
Delivery USPS Tracking #: PS00001000014

October 7, 2025

License Number: AL5530

Ms. Cara Northcutt, Administrator
Arbor House Assisted Living Of Midwest City
9240 East Reno Avenue
Midwest City, OK 73110

Survey Event ID: TTX211

Dear Ms. Northcutt:

On **August 28, 2025**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

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

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

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

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

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

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

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

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

IDR Coordinator
IDRCoordinator@ok.health.gov
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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Arbor House Midwest City
Address: 9240 E Reno Ave
City, State, Zip: Midwest City, Ok 73130
Provider #: AL5530
Complaint #: OK00074588
Investigation Date: 08/25/25 through 08/28/25

ALLEGATION(S)
1. The facility failed to ensure care was provided (bathing assistance) according to the physician orders and plan of care.
2. The facility failed to provide sufficient staff to ensure residents received care and services according to their physician orders and plan of care.
3. The facility failed to ensure meals resident's received meals three times per day to maintain their nutritional status.

An unannounced on-site investigation was initiated 08/25/2025 at 8:40 a.m.

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

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

A Summary of Complaint Investigation: A tour of the facility was conducted upon entrance into the center. Residents were observed for abuse and neglect concerns, personal care concerns, staffing, meals, medications and infection control measures. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and police reports. Residents and staff were asked questions regarding abuse and abuse training.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2025

INVESTIGATIVE REPORT

Facility: Arbor House Midwest City
Address: 9240 E Reno Ave
City, State, Zip: Midwest City, Ok 73130
Provider #: AL5530
Complaint #: OK00074604
Investigation Date: 08/25/25 through 08/28/25

ALLEGATION(S)
1. The facility failed to ensure antibiotics were administered according to the physician order.
2. The facility failed to ensure adequate staff to meet the needs of the residents, and to ensure staff were competent to administer medications.
3. The facility failed to ensure staff maintained infection control measures when administering medications. Invest.
4. The facility failed to ensure adequate staff to prevent falls and supervision of meals.

An unannounced on-site investigation was initiated 08/25/2025 at 8:40 a.m.

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

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

A Summary of Complaint Investigation: A tour of the facility was conducted upon entrance into the center. Residents were observed for abuse and neglect concerns, personal care concerns, staffing, meals, medications and infection control measures. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and police reports. Residents and staff were asked questions regarding abuse and abuse training.

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Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2025

INVESTIGATIVE REPORT

Facility: Arbor House Midwest City
Address: 9240 E Reno Ave
City, State, Zip: Midwest City, Ok 73130
Provider #: AL5530
Complaint #: OK00074733
Investigation Date: 08/25/25 through 08/28/25

ALLEGATION(S)
1. The center failed to ensure adequate supervision was provided to prevent falls with major injury.
2. The center failed to ensure adequate staff to provide care.
3. The center failed to ensure staff were certified to administer medications

An unannounced on-site investigation was initiated 08/25/2025 at 8:40 a.m.

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

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

A Summary of Complaint Investigation: A tour of the facility was conducted upon entrance into the center. Residents were observed for abuse and neglect concerns, personal care concerns, staffing, meals, medications and infection control measures. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and police reports. Residents and staff were asked questions regarding abuse and abuse training.

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Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2025

INVESTIGATIVE REPORT

Facility: Arbor House Midwest City
Address: 9240 E Reno Ave
City, State, Zip: Midwest City, Ok 73130
Provider #: AL5530
Complaint #: OK00082765
Investigation Date: 08/25/25 through 08/28/25

ALLEGATION(S)
1. The center failed to ensure food was served under sanitary conditions.
2. The center failed to have and/or implement an effective infection control program for housekeeping and laundry.
3. The center failed to ensure adequate staff to meet the needs of the residents
4. The center failed to ensure call lights were answered in a timely manner.

An unannounced on-site investigation was initiated 08/25/2025 at 8:40 a.m.

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

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Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2025

Facility: Arbor House Midwest City
Address: 9240 E Reno Ave
City, State, Zip: Midwest City, Ok 73130
Provider #: AL5530
Complaint #: OK00082781
Investigation Date: 08/25/25 through 08/28/25

ALLEGATION(S)
1. The center failed to follow medication administration policies and procedures
2. The center failed to have adequate staffing to meet residents needs.
3. The center failed to ensure equipment was maintained in proper working order.

An unannounced on-site investigation was initiated 08/25/2025 at 8:40 a.m.

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

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

A Summary of Complaint Investigation: A tour of the facility was conducted upon entrance into the center. Residents were observed for abuse and neglect concerns, personal care concerns, staffing, meals, medications and infection control measures. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and police reports. Residents and staff were asked questions regarding abuse and abuse training.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2025

INVESTIGATIVE REPORT

Facility: Arbor House Midwest City
Address: 9240 E Reno Ave
City, State, Zip: Midwest City, Ok 73130
Provider #: AL5530
Complaint #: OK00085362
Investigation Date: 08/25/25 through 08/28/25

ALLEGATION(S)
1. The center failed to ensure advance directives were honored.
2. The center failed to ensure a safe, clean, comfortable and homelike environment.
3. The center failed to ensure adequate staff to meet the needs of the residents.
4. The center failed to administer medication according to the physicians' orders.

An unannounced on-site investigation was initiated 08/25/2025 at 8:40 a.m.

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

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

A Summary of Complaint Investigation: A tour of the facility was conducted upon entrance into the center. Residents were observed for abuse and neglect concerns, personal care concerns, staffing, meals, medications and infection control measures. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and police reports. Residents and staff were asked questions regarding abuse and abuse training.

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Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING OF MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 9240 EAST RENO AVENUE MIDWEST CITY, OK 73110		
(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 (#OK00074588, OK00074604, OK00074733, OK00082765, OK00082781 and #OK00085362) was conducted from 08/25/25 through 08/28/25. Deficiencies were cited as a result of the survey. Facility Census: 58 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nurse aide DON - director of nursing LPN - licensed practical nurse RN - registered nurse	C 000		
C 328 SS=F	310:663-3-3(a)(8) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (8) planned programs for socialization, activities and exercise; and This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents in	C 328		

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: AL5530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
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C 328	Continued From page 1 the memory care unit received activity programs to meet cognitive needs described in the residents' residency agreement for 14 of 14 residents in the memory care unit. The residence director identified 14 residents resided in the memory care unit. Findings: On 08/26/25 at 2:20 p.m., an initial tour of the memory care unit was conducted. There were eight residents in the common area watching television. There were no activities posted. On 08/27/25 at 9:30 a.m., there were residents in the common area on the memory care unit. There were no activities noted or posted. A review of the "Resident Admission Agreement," read in part, "Specialized services for residents with Alzheimer's or related dementias. The community will assist with cognitive orientation, which includes interventions to re-orient the resident, divert attention to more pleasant activity, and encourage socialization and participation in activities." An undated facility marketing material brochure titled "Arbor House," showed the services and amenities included in the memory care included programs that supported memory retention, slowed cognitive decline, and reduced anxiety. On 08/27/25 at 11:05 a.m., the life enrichment coordinator was asked about the activities in memory care. The life enrichment coordinator stated they would try to bring some of the residents out to the assisted living side for participation in activities, but did not have enough	C 328		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
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C 328	Continued From page 2 time to do activities in both areas. The life enrichment coordinator was asked if all residents from memory care were brought out to participate. The life enrichment coordinator stated they were not, it was usually only three to four of the f14 residents in memory care. They stated there was another staff member that was supposed to assist with activities in memory care, but they had not been able to be assigned to activities since they were working on the floor as a CNA. The life enrichment coordinator stated they were aware there were not any activities being done consistently in memory care, and had not been for several months. On 08/28/25 at 9:53 a.m. CNA #3 stated they were supposed to do activities in memory care but was often reassigned to other areas to perform other tasks. CNA #3 stated they had not done any activities in memory care in some time.	C 328		
C 391 SS=D	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: a. the kitchen floors were clean and free of a buildup of debris, and b. ice machine filter changed and cleaned by	C 391		

Oklahoma State Department of Health

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C 391	Continued From page 3 date posted on ice machine filter. The dietary manager identified 58 residents received nutrition from the kitchen. Findings: On 08/25/25 at 11:00 a.m., during a kitchen tour observation, the kitchen floors were observed to have a buildup of dark colored debris under the sink and dishwasher and debris throughout the kitchen on the floors. On 08/25/25 at 11:05 a.m. the back of the ice machine in the kitchen had a "clean by" sticker and a "change by" sticker on the filter cartridge. A facility policy titled "Kitchen Sanitation and Safety," dated 03/18/1014, read in part, "A schedule for routine and deep cleaning should be maintained and followed." On 08/25/25 at 12:40 p.m., the culinary services coordinator was shown the kitchen floor. The culinary services coordinator was asked if they identified any issues with the amount of debris throughout the kitchen on the floor, as well as the dark buildup areas under sink and dishwasher. They stated "yes, it looked like it needed a good cleaning." On 08/25/25 at 12:42 p.m., the culinary services coordinator was shown the outdated stickers showing "change by" and the "clean" by dates of 07/05/25, located on the cartridge behind the ice machine. The culinary services director stated maintenance looked after the cleaning schedule of the machine and they would need to reach out to them, but was pretty sure it should have been changed out and cleaned.	C 391		

Oklahoma State Department of Health

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C 391	Continued From page 4 On 08/26/25 at 3:02 p.m. the maintenance supervisor was asked about the cleaning process for the ice machine in the kitchen. They stated it was cleaned monthly and they had a log of this. The maintenance supervisor was asked about the stickers on the cartridge behind the machine. They stated that was the water filter cartridge for the machine and it was to be serviced annually. They had changed the company that was doing this and did not make sure the new company had it on their list. The maintenance supervisor stated they had called them and they were supposed to be out later this week to change and clean the filter. The maintenance supervisor stated they should have noted that it had not been completed.	C 391			
C 910 SS=F	310:663-9-1 NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged:	C 910			

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
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C 910	Continued From page 6 needs." The "Resident Admission Agreement", updated 10/2022, read in part ... "The community has procedures for fire, blizzard, tornado, earthquake and other calamities, and staff adequate to meet evacuation needs".... "Receive a prompt response to emergency calls or requests for assistance." A resident matrix, dated 08/26/25, identified two residents were bedbound and four chairfast. A "Resident Care and Information" form, dated 08/26/25, showed five residents needed special assistance with evacuation (wheelchair bound, bed bound, limited mobility). A "Resident Condition and Care Overview" form, dated 08/26/25, showed 14 residents with dementia and five residents not capable of responding to emergency situations without physical assistance from staff of the facility or were not capable of self-preservation. A review of Pendant call report, the call light system for residents, dated 08/01/25 through 08/28/25, showed 55 call light response times were over 15 minutes long. A review of staff schedules, dated 06/08/25 through 08/17/25, showed the following dates with 3 staff members on 11 p.m. to 7 a.m. shift for both memory care and assisted living areas: 6/08/25, 06/11/25, 06/14/2025, 06/15/25, 06/21/25, 06/22/25, 06/25/25, 06/29/25, 07/05/25, 07/13/25, 08/08/25, and 08/11/25. Review of staff schedules on 07/06/2025 showed 2 staff members scheduled.	C 910		

