OKLAHOMA
State Department
of Health

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

April 3, 2026

License Number: AL5543

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

Survey Event ID: Q7P511

Dear Ms. Leehan:

On **March 13, 2026,** 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 OF OKLAHOMA CITY
Address: 2232 SOUTHWEST 104TH STREET
City, State, Zip: OKLAHOMA CITY, OK, 73159
Provider #: AL5543
Complaint #: OK00089942
Investigation Date(s): 03/11/26 through 03/13/26

ALLEGATION(S)
The center failed to ensure residents were not abused.
The facility failed to ensure the Hoyer lift was utilized with 2 staff members.
The center failed to ensure therapeutic diets were provided according to physician orders.
The center failed to ensure adequate staff to safely meet the needs of the residents.

An unannounced on-site investigation was initiated 03/11/2026 at 10:22 a.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Residents were observed for lift transfers, meals, and staff interactions with residents. Staff on duty was observed.

Facility policy and procedures were reviewed. Nurses' notes, physician orders, and resident assessments were reviewed. State reportables and staff schedules, in-services, and background checks were reviewed.

Residents were interviewed regarding abuse, lift transfers, diets, and adequate staffing. Staff were interviewed regarding facility policy and procedure related to abuse, lift transfers, diets, and adequate staffing.

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: 03/13/2026

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 03/13/2026

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 (#OK00089942) was conducted on 03/11/26 through 03/13/26. Facility Census: 35 Listed below are abbreviations that will be used throughout this document. CNA- certified nurse aide	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure a comprehensive assessment was completed every 12 months for 1 (#3) of 8 sampled residents reviewed for comprehensive assessments. The administrator identified 35 residents resided in the center. Findings: An admission comprehensive assessment for Resident #3, dated 01/31/25, showed the resident was admitted to the center on 01/24/25 with	C 522		

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C 522	Continued From page 1 diagnoses which included Parkinson's and altered mental status. A review of Resident #3's assessments did not contain an annual comprehensive assessment for 01/2026. On 03/13/26 at 10:01 a.m., the wellness director stated unless the resident had a significant change in condition, an annual assessment should have been completed by 01/31/26. On 03/13/26 at 10:03 a.m., the wellness director stated an annual assessment was not completed for Resident #3. They stated there was no other comprehensive assessment completed for Resident #3.	C 522		
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	C1505		

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C1505	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure: a. a sit-to-stand mechanical lift had brakes and the lowering mechanism was functional for 1 (#8), and b. a resident had post fall care plan interventions for 1 (#3) of 3 sampled residents reviewed for accidents. The wellness director identified six residents used a mechanical lift device for transfers resided in the center. Findings: 1. On 03/11/26 at 10:53 a.m., CNA #1 and CNA #2 was observed to assist Resident #8 to a standing position from their Geri-chair using a sit-to-stand mechanical lift. CNA #1 used their feet to block the lift from sliding. CNA #1 and CNA #2 checked the resident for incontinence. CNA #1 lowered the resident down by pushing on the handlebar with their hands. An undated facility "Resident Handling & Mechanical Lift Use" policy, read in part, "Malfunctioning equipment shall be removed from service and reported immediately."	C1505		

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C1505	Continued From page 3 On 03/11/26 at 10:53 a.m., CNA #1 stated the lift did not have a brake. On 03/11/26 at 10:55 a.m., CNA #1 stated the lift was supposed to lower the resident down when the knob on the lift was moved to position but it did not so they had to push the handle to lower the resident. CNA #1 stated they used the lift to get Resident #8 out of bed and for incontinent care. On 03/12/26 at 9:40 a.m., CNA #1 stated the sit-to-stand lift had not had a brake since it was brought to the facility when the resident admitted. They stated the resident's hospice company was aware because their staff used the lift for transfer assistance. They stated they reported the lift problem to the hospice company on 03/11/26. On 03/12/26 at 9:45 a.m., CNA #1 stated they had not reported the problems with the lift to the facility. On 03/12/26 at 11:22 a.m., the wellness director stated they were made aware of Resident #8's lift issues today. On 03/12/26 at 11:24 a.m., the wellness director stated staff were supposed to report mechanical lift issues to them or the medication aide. They stated they would notify the hospice company. On 03/13/26 at 12:40 p.m., the hospice representative stated they were not aware Resident #8's lift did not have a brake or the lowering mechanism was not functioning. On 03/13/26 at 12:43 p.m., the hospice representative stated they relied on	C1505		

