL5525
Survey Event ID: VNKP11
Date Survey Completed: 10/30/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 543	Based on: Record review and interview, the center failed to include a personal interview between the resident and/or the resident representative for 1(#6) of 8 sampled residents reviewed for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #6's interview has been completed as reflected by signature on assessment.
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 residents have the potential to be affected.
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?	Resident Services received re-education on interview techniques, signature requirements, and documentation standards.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Resident Services Director will audit all resident comprehesive assessments to verify a personal interview has been completed. The QA Committee reviews audit results quarterly for compliance, discusses trends, and issues corrective action plans as needed. Enter methods to incorporate into QA system: Monitoring records are maintained and reviewed at each QA meeting to ensure sustained compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/15/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator's signature required. **Date 11/13/2025**
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	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.

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Delivery via email to: cdobbs@lyndalelife.com

November 14, 2025

License Number: AL5525

Christi Dobbs, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event VNKP11

Dear Ms. Dobbs:

On **October 30, 2025**, a Licensure inspection with complaints was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your 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 timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **December 15, 2025**.

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/11/2025** **Facility Name:** Lyndale Edmond **License Number:** AL5525 **Survey Event ID:** VNKP11 **Date Survey Completed: 10/30/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 391	Based on: Observation, record review and interview, the center failed to endure used food items were: A. Labeled with opened/used date; B. Properly secured for 2 of 2 kitchens observed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All 36 residents who receive meals from the kitchen will receive meals prepared only with properly labeled and sealed food items. The Culinary Director immediately conducted a comprehensive clean- out of all refrigerators and freezers, discarding any unlabeled or improperly stored items and replaced them with correctly labeled, sealed products.
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 residents have the potential to be affected.
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 "Culinary Standard Operating Procedures" have been reviewed to include a mandatory "Open-Date Labeling" for all perishable items. All kitchen staff received an in-service training on proper labeling, covering, and storage of opened foods
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Culinary Director performs a random visual audit of the perishable food items and records findings on the "Kitchen Checklist." The random visual audits will be completed at least twice a week. The Administrator and Culinary Director will review audit results monthly, noting any deviations and corrective actions taken Monitoring audits are reviewed at each QA meeting to ensure sustained compliance.

	Monitoring records are maintained at each QA meeting to ensure sustained compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/15/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Alicia Dobbs, CPA OAC 310:663-25-4(F)	**Date 11/14/2025**

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/11/2025** **Facility Name:** Lyndale Edmond **License Number:** AL5525 **Survey Event ID:** VNKP11 **Date Survey Completed: 10/30/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 543	Based on: Record review and interview, the center failed to include a personal interview between the resident and/or the resident representative for 1(#6) of 8 sampled residents reviewed for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #6's interview has been completed as reflected by signature on assessment.
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 residents have the potential to be affected.
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?	Resident Services received re-education on interview techniques, signature requirements, and documentation standards.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Resident Services Director will audit all resident comprehesive assessments monthly to verify a personal interview has been completed. The QA Committee reviews audit results quarterly for compliance, discusses trends, and issues corrective action plans as needed. Enter methods to incorporate into QA system: Monitoring records are maintained and reviewed at each QA meeting to ensure sustained compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/15/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required OAC 310:663-25-4(F)	**Date 11/14/2025**

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department
of Health

Delivery via email to: cdobbs@lyndalelife.com

January 8, 2026

License Number: AL5525

Christi Dobbs, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event VNKP12

Dear Ms. Dobbs:

On **December 22, 2025,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your relicensure survey with complaints on **October 30, 2025,** have now been corrected effective **December 15, 2025.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A. BUILDING: _____ B. WING _____	R-C 12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 12/22/25. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE