OKLAHOMA
State Department of Health

Delivery via email to: foglesby@villageatoakwood.com

May 2, 2025

License Number: AL5534

Ms. Fidelia Oglesby, Executive Director
Village At Oakwood
817 Southwest 59th Street
Oklahoma City, OK 73109

RE: Survey Event ID: U1B011

Dear Ms. Oglesby:

On **April 23, 2025**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **April 23, 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 public record, and any such names will be available for disclosure.

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

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

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

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

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

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

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;

- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

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

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

Respectfully,

Tempal Killman

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Village at Oakwood**
Address: **817 Southwest 59th Street**
City, State, Zip: **Oklahoma City, Ok 73109**
Provider #: **AL5534**
Complaint #: **OK00075918**
Investigation Date: **04/22/25 through 04/23/25**

ALLEGATION(S)
1. The facility center failed to ensure residents were not sexually or psychosocially abused.

An unannounced on-site investigation was initiated 04/22/2025 at 10:00 a.m.

A sample of three participants, including any identified participants, were 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. 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: 04/23/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Village at Oakwood**
Address: **817 Southwest 59th Street**
City, State, Zip: **Oklahoma City, Ok 73109**
Provider #: **AL5534**
Complaint #: **OK00076202**
Investigation Date: **04/22/25 through 04/23/25**

ALLEGATION(S)
1.The center failed to ensure residents were not physically, verbally or psychosocially abused.
2.The center failed to ensure residents were not involuntarily secluded.
3.The center failed to ensure assistance with activities of daily living were provided in a timely manner and according to the plan of care/contract
4.The center failed to ensure medications were administered according to the physicians' orders.
5.The center failed to ensure residents the right to choose their bed time

An unannounced on-site investigation was initiated 04/22/2025 at 10:00 a.m.

A sample of three 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. 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: 04/23/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Village at Oakwood**
Address: **817 Southwest 59th Street**
City, State, Zip: **Oklahoma City, Ok 73109**
Provider #: **AL5534**
Complaint #: **OK00080448**
Investigation Date: **04/22/25 through 04/23/25**

ALLEGATION(S)
1.The center failed to ensure resident were not over sedated.
2.The facility failed to ensure residents were not involuntarily secluded.
3.The facility failed to provide palatable meals

An unannounced on-site investigation was initiated 04/22/2025 at 10:00 a.m.

A sample of three 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. 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: 04/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5534	A. BUILDING: _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE AT OAKWOOD	817 SOUTHWEST 59TH STREET OKLAHOMA CITY, OK 73109

(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 was conducted from 04/22/25 through 04/23/25. Complaint investigations (#OK00075918, OK00076202, and #OK00080448) were conducted in conjunction with the survey. Facility Census: 80 Listed below are abbreviations that will be used throughout this document. APS - adult protective services	C 000		
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		

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C1911	Continued From page 1	C1911		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure incident reports were submitted to the department within 1 business day for 1 (#9) of 3 sampled residents whose charts were reviewed for timely submission of incident reports to the department.

The executive director identified 80 residents resided in the facility.

Findings:

On 04/23/25 the electronic medical record showed Resident #9 had diagnoses which included coronary artery disease, depressive disorder, and hypertension.

An undated facility policy titled, "Reporting Abuse, Neglect, and Misappropriation," read in part, "The executive director or designee will notify the appropriate regulatory agency. "

A facility investigation, dated 01/11/25 at 6:15 p.m., read in part, "Member reported to administration on 01/10/25 that their friend (another resident) had made sexual advances at them."

A facility investigation, dated 01/16/25 at 11:40 a.m., showed case manager #1 advised after the initial meeting with the executive director,

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C1911	Continued From page 2 Resident #9 reported a note was given to them by another resident that "contained at least one sentence of a sexual nature"..." and continues to express their desire for the other resident to stay away from them." On 04/23/25 at 1:10 p.m., the executive director was asked if they had received a report of unwanted sexual advances from one resident to another. They stated yes, they had received a report from a resident regarding unwanted sexual advances from another resident and they had investigated the incident. The executive director was asked if they reported the allegations of sexual abuse to the state agency and they stated "No, they did not."	C1911		