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C1505	Continued From page 4 communication with third parties and expected them to communicate if something was not right. 2. An undated facility "Fall Prevention" policy, read in part, "If indicated by assessment, fall interventions will be initiated and care planned. Continued monitoring will occur and care plan with [sic] be updated as indicated." An undated resident face sheet for Resident #3 showed the resident was admitted on 11/10/25 with a diagnosis of dementia. A care plan for Resident #3, dated 12/01/25, showed the resident had a risk for falls and ambulates with wheelchair and one person assistance. The care plan showed the resident used a sit-to-stand mechanical lift. A review of Resident #3's progress notes, from 12/2025 through 03/2026 showed the resident had non injury falls on 12/15/25, 01/17/26, 01/19/26, 02/15/26, and 02/25/26. There was no documentation the resident's care plan was updated with each fall. On 3/12/26 at 11:58 a.m. the wellness director stated they should have updated Resident #3's care plan with fall interventions after each fall. On 03/12/26 at 2:08 p.m., certified medication aide #2 stated Resident #3 had falls in the facility.	C1505		
C5015 SS=D	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria:	C5015		

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C5015	Continued From page 5 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a resident who required specialized equipment had a plan of accommodation for 1 (#8) of 3 sampled residents reviewed for accidents. The wellness director identified six residents used a mechanical lift device for transfers resided in the center. Findings: On 03/11/26 at 10:53 a.m., CNA #1 and CNA #2 was observed to assist Resident #8 to a standing	C5015		

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C5015	Continued From page 6	C5015		

position from their Geri-chair using a sit-to-stand mechanical lift. CNA #1 and CNA #2 checked the resident for incontinence.

An undated facility "Jasmine Estates Memory Care Admission Criteria Policy," read in part, "A resident may be admitted to Jasmine Estates Memory Care when the individual requires one or more of the following services"..."6. Mobility Assistance"..."Assistance with ambulation, transfers, or the use of mobility aids such as walkers or wheelchairs."

A comprehensive assessment for Resident #8, dated 01/30/26, showed the resident was admitted to the center on 01/30/26 with diagnoses which included dementia and muscle weakness. The assessment showed the resident required two person assistance with transfers and used a mechanical lift device.

There was no documentation the facility had an accommodation of needs to address Resident #8 use of the mechanical lift device.

On 03/11/26 at 10:55 a.m., CNA #1 stated they used the lift to get Resident #8 out of bed and for incontinent care.

On 03/12/26 at 1:38 p.m., the wellness director stated Resident #8 did not have a plan of accommodation.

On 03/13/26 at 3:03 p.m., the administrator stated the facility's admission criteria did not include residents who used mechanical lift device for transfers.

OKLAHOMA
State Department of Health

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

April 17, 2026

CCN:
Survey Event ID: **Q7P511**

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

Dear Ms. Leehan:

On **March 13, 2026**, 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:

- **C522-** The plan of correction does not include any responsible staff, education or QAPI monitoring.

- **C1505-** The plan of correction does not sufficiently address: Part a. of based on statement (mechanical lift)- No systemic process for monitoring and QAPI monitoring; and Part b. of based on statement (post fall care plan interventions)- No responsible staff, Education, systemic process for monitoring, and QAPI monitoring.

- **C5015-** The plan of correction does not include/identify responsible staff, Education, systemic process for monitoring, and QAPI monitoring.

Please provide an AMENDED plan of correction for these deficiencies and return with amendments as soon as possible. **Medicare/Medicaid certification cannot be processed without an acceptable plan of correction.**

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A complaint investigation (#OK00089942) was conducted on 03/11/26 through 03/13/26. Facility Census: 35 Listed below are abbreviations that will be used throughout this document. CNA- certified nurse aide	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure a comprehensive assessment was completed every 12 months for 1 (#3) of 8 sampled residents reviewed for comprehensive assessments. The administrator identified 35 residents resided in the center. Findings: An admission comprehensive assessment for Resident #3, dated 01/31/25, showed the resident was admitted to the center on 01/24/25 with	C 522	**POC Response to C 522** **A facility policy addressing Assessment and Care Plan Time Frames has been developed and implemented.** **All resident assessments are currently being audited audited by the Wellness Director to ensure completion and accuracy.** **Care plan meetings have been scheduled with responsible parties - care plans are under review and will be updated accordingly to reflect current resident needs and any identified changes in condition.** **Resident #3 passed away on 2/22/26**	3/18/26 4/30/26 4/30/26

