OKLAHOMA
State Department
of Health

Delivery via email to: laura.leehan@jasmineestatesokc.com

August 18, 2025

License Number: AL5543

Laura Leehan, Administrator
Jasmine Estates Of Oklahoma City
2232 Southwest 104th Street
Oklahoma City, OK 73159

Survey Event ID: 3VM111

Dear Ms. Leehan:

On **August 8, 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
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 OSDH.LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Jasmine Estates OKC
Address:2232 SW 104th St.
City, State, Zip: Oklahoma City, OK, 73159
Provider #: AL5543
Complaint #: OK00084992
Investigation Date(s):08/07/25 -08/0825

ALLEGATION(S)
The center failed to provide adequate supervision to prevent elopements of missing residents.

An unannounced on-site investigation was initiated 08/07/2025 at 8:50 a.m..

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the facility was conducted at entrance and various times throughout the survey.

Physician orders, nursing notes, care plans and diagnosis were reviewed. Incident reports, grievances and company policy and procedures were reviewed. Admission packets and face sheets were reviewed.

Resident observations were conducted.

Residents were asked if they felt safe.

Residents were asked if they ever left the facility without telling anyone.

Residents were asked if they had any concerns.

Staff were asked about elopement policy and procedures.

Staff were asked about how to prevent elopement.

Staff were asked if they have witnessed elopement.

Staff were asked how often they perform well checks on residents.

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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: 08/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	C 08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 complaint investigation (#OK00084992) was conducted on 08/07/25 through 08/08/25. Deficiencies were cited as a result of the survey. Facility Census: 42	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to provide supervision for 1 (#1) of 3 residents reviewed for elopement.

The administrator reported 42 residents resided in the facility.

Findings:

An undated facility's policy titled "Resident Care and Services," read in part, "All services will be tailored to each individual's specific needs. This service plan will be the basis for coordination of services"..."Care team members will be familiar with each resident's needs and overall situation."

A comprehensive assessment, dated 05/09/25, read in part, "Elopement risk assessment, Resident #1 has a history of leaving home, other facilities, or current community in the past 6 months; resident has exit seeking tendencies."

An undated face sheet in the electronic records showed Resident #1 was admitted to the facility on 04/28/25.

A care plan, dated 05/09/25, read in part, "Elopement Risk Intervention dated 07/19/25, spot check order increased to 12 times daily." The facility failed to document 19 opportunities to monitor Resident #1 for elopement.

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C1505	Continued From page 2 An incident report, dated 07/19/25, read in part, "Staff were notified by another family member that Resident #1 was observed walking to the side walk headed north at 1:55 p.m. on 07/19/25. CNA #1 exited the building to observe Resident #1 crossing the road at 1:56 p.m., CNA #1 were able to catch up to Resident #1." A care plan tracking sheet, dated 07/20/25, read in part, "The increased elopement spot interventions did not start until 07/22/25 at 6:00 p.m." On 08/07/25 at 1:55 p.m., CNA #1 stated another resident family member came and told them Resident #1 was on the sidewalk about to cross the street. There was no staff following Resident #1. On 08/07/25 at 1:56 p.m., CNA #1 stated they observed Resident #1 crossing the four lane street with no staff. On 08/07/25 at 4:39 p.m., the senior executive director stated they had the updated care plan elopement interventions started on 07/19/25, but they did not start documenting the spot check orders until 07/22/25 at 4:39 p.m.	C1505		

Oklahoma State Department of Health

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	AL5543	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 09/05/25. 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

OKLAHOMA
State Department of Health

Delivery via email to: laura.leehan@jasmineestatesokc.com

August 27, 2025

License Number: AL5543

Laura Leehan, Administrator
Jasmine Estates Of Oklahoma City
2232 Southwest 104th Street
Oklahoma City, OK 73159

Survey Event ID: 3VM111

Dear Ms. Leehan:

On **August 8, 2025,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 28, 2025**.

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/26/2025** **Facility Name:** Jasmine Estates OKC **License Number:** AL5543 **Survey Event ID:** 3VM111 **Date Survey Completed: 8/8/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Based on record review and interview, the facility failed to provide supervision for 1 (#1) of 3 residents reviewed for elopement.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Regarding Citation C1505: The facility is committed to ensuring appropriate and frequent elopement prevention training and regular implementation of elopement drills.

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 affected resident/s will be closely monitored by staff, especially during day's & time's that the front door (high risk area) is not monitored by office/admin staff.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An elopement risk sheet will be provided to all staff identifying residents with exit seeking behaviors, including a picture of the resident and other relevant information.
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?	Door alarms /egress are currently in place on all exit door's. Staff have been reminded of the importance of responding to the alarms immediately. Med Aide's have been instructed to place their cart in high risk area's during their med-pass to ensure additional observation. Weekend activity staff have been advised to execute activities in the front entry (high risk area) for greater observation.
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.	Continuing education for all staff will be conducted regularly. a. Correction will be monitored and evaluated on a quarterly basis (Elopement Drill), requiring all staff to verbalize and demonstrate understanding. An Elopement Drill is scheduled for 8/28/2025. b. An Elopement Prevention In-Service was conducted between 8/11-8/13 for all staff and has been added to the new hire on-boarding packet. Elopement risk and prevention will be monitored closely and reviewed in quarterly QAIP Committee Meeting. c. WD will ensure that care plan's and assessments are up to date with any changes updated in a timely manner. Facility incident reports will be filled out in addition to State incident forms in a

	timely manner and filed in ED & WD office. Reporting and filing practices will be reviewed during quarterly QAIP Committee Meeting.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	8/28/2025		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Laura J. Leehan** OAC 310:663-25-4(F)		**Date 8/26/2025**	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department of Health

Delivery via email to: laura.leehan@jasmineestatesokc.com

September 5, 2025

License Number: AL5543

Laura Leehan, Administrator
Jasmine Estates Of Oklahoma City
2232 Southwest 104th Street
Oklahoma City, OK 73159

Survey Event ID: 3VM112

Dear Ms. Leehan:

On **September 5, 2025,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **August 8, 2025,** have now been corrected effective **August 28, 2025.**

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

Respectfully,

Lisa Calvin

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

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 09/05/25. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health
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