Oklahoma State Department of Health

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C 910	Continued From page 7 An "Entry Conference Checklist" form, dated 08/26/25, showed 13 residents resided in the memory care unit (a locked unit within the facility). On 08/25/25 at 10:29 a.m., family member #1 stated their family member lived on the assisted living side and had several issues with the length of time to get a response when the pendant call system was activated. Family Member #1 stated their family member often called them on the phone and they then called the main number to get someone to help them. On 08/25/25 at 1:42 p.m., family member #2 stated their family member lived on assisted living side and had several instances in past several months there was not enough staff and no one in charge, resulting in them being incontinent and had to sleep in urine soaked clothing. Family Member #2 stated her family member was not mobile and needed full assist to get up. Family Member #2 stated there was often not enough staff to assist with basic needs. On 08/27/25 at 2:48 p.m., Resident #1 stated staff were as good as you can expect for the wages they pay. Resident #1 stated they did not have a quick response to call lights, if there was a true emergency, the response would be too long to save anyone's life. On 08/26/25 at 10:50 a.m., CNA #1 was asked about staffing. They stated there was never enough staff. Residents were often waiting for periods of time before anyone could get to them to help them. There had been times when there may be only one person in the building because other staff members had went to lunch or left the	C 910		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING OF MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 9240 EAST RENO AVENUE MIDWEST CITY, OK 73110		
(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 910	Continued From page 8 premises for some reason. CNA #1 stated they felt like they used to be able to meet the needs of the residents, but have had so many staff members leave, they were struggling to be able to get everything done that needed to be done, especially for the residents that were not independent. CNA #1 stated they did not feel like anyone understood the amount of help a lot of the residents required, there were not that many that were truly independent. On 08/28/25 at 8:49 a.m., CMA #2 stated they were the full time CMA in the memory care unit. CMA #2 was asked about staffing. CMA #2 stated they were frequently short staffed, there had been several times when the staff were pulled to other areas and it left minimal people in the locked unit, even though it looked like there were several if you looked at the assignment sheets. CMA #2 stated they "just do the best we can." CMA #2 was asked if they thought they could evacuate if they needed to with the staff they had. CMA #2 stated if they had the staff the assignment sheet showed they might, but frequently did not have those people in the area. On 08/28/25 at 9:53 a.m., CNA #3 stated they were supposed to do activities in memory care but was often reassigned to other areas to perform other tasks. CNA #3 stated they had not done any activities in memory care in some time due to staffing and being pulled to different areas. CNA #3 stated the staff assignments never were what was actually there. On 08/28/25 at 2:20 p.m., the residence director was asked about staffing for resident care needs and evacuation. The residence director stated they felt like there was sufficient staff as there was not a staffing ratio for assisted living and	C 910		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING OF MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 9240 EAST RENO AVENUE MIDWEST CITY, OK 73110		
(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 910	Continued From page 9 there were several staff members lived close and could come in to facility if they ever needed to evacuate residents.	C 910		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		
	This Rule is not met as evidenced by:			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING OF MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 9240 EAST RENO AVENUE MIDWEST CITY, OK 73110		
(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
C1911	Continued From page 10 Based on record review and interview, the center failed to submit an incident report within one business day, and a final incident report to the department within five business days of a reportable incident's discovery for 1 (#10) of 4 sampled residents reviewed for incident reports. The DON identified 58 residents resided in the facility. Findings: A review of Resident #10's medical record showed an "Incident Report Form," with an incident dated 04/12/25 and faxed to OSDH on 04/22/25, showed an allegation of abuse/mistreatment. The report statement showed the allegation was made by a resident's son in regard to a hospice nurse conversation with the family member. No final report noted in the record. A review of OSDH's incident report system did not show a final report form was received by OSDH. On 08/27/25 at 12:30 p.m., the residence director was asked for the fax confirmation showing the incident report form for Resident #10 was sent and received by OSDH. The residence director was unable to locate the fax confirmation. The residence director was asked about the timing of the initial report. The residence director stated they were not sure but thought it was not reported by the family member until 04/22/25. The residence director was asked about final report. The residence director stated they did not know why it was not sent in.	C1911		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING OF MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 9240 EAST RENO AVENUE MIDWEST CITY, OK 73110		
(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
C1922	Continued From page 11	C1922		
C1922 SS=F	310:663-19-2(a)(2) MEDICATION ADMINISTRATION (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour prior to administration. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to have medications available for 1 (#8) of 3 sampled residents observed for medication administration. Findings: On 08/26/25 at 8:37 a.m., during a medication pass with CMA #4, the following medications were not available on the medication cart or in backup stock for morning medication pass for Resident #8. a. Acidophilus, a probiotic medication for gut health, b. Metformin 750 mg ER, a medication for diabetes, c. Nystatin powder, a topical medication for fungus infections, d. Omeprazole 20 mg, a medication used to treat too much acid in the stomach, e. Tab-a-vite tab iron/bet, an iron supplement, and f. Donepezil 23 mg, a medication used to treat dementia. The medication administration record for the month of 08/2025, printed 08/27/25, showed the following medications were "not available," not on	C1922 C1922		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING OF MIDWEST			STREET ADDRESS, CITY, STATE, ZIP CODE 9240 EAST RENO AVENUE MIDWEST CITY, OK 73110		
(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
C1922	Continued From page 12 cart," and "on order" per the notations on the record for Resident #8. a. Acidophilus, a probiotic medication for gut health, was not administered from 08/01/25 through 08/27/25, b. Metformin 750 mg ER, a medication for diabetes, was not administered from 08/16/25 through 08/26/25, c. Nystatin powder, a topical medication for fungus infections, was not administered for 24 doses between 08/01/25 through 08/27/25, d. Omeprazole 20 mg, a medication used to treat too much acid in the stomach, was not administered from 08/01/25 through 08/27/25, e. Tab-a-vite tab iron/bet, an iron supplement, was not administered from 08/01/25 through 08/27/25, and f. Donepezil 23 mg, a medication used to treat dementia, was not administered on 08/26/25. On 08/26/25 at 8:37 a.m., CMA #4 stated Resident #8 had been out of the medications for a while. They had told the family, and turned in a request to nursing for refills, but had not heard anything back. CMA #4 stated they documented on the medication administration record when a resident was out of medication or if not administered for any other reason. On 08/28/25 at 8:40 a.m., CMA #1 stated they usually worked double shifts on weekends. CMA #1 was asked if there were times when there were not medications available for residents. They stated the assisted living side did not tend to have issues, only occasionally. CMA #1 stated there was usually notes related to ordering, but the memory care had frequent issues, usually at least once or twice a month when she worked. On 08/28/25 at 8:45 a.m., CMA #2 stated they	C1922			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5530	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/28/2025
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING OF MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 9240 EAST RENO AVENUE MIDWEST CITY, OK 73110		
(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
C1922	Continued From page 13 were the full time CMA in the memory care unit and they took care of ordering and maintaining the medications. CMA #2 was asked about the process. CMA #2 stated they ordered when there were two rows or weeks of medication left on the card or in container. The CMA stated they log when they order them and when they come in. CMA #2 was asked if they had issues getting medications in. The CMA stated they reported to nursing staff if they got close and had not received them. CMA #2 stated they were not aware of any that had been out of medications. On 08/28/25 at 11:15 a.m., the DON was asked about medication availability for Resident #8. The DON stated they were not aware the medications were not available until the medication pass with the surveyor, but they had followed up on them. The DON stated they had been ordered and received and were being administered now.	C1922		