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C 522	Continued From page 1 diagnoses which included Parkinson's and altered mental status. A review of Resident #3's assessments did not contain an annual comprehensive assessment for 01/2026. On 03/13/26 at 10:01 a.m., the wellness director stated unless the resident had a significant change in condition, an annual assessment should have been completed by 01/31/26. On 03/13/26 at 10:03 a.m., the wellness director stated an annual assessment was not completed for Resident #3. They stated there was no other comprehensive assessment completed for Resident #3.	C 522		
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	C1505	**POC Response to C 1505** **All staff have been in-serviced on Residents Rights. The Residents Bill of Rights is included in the new hire orientation packet, posted in the employee break room, and hung in the front entry of the building.**	**4/9/26**

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C1505	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure: a. a sit-to-stand mechanical lift had brakes and the lowering mechanism was functional for 1 (#8), and b. a resident had post fall care plan interventions for 1 (#3) of 3 sampled residents reviewed for accidents. The wellness director identified six residents used a mechanical lift device for transfers resided in the center. Findings: 1. On 03/11/26 at 10:53 a.m., CNA #1 and CNA #2 was observed to assist Resident #8 to a standing position from their Geri-chair using a sit-to-stand mechanical lift. CNA #1 used their feet to block the lift from sliding. CNA #1 and CNA #2 checked the resident for incontinence. CNA #1 lowered the resident down by pushing on the handlebar with their hands. An undated facility "Resident Handling & Mechanical Lift Use" policy, read in part, "Malfunctioning equipment shall be removed from service and reported immediately."	C1505	**Resident #8 passed away on 3/20/2026** **Center currently has 5 residents who require the use of mechanical equipment.** **See response below. The formatted font on this page is too small**	

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 03/13/2026

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
C1505	Continued From page 3 On 03/11/26 at 10:53 a.m., CNA #1 stated the lift did not have a brake. On 03/11/26 at 10:55 a.m., CNA #1 stated the lift was supposed to lower the resident down when the knob on the lift was moved to position but it did not so they had to push the handle to lower the resident. CNA #1 stated they used the lift to get Resident #8 out of bed and for incontinent care. On 03/12/26 at 9:40 a.m., CNA #1 stated the sit-to-stand lift had not had a brake since it was brought to the facility when the resident admitted. They stated the resident's hospice company was aware because their staff used the lift for transfer assistance. They stated they reported the lift problem to the hospice company on 03/11/26. On 03/12/26 at 9:45 a.m., CNA #1 stated they had not reported the problems with the lift to the facility. On 03/12/26 at 11:22 a.m., the wellness director stated they were made aware of Resident #8's lift issues today. On 03/12/26 at 11:24 a.m., the wellness director stated staff were supposed to report mechanical lift issues to them or the medication aide. They stated they would notify the hospice company. On 03/13/26 at 12:40 p.m., the hospice representative stated they were not aware Resident #8's lift did not have a brake or the lowering mechanism was not functioning. On 03/13/26 at 12:43 p.m., the hospice representative stated they relied on	C1505	The policy has been renamed to "Resident Transfer & Mechanical Lift Safety" and has been revised to include disciplinary action for failure to adhere to policy requirements. Staff have been in-serviced on Mechanical Lift Safety and Incident Reporting. including proper transfer techniques, equipment safety checks, and the requirement to immediately report any incidents, malfunctions, or safety concerns related to mechanical lift use. Upon discovery of the faulty equipment, hospice ordered a new sit-to-stand lift for resident #8 which was delivered immediately. The resident has since passed away on 3/20/2026	4/2/26 4/9/26 3/13/26