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/15/2025** **Facility Name:** Village at Oakwood **License Number:** AL5534 **Survey Event ID:** U1B011 **Date Survey Completed: 4/23/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1911	Based on: Based on record review and interview, the facility failed to ensure incident reports were submitted to the department within 1 business day for 1 (#9) of 3 sampled residents whose charts were reviewed for timely submission of incident reports to the department.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: At the time of the incident, the facility did not interpret the situation as sexual abuse and, therefore, did not submit a report to the Oklahoma State Department of Health. This determination was based on the context of the residents' prior relationship and observed behaviors. Resident #9 and the alleged resident had an established friendship and were frequently seen engaging in friendly interactions by both staff and other residents. Their relationship appeared mutually amicable, with reports of the alleged resident taking resident #9 out in his personal vehicle for meals off-site, running errands together, and spending time within the facility. These observations led staff and others to perceive a close and potentially reciprocal connection between the two residents. It is important to emphasize that the facility in no way discredits Resident #9's report or concerns. However, at the time, due to the nature of their prior interactions and the absence of any prior complaints, the incident was initially understood as a possible misunderstanding rather than a clear instance of abuse. The alleged resident expressed remorse for any discomfort caused and apologized for his actions. In hindsight, the facility acknowledges that, despite these contextual factors, the allegation itself may have warranted reporting under state regulations and has since updated its policies and procedures to ensure compliance moving forward. However, it should be understood that Resident #9 has re-establish a friendship with the alleged resident and resident #9 has asked the alleged resident to take her dog outside to use the restroom, had him run some errands for her, he took her to run errands in his personal vehicle, and they have gone out of the facility to eat together. This was all done without discussion with adminsitation at VAO and was kept undisclosed. VAO found out after the fact that these interactions had been happening and were being accepted and asked to be done by Resident #9. It is the alleged residents vehicle being used for outings away form the building and for which resident #9 is willing leaving in. She was asked about why she is doing this after the situations occurred for which she displayed distaste for the alleged resident and she said that she has forgiven him and just wants to move past it.

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 #9, who made the allegation of unwanted sexual advances, was interviewed and appropriate actions were taken to ensure their safety at the time of initial reporting, including separation from the alleged resident. The alleged resident was asked to refrain from any further contact with resident #9. The alleged residents Advantage Waiver case manager was made aware of the situation and the alleged resident was also educated by them that he was to avoid contact with resident #9. It was further established that continued unwanted physical contact could result in discharge from the facility. It was not reported at the time by Resident #9 that it was sexual abuse but instead was reported as unwanted physical contact and that resident #9 just wanted the alleged resident to stay away. At the time it was not believed that

	this was abuse but more of a misunderstanding by the alleged resident due to prior behavior and close friendship had prior to this reported incident. Although the internal investigation concluded the claim was more of a misunderstanding of the relationship that resulted in the unwanted physical contact, we recognize that the nature of the allegation may be interpurted as a qualified reportable incident. A **late incident report** has now been submitted to the Oklahoma State Department of Health (OSDH), for proper reporting and transparency. Additionally, the Executive Director (Administrator) received copy of the updated abuse, neglect, and misappropriation policy.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Staff and residents interviews will be completed to ensure no allegations were missed or unreported. Allegation that are found will be reviewed and reporting submitted to OSDH.
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 facility policy titled "**Reporting Abuse, Neglect, and Misappropriation**" has been **updated** to reflect explicit timelines and definitions of reportable incidents in accordance with **OAC 310:663-19-1(a)**. The policy now clearly states that **all reportable allegations of abuse must be reported to OSDH within one business day**. All staff were in-serviced on reporting alegations of abuse, neglect, and misappropriation on May 9 through May 10, 2025. All administrative staff and department heads received **mandatory in-service training** on May 8, 2025, focused on identifying reportable events, using the correct forms (including ODH Form 718), and timelines for initial, follow-up, and final reporting. Identified future allegations will prompting the Director of Nursing or Executive Director (Administrator) or designee to submit reports.
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.	Enter methods to ensure corrections are sustained: A monthly audit of all incident reports will be performed by the Director of Nursing (DON) and Executive Director (Administrator) for six months to ensure that: All reportable events are submitted within 1 business day. ODH Form 718 is used when applicable. Internal investigations and final reports meet the 10-day maximum timeline. Compliance with reporting timelines will be a standing agenda item in Quality Assurance meetings. Incident reporting compliance will be tracked and discussed, with corrective steps planned immediately upon identification of any lapse.

	An Incident Report Log will be maintained and signed monthly by both the Executive Director (Administrator) and DON for the 6 month period confirming review and ensuring carry over of effective reporting. It will contain the date of incident, date discovered, date reported to OSDH, and confirmation of follow-up/final reports. This log and supporting documentation will be retained in the facility's compliance file/binder and made available to surveyors upon request.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/23/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required OAC 310:663-25-4(F) Idelia Oglesby	**Date 5/15/2025**

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.

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	AL5534	A. BUILDING: _____ B. WING _____	C 04/23/2025

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	AL5534	A. BUILDING: _____ B. WING _____	C 04/23/2025

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VILLAGE AT OAKWOOD	817 SOUTHWEST 59TH STREET OKLAHOMA CITY, OK 73109

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OKLAHOMA
State Department of Health

Delivery via email to: foglesby@villageatoakwood.com

June 2, 2025

License Number: AL5534

Ms. Fidelia Oglesby, Executive Director
Village At Oakwood
817 Southwest 59th Street
Oklahoma City, OK 73109

RE: Survey Event U1B012

Dear Ms. Oglesby:

On **May 27, 2025,** an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your survey on **May 23, 2025,** have now been corrected effective **May 23, 2025.**

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

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5534	A. BUILDING: _____ B. WING _____	R-C 05/27/2025

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 05/27/25. 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