Delivery via email to: Melinda.Hawkins@legendseniorliving.com

October 22, 2025

License Number: AL5530

Ms. Melinda Hawkins, Administrator
Arbor House Assisted Living Of Midwest City
9240 East Reno Avenue
Midwest City, OK 73110

Survey Event ID: TTX211

Dear Ms. Hawkins:

On **August 28, 2025**, agents from our office completed a complaint investigation 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:

- Requesting Quality monitoring/reporting for the following areas:
 - Memory care activities
 - Kitchen cleaning
 - Staffing
 - Incident reporting

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health		(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/28/2025
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5530		
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING OF MIDWEST		STREET ADDRESS, CITY, STATE, ZIP CODE 9240 EAST RENO AVENUE MIDWEST CITY, OK 73110		
(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 (#OK00074588, OK00074604, OK00074733, OK00082765, OK00082781 and #OK00085362) was conducted from 08/25/25 through 08/28/25. Deficiencies were cited as a result of the survey. Facility Census: 58 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nurse aide DON - director of nursing LPN - licensed practical nurse RN - registered nurse	C 000		
C 328 SS=F	310:663-3-3(a)(8) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (8) planned programs for socialization, activities and exercise; and This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents in	C 328	Refer to POC template Survey event ID: <u>TTX211</u> ID Prefix tag <u>C328</u> Refer to POC template survey event ID <u>TTX211</u> ID Prefix <u>C391</u> Refer to POC template Survey event ID <u>TTX211</u> ID Prefix <u>C910</u> Refer to POC template Survey event ID <u>TTX211</u> ID Prefix <u>C1911</u> Refer to POC template Survey event ID <u>TTX211</u> ID Prefix <u>C1922</u>	

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

If continua



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/16/2025

Facility Name: Arbor House Midwest City

License Number: AL5530

Survey Event ID: TTX211

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C328 This rule
is not met as evidenced by:

Based on: Observation, record review, and interview, the facility failed to ensure residents in the memory care unit received activity programs to meet cognitive needs described in the residency agreement for 14 of 14 residents in memory care.

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

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 Memory Care activity calendar will be posted by the 1st of each month.

Paralell Programing training will be provided to team members in memory care by November 16, 2025.

The life enrichment coordinator will be responsible for overseeing the daily activities and ensure implementation.

Resources and materials will be provided for staff on engaging activities. This will be an ongoing basis.

OSDH Response: Element accepted Yes ☐ No ☐

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

Collection of feedback from residents, families and staff.

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 activity participation will monitored by the Life Enrichment Coordinator.

OSDH Response: Element accepted Yes ☐ No ☐

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

Regular Scheduled follow-up meeting with the residence director to discuss the progress.

a. How the correction will be evaluated for effectiveness;

Increased number of participants during memory care activities.