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 03/13/2026

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C1505	Continued From page 4 communication with third parties and expected them to communicate if something was not right. 2. An undated facility "Fall Prevention" policy, read in part, "If indicated by assessment, fall interventions will be initiated and care planned. Continued monitoring will occur and care plan with [sic] be updated as indicated." An undated resident face sheet for Resident #3 showed the resident was admitted on 11/10/25 with a diagnosis of dementia. A care plan for Resident #3, dated 12/01/25, showed the resident had a risk for falls and ambulates with wheelchair and one person assistance. The care plan showed the resident used a sit-to-stand mechanical lift. A review of Resident #3's progress notes, from 12/2025 through 03/2026 showed the resident had non injury falls on 12/15/25, 01/17/26, 01/19/26, 02/15/26, and 02/25/26. There was no documentation the resident's care plan was updated with each fall. On 3/12/26 at 11:58 a.m. the wellness director stated they should have updated Resident #3's care plan with fall interventions after each fall. On 03/12/26 at 2:08 p.m., certified medication aide #2 stated Resident #3 had falls in the facility.	C1505	POC Response to C 1505 Cont: The Fall Prevention Policy has been reviewed and updated to provide a more comprehensive and detailed outline of the facility's fall prevention procedures, interventions, and expectations for staff compliance. Care plan has been updated to indicate relevant changes and post fall care plan interventions for resident #3	4/2/26 4/13/26
C5015 SS=D	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria:	C5015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C5015	Continued From page 5 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a resident who required specialized equipment had a plan of accommodation for 1 (#8) of 3 sampled residents reviewed for accidents. The wellness director identified six residents used a mechanical lift device for transfers resided in the center. Findings: On 03/11/26 at 10:53 a.m., CNA #1 and CNA #2 was observed to assist Resident #8 to a standing	C5015	**POC Response to C 5015:** **Plan of accommodation has been implemented for 5 residents requiring use of mechanical lift equipment and will be signed by center physician, Wellness Director, and resident representative. Equipment will be inspected by a hospice representative or qualified designee on a quarterly basis. Wellness Director has conducted initial inspection.** **Currently five residents in the community require mechanical equipment. One of the 6 residents has passed away (resident #8)**	**4/17/26**

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 03/13/2026

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

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C5015	Continued From page 6 position from their Geri-chair using a sit-to-stand mechanical lift. CNA #1 and CNA #2 checked the resident for incontinence. An undated facility "Jasmine Estates Memory Care Admission Criteria Policy," read in part, "A resident may be admitted to Jasmine Estates Memory Care when the individual requires one or more of the following services"..."6. Mobility Assistance"..."Assistance with ambulation, transfers, or the use of mobility aids such as walkers or wheelchairs." A comprehensive assessment for Resident #8, dated 01/30/26, showed the resident was admitted to the center on 01/30/26 with diagnoses which included dementia and muscle weakness. The assessment showed the resident required two person assistance with transfers and used a mechanical lift device. There was no documentation the facility had an accommodation of needs to address Resident #8 use of the mechanical lift device. On 03/11/26 at 10:55 a.m., CNA #1 stated they used the lift to get Resident #8 out of bed and for incontinent care. On 03/12/26 at 1:38 p.m., the wellness director stated Resident #8 did not have a plan of accommodation. On 03/13/26 at 3:03 p.m., the administrator stated the facility's admission criteria did not include residents who used mechanical lift device for transfers.	C5015	**POC Response to C 5015Cont:** **The facility Admission Criteria has been updated to include specific criteria on use of mechanical equipment based on change of condition only.** **Resident #8 passed away on 3/20/26 prior to plan of accommodation form being implemented.**	**4/9/26**

OKLAHOMA
State Department of Health

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

May 8, 2026

License Number: AL5543

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

Survey Event ID: Q7P511

Dear Ms. Leehan:

On **March 13, 2026,** 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 amended plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 15, 2026**.

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/18/2026** **Facility Name:** Jasmine Estates Memory Care **License Number:** AL5543 **Survey Event ID:** Q7P511 **Date Survey Completed: 3/13/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 522	Based on: Based on record review and interview, the centerfailed to ensure a comprehensive assessmentwas completed every 12 months for 1 (#3) of 8sampled residents reviewed for comprehensiveassessments

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The facility acknowledges the requirement for timely comprehensive assessments and is conducting a review of current residents to determine if any others were affected. Corrective actions are being implemented to ensure compliance with required timeframes.

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 identified resident (#3) was no longer residing in the facility at the time the deficient practice was identified due to being deceased. Therefore, a comprehensive assessment could not be completed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The center has implemented a system to ensure timely completion of comprehensive assessments and care plans. The electronic medical record system (Alis) will be utilized to track all resident assessment and care plan due dates. Staff have been In-Serviced/educated on appropriate documenting and reporting of changes in resident condition. In addition, A facility policy addressing Assessment and Care Plan Time Frames has been developed and implemented.
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 Wellness Director, Neke Sims or will review Alis on a weekly basis to monitor residents with upcoming annual comprehensive assessment due dates and ensure completion within required timeframes. A weekly clinical meeting between the Wellness Director, Neke Sims, and the Executive Director, Laura Leehan will be conducted to review all residents, discuss any changes in condition, and identify care needs. Care plans will be updated in a timely manner based on any significant changes identified during these reviews.
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	A resident Care Tracking Form has been implemented and will be used to indicate change of condition in resident/s and will be charted in Alis accordingly. The tracking form will be maintained in a file to be kept in the Wellness Directors office. a. Wellness Director, Neke Sims will Monitor care plan and

c. How monitoring records will be kept to evidence the correction.	assessment time frames in Alis to ensure facility compliance and timely completion. b. This correction will be incorporated into the centers QA program. The identified deficiency related to timely completion of comprehensive assessments will be reviewed at the scheduled QA meeting on 4/30/2026. At that time, the Wellness Director, Neke Sims, will present audit results from ALIS tracking, weekly clinical review findings, and compliance monitoring related to annual assessments and change of condition care plan updates.This topic will remain on the QA agenda and be reviewed quarterly thereafter to ensure ongoing compliance, identify trends, and verify required corrective action. c. Monitoring records will be maintained in a QA file kept in the Executive Directors office. The Wellness Director, Neke Sims, will document weekly ALIS reviews, monthly audits, and any identified issues or corrective actions. Change of condition tracking forms, and review summaries will be filed in the QA File. These documents will be reviewed during quarterly QA meetings to show ongoing compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/15/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Laura J. Leehan** OAC 310:663-25-4(F)	**Date 4/20/2026**

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	4/20/2026	**Submitted by**	Laura J. Leehan, Executive Director

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/20/2026** **Facility Name:** Jasmine Estates Memory Care **License Number:** AL5543 **Survey Event ID:** Q7P511 **Date Survey Completed: 3/13/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505 Part A	Based on: Based on observation, record review, andinterview, the center failed to ensure:a. a sit-to-stand mechanical lift had brakes andthe lowering mechanism was functional for 1 (#8)

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The facility acknowledges the importance of maintaining mechanical lift equipment in safe working condition to ensure safe resident handling and prevention of injury to staff and resident.

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?	Upon discovery of the faulty sit-to-stand lift, hospice services ordered a replacement lift for resident #8, which was delivered immediately (3/13/26) to ensure safe transfer capability. Resident #8 has since passed away on 3/20/2026; therefore, no further corrective action is applicable for the resident.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Mechanical lift equipment (sit-to-stand/Hoyer) have undergone a complete inspection by Wellness Director, Neke Sims for functionality & safety for the five remaining residents who require use of the equipment for lifting and transitioning purposes. The inspections have been noted on the plan of accommodation form for residents requiring mechanical equipment.
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?	Staff have been in-serviced/educated by Wellness Director, Neke Sims on mechanical lift safety and incident reporting, including proper transfer techniques, equipment safety checks, and the requirement to immediately report any incidents, malfunctions, or safety concerns related to mechanical lift use. The company policy "Resident Transfer & Mechanical Lift Safety" and has been revised to include quarterly monitoring and disciplinary action for failure to adhere to policy requirements.
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	The center will monitor its performance to make sure corrections are sustained by maintaining documentation and reporting on equipment inspections, staff compliance, and incident trends through routine audits and quality assurance reviews. a.Center will ensure that mechanical lift equipment will be inspected on a quarterly basis by the Wellness Director,

correction.	Neke Sims or a Hopice designee. Faulty equipment identified prior to quarterly checks will be replaced immediately by the respective Hospice company and documentation will be noted in Alis. b. Compliance will be verified through review of incident reports and staff adherence to lift safety procedures during routine observations. Findings will be reviewed and reported during the facility's QA meeting, scheduled on 4/30/2026 and quarterly QA thereafter to ensure compliance and corrective measures if applicable. c. A plan of accommodation form has been implemented for all residents requiring mechanical lift equipment. The form includes an initial inspection verification and a quarterly inspection schedule. All forms have been signed by Wellness Director, Neke Sims, Medical Director, Dr. Krablin, and families-POA. The forms will be maintained in a file in the Wellness Directors office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/24/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Laura J. Leehan** OAC 310:663-25-4(F)	**Date 4/20/2026**

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	4/20/2026	**Submitted by**	Laura J. Leehan, Executive Director

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/20/2026** **Facility Name:** Jasmine Estates Memory care **License Number:** AL5543 **Survey Event ID:** Q7P511 **Date Survey Completed: 3/13/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505 Part B	Based on: Based on observation, record review, and interview, the center failed to ensure a resident had post fall care plan interventions for 1 (#3) of 3 sampled residents reviewed for accidents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The center is committed to ensuring timely review and revision of care plans following all fall incidents to maintain resident safety and regulatory compliance.

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?	Care plan for resident #3 has been updated by Wellness Director, Neke Sims to reflect post fall care plan interventions.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All current residents with a history of falls or identified fall risk will have their care plans audited by Wellness Director, Neke Sims to ensure post-fall care plan interventions are in place. Any resident found without appropriate interventions will have their care plan promptly updated to reflect individualized post-fall measures.
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?	A post-fall checklist has been put into place to ensure all required steps, including documentation and care plan revision, are completed in timely manner. Staff have been re-educated on expectations for post-fall interventions and documentation, and routine re-educaiton and staff observations of fall protocol will be conducted to ensure ongoing adherence to policy & procedure..
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 center will monitor sustained compliance through ongoing monthly audits of fall incidents and applicable care plan updates. a.The Wellness Director, Neke Sims will review all fall reports to ensure post-fall interventions are implemented timely and appropriately documented. b. Post-fall assessments and care plan results will be reviewed during QA meeting on 4/30/2026 and quarterly thereafter to identify trends and ensure corrective actions are implemented as needed. Any deficiencies identified through audits will trigger immediate re-education and follow-up review to ensure compliance.

	c. Post fall assessments and incidednt reports will be retained in Alis and reviewed monthly by the Wellness Director, Neke Sims.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/15/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Laura J. Leehan OAC 310:663-25-4(F)	**Date 4/20/2026**

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	4/20/2026	**Submitted by**	Laura. J. Leehan, Executive Director

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Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/21/2026** **Facility Name:** Jasmine Estates Memory Care **License Number:** AL5543 **Survey Event ID:** Q7P511 **Date Survey Completed: 3/13/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C5015	Based on: Based on observation, record review, and interview, the center failed to ensure a resident who required specialized equipment had a plan ofaccommodation for 1 (#8) of 3 sampled residentsreviewed for accidents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The facility acknowledges that plans of accommodation were not in place for several residents requiring the use of mechanical equipment and has implemented corrective actions to ensure all residents have appropriate plans in place moving forward.

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 (#8) passed away on 3/20/26 prior to implementation of the plan of accommodation form.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Five (5) additional residents were identified as requiring the use of mechanical lift equipment. The center has ensured that all identified residents now have individualized plans of accommodation in place, and care plans have been audited and/or updated accordingly to reflect current needs and safety requirements.
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 Admission Criteria has been updated to include specific guidance regarding the use of mechanical equipment. An in-service education on mechanical lift safety, change of condition reporting, and reporting of faulty or malfunctioning equipment was conducted on 4/9/26 and facilitated by the Wellness Director, Neke Sims. Clinical staff have been educated by the Wellness Director on identifying and promptly reporting changes in resident condition that result in increased assistance needs with transfers, as well as immediately reporting any concerns related to mechanical lift safety, performance, or equipment malfunction.
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 center will monitor performance through monthly audits of care plans to ensure all residents requiring mechanical equipment have current plans of accommodation in place. a. Effectiveness of the correction will be evaluated through monthly audits of care plans and related documentation to verify that all residents requiring mechanical equipment have current plans of accommodation in place and that

	transfer needs are accurately identified and updated as changes occur. b. The correction will be incorporated into the center's QA program through monthly audits of care plans and related documentation to ensure all residents requiring mechanical equipment have current plans of accommodation in place and that transfer needs are accurately identified and updated as changes occur. Findings will be reviewed in the QA on 4/30/2026 and on a quarterly basis thereafter to identify trends, and ensure ongoing compliance. c. Plan of accommodation forms for all residents requiring mechanical equipment will be kept in a file in the Wellness Director's office. Forms will be completed and signed by the Wellness Director, Medical Director, and resident family/POA, and updated as needed. Records will be maintained in an organized file and available for review during audits, QA monitoring, and surveys to show compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Laura J. Leehan** OAC 310:663-25-4(F)	**Date 4/21/2026**

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	4/21/2026	**Submitted by**	Laura J. Leehan, Executive Director

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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

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

June 1, 2026

License Number: AL5543

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

RE: Survey Event Q7P512

Dear Ms. Leehan:

On **May 28, 2026,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **March 13, 2026,** have now been corrected effective **May 15, 2026.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	R-C 05/28/2026

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 revisit survey was conducted on 05/28/26. All deficiencies from the 03/13/26 survey were cleared.	{C 000}		

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