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.

Monitoring of participation will be kept electonically in Arbor House programing system.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

11/16/2025

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

Melinda Hawkins

Date Enter a date of signature.

10/21/25

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.

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 10/16/2025		
	Facility Name: Arbor House Midwest City		
	License Number: AL5530		
	Survey Event ID: TTX211		
Date Survey Completed: 8/28/2025			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C391		Based on: Based on observation, record review, and interview the center failed to ensure kitchen floors were clean and free of debris, and b) ice machine filter changed and cleaned by the date posted on the ice machine.	
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?		The ice machine filter was changed on 08.29.2025 On 8.29.2025 Immediate action was taken to conduct a thorough cleaning of all kitchen floors.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Enter method for identifying other potentially affected residents.	
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?		Daily cleaning schedules for floors, including specific task(sweeping, mopping and sanitizing will be adhered to by the culinary team per Legend Senior Living 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 food service coordinator will observe and review the kitchen floors for cleanliness. Observation Enter methods to incorporate into QA system: Cleaning schedule checklist with signature. Service agreement with Easy ice for filter changes.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		8/29/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required OAC 310:663-25-4(F)		Date Enter a date of signature. 10/21/2025	
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

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/8/2025

Facility Name: Arbor House Midwest City

License Number: AL5530

Survey Event ID: TTX211

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C910

Based on: observation, record review, and interview the center failed to provide sufficient staff to meet the the services in the assisted living's contract for resident care needs and evacuation.

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

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:

- 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.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

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.

Items Below Are For OSDH Use Only

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



Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/16/2025

Facility Name: Arbor House Midwest City

License Number: AL5530

Survey Event ID: TTX221

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1911

Based on: record review and interview the center failed to submit an incident report within one business day, and final incident report to the department within five business days of a reportable incident's discovery for 1 (#10) of 4 sampled residents reviewed for incident reports.

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

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 ☐

Administrator's Signature *Melinda Harris*
OAC 310:663-25-4(F)

Date *10-21-25* 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.

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: 10/16/2025

Facility Name: Arbor House Midwest City

License Number: AL5530

Survey Event ID: TTX211

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1922

Based on: observation, record review and interview, the facility failed to have medications available on the medication cart or in backup stock for morning medication pass for resident # 8

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

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 ☐

Administrator's Signature

Administrator signature required

OAC 310:663-25-4(F)

Melinda Hawkins

Date Enter a date of signature.

10.21.25

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.

Delivery via email to: Melinda.Hawkins@legendseniorliving.com

October 24, 2025

License Number: AL5530
Survey Event ID: TTX211

Ms. Melinda Hawkins, Administrator
Arbor House Assisted Living Of Midwest City
9240 East Reno Avenue
Midwest City, OK 73110

Dear Ms. Hawkins:

On **August 28, 2025**, a Licensure inspection was conducted at your Adult Day Care 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 will be corrected on **November 16, 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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure



Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/16/2025

Facility Name: Arbor House Midwest City

License Number: AL5530

Survey Event ID: TTX221

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1911

Based on: record review and interview the center failed to submit an incident report within one business day, and final incident report to the department within five business days of a reportable incident's discovery for 1 (#10) of 4 sampled residents reviewed for incident reports.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather is submitted as a confirmation of our ongoing efforts to comply with all the statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or findings. We have not presented all contrary, factual or legal arguments or have we identified mitigating factors.

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 ☐

Administrator's Signature *Melinda Hawker*

OAC 310:663-25-4(F)

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All reports to the department will be made via fax or telephone within 1 department business day.

The health care director and the residence director will audit reportable incidences as they occur to assure compliance of reporting.

All reportable events will be audited as they occur by the residence director and or health care director as they occur.

All reportable events will have a fax confirmation attached to the original report.

Audit of reportable events as they occur.

Review of the audits will be incorporated to the QA meeting and need for any additional intervention will be put into place.

All reportable events will be maintained by the residence director.

11/1/2025

Date 10/23/2025

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	10/23/2025	Submitted by	Melinda Hawkins
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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.](#)

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 10/8/2025	
	Facility Name: Arbor House Midwest City	
	License Number: AL5530	
	Survey Event ID: TTX211	
	Date Survey Completed: 8/28/2025	
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C910	Based on: observation, record review, and interview the center failed to provide sufficient staff to meet the the services in the assisted living's contract for resident care needs and evacuation.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty(with the right to correct) on the community. Rather is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) ir findings. We have not presented all contrary, factual or legal arguments or have we identified mitigating factors.		
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?		An additional full time employee was added to the night shift.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Health Care director will periodically review service plans to identify increased needs for evacuation assistance. The residence director will review the pendent call report daily.
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?		Staffing schedules will reflect the care needs and and evacuation needs of residents based on service plans.
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.		Service plans will be periodically audited by the health care director to assist in identifying residents who require additional assistance with evacuations. Maintenance will conduct drills per Legend protocol. Observation, service plan updates. Service Plan audits will be reviewed and incorporated into the QA meeting. Any need for additional intervention identified will be put into place. Staff that participate in disaster drills will provide their signature to the drill report.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		11/16/2025
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature <i>Melinda Hawkins</i> Administrator signature required. OAC 310:663-25-4(F)		Date 10/21/2025

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	10/23/2025	Submitted by	Melinda Hawkins
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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: 10/16/2025		
	Facility Name: Arbor House Midwest City		
	License Number: AL5530		
	Survey Event ID: TTX211		
Date Survey Completed: 8/28/2025			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C391		Based on: Based on observation, record review, and interview the center failed to ensure kitchen floors were clean and free of debris, and b) ice machine filter changed and cleaned by the date posted on the ice machine.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: This plan of correction is not be construed as an admission of our agreement of the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary ,factual or legal arguments or have we identified mitigating factors.			
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 ice machine filter was changed on 08.29.2025 On 8.29.2025 Immediate action was taken to conduct a thorough cleaning of all kitchen floors.	
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?		Daily cleaning schedules for floors, including specific task(sweeping, mopping and sanitizing will be adhered to by the culinary team per Legend Senior Living Standards.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		The food service coordinator will observe and review the kitchen floors for cleanliness.	
a. How the correction will be evaluated for effectiveness;		Observation	
b. How the correction will be incorporated into the center's quality assurance system; and		Review of cleaning schedule checklist will be incorporated into the Quality Assurance meeting. Any need identified to require additional intervention will be put in to place.	
c. How monitoring records will be kept to evidence the correction.		Cleaning schedule checklist with signature. Service agreement with Easy ice for filter changes.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		8/29/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Melinda Hawkins</i> OAC 310:663-25-4(F)		Date <i>10/23/25</i> 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	10/23/2025	Submitted by	Melinda Hawkins
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: 10/16/2025

Facility Name: Arbor House Midwest City

License Number: AL5530

Survey Event ID: TTX211

Date Survey Completed: 8/28/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C328 This rule is not met as evidenced by:

Based on: Observation, record review, and interview, the facility failed to ensure residents in the memory care unit received activity programs to meet cognitive needs described in the residency agreement for 14 of 14 residents in memory care.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The plan of correction is not to be construed as an admission of agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our on going efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not

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 Memory Care activity calendar will be posted by the 1st of each month.

Parallel Programming training will be provided to team members in memory care by November 16, 2025.

The life enrichment coordinator will be responsible for overseeing the daily activities and ensure implementation.

Resources and materials will be provided for staff on engaging activities. This will be an ongoing basis.

OSDH Response: Element accepted Yes ☐ No ☐

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

Collection of feedback from residents, families and staff.

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 activity participation will be monitored by the Life Enrichment Coordinator.

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.

Regular Scheduled follow-up meeting with the residence director to discuss the progress.

Increased number of participants during memory care activities.

Review of the number of participants during memory care activities will be incorporated in the Quality Assurance meeting. Needs for additional interventions will be incorporated.

Monitoring of participation will be kept electronically in Arbor House programming system.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		11/16/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Melinda Hawkins</i> OAC 310:663-25-4(F)		Date <i>10/23/2025</i> 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	10/22/2025	Submitted by	Melinda Hawkins
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.			

Delivery via email to: Melinda.Hawkins@legendseniorliving.com

December 26, 2025

License Number: AL5530
Survey Event ID: TTX212

Ms. Melinda Hawkins, Administrator
Arbor House Assisted Living Of Midwest City
9240 East Reno Avenue
Midwest City, OK 73110

Dear Ms. Hawkins:

On **December 23, 2025**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **August 28, 2025**, have now been corrected and your facility is in compliance with licensure standards effective **November 16, 2025**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure