OKLAHOMA
State Department of Health

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

April 2, 2026

License Number: AL5543

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

Survey Event ID: QPCE11

Dear Ms. Leehan:

On **March 5, 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 #: **OK00086031**
Investigation Date(s): **03/03/26 through 03/05/26**

ALLEGATION
The center failed to protect residents from abuse.

An unannounced on-site investigation was initiated 03/03/2026 at 8:28 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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 center was conducted upon entrance and at other various times throughout the survey. Residents were observed in their rooms, in common areas, during meal services, and during activities. Hallways were observed for staff assistance with resident care needs. Resident and staff interactions were observed.

Resident records were reviewed including assessments, care plans, physician orders, progress notes, treatment records, and activities of daily living (ADL) records. Facility policy and procedures were reviewed. State reports and grievances were reviewed.

Family members were interviewed in regard to abuse. Staff were interviewed in regard to the centers abuse policy.

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: 03/09/2026

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 #: **OK00087523**
Investigation Date(s): **03/03/26 through 03/05/26**

ALLEGATION
The center failed to protect residents from abuse.

An unannounced on-site investigation was initiated 03/03/2026 at 8:28 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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 center was conducted upon entrance and at other various times throughout the survey. Residents were observed in their rooms, in common areas, during meal services, and during activities. Hallways were observed for staff assistance with resident care needs. Resident and staff interactions were observed.

Resident records were reviewed including assessments, care plans, physician orders, progress notes, treatment records, and activities of daily living (ADL) records. Facility policy and procedures were reviewed. State reports and grievances were reviewed.

Family members were interviewed in regard to abuse. Staff were interviewed in regard to the centers abuse policy.

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

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Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/09/2026

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INVESTIGATIVE REPORT

Facility: **Jasmine Estates of Oklahoma City**
Address: **2232 Southwest 104th Street**
City, State, Zip: **Oklahoma City, OK, 73159**
Provider #: **AL5543**
Complaint #: **OK00087637**
Investigation Date(s): **03/03/26 through 03/05/26**

ALLEGATION
The center failed to ensure care and treatment was provided according to the plan of care and standard of care.

An unannounced on-site investigation was initiated 05/02/2023 at 8:28 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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 center was conducted upon entrance and at other various times throughout the survey. Residents were observed in their rooms, in common areas, during meal services, and during activities. Hallways were observed for staff assistance with resident care needs. Resident and staff interactions were observed.

Resident records were reviewed including assessments, care plans, physician orders, weight tracking and variance reports, progress notes, treatment records, and activities of daily living (ADL) records. Facility policy and procedures were reviewed. State reports and grievances were reviewed.

Family members were interviewed in regard to care provided to residents. Staff were interviewed in regard to providing adequate care to residents.

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

Thank you for bringing your concerns to our attention.

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Facility: **Jasmine Estates of Oklahoma City**
Address: **2232 Southwest 104th Street**
City, State, Zip: **Oklahoma City, OK, 73159**
Provider #: **AL5543**
Complaint #: **OK00088710**
Investigation Date(s): **03/03/26 through 03/05/26**

ALLEGATIONS
The center failed to provide adequate care and supervision to prevent accidents with major injury.
The center failed to provide adequate and appropriate medical care after a fall.

An unannounced on-site investigation was initiated 03/03/2026 at 8:28 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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 center was conducted upon entrance and at other various times throughout the survey. Residents were observed in their rooms, in common areas, during meal services, and during activities. Hallways were observed for staff assistance with resident care needs. Resident and staff interactions were observed.

Resident records were reviewed including assessments, care plans, physician orders, hospice records, fall reports, progress notes, treatment records, and activities of daily living (ADL) records.

Facility policy and procedures were reviewed. State reports and grievances were reviewed.

Family members were interviewed in regard to care provided to residents. Staff were interviewed in regard to providing adequate care to residents.

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

Thank you for bringing your concerns to our attention.

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INVESTIGATIVE REPORT

Facility: **Jasmine Estates of Oklahoma City**
Address: **2232 Southwest 104th Street**
City, State, Zip: **Oklahoma City, OK, 73159**
Provider #: **AL5543**
Complaint #: **OK00089673**
Investigation Date(s): **03/03/26 through 03/05/26**

ALLEGATIONS
The center failed to ensure incidents of falls were reported according to State law.
The center failed to ensure records were not falsified.
The center failed to ensure a safe, comfortable, and homelike environment.

An unannounced on-site investigation was initiated 03/03/2026 at 8:28 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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 center was conducted upon entrance and at other various times throughout the survey. Residents were observed in their rooms, in common areas, during meal services, and during activities. Hallways were observed for staff assistance with resident care needs. Resident areas were observed for accident hazards.

Resident records were reviewed including assessments, care plans, physician orders, hospice records, fall reports, progress notes, treatment records, and activities of daily living (ADL) records.

Facility policy and procedures were reviewed. State reports and grievances were reviewed.

Family members were interviewed in regard to a safe and homelike environment.

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

OKLAHOMA
State Department
of Health

Date report completed: 03/09/2026

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 03/05/2026

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 Complaint investigations (#OK00086031, OK00087523, OK00087637, OK00088710, and #OK00089673) were conducted on 03/03/36 through 03/05/26 . Deficiencies were cited as a result of the survey. Facility Census: 33 Listed below are abbreviations that will be used throughout this document. CNA - certified nursing assistant CPR - cardiopulmonary resuscitation ED - executive director	C 000		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff were trained in CPR and first aid for 1 (CNA #3) of 5 sampled direct care staff reviewed for required staff training. The regional maintenance director identified 33 residents resided in the facility. Findings: An undated "Staff Training" policy, read in part, "Prior to beginning floor training or working independently, all new hires must complete and document the following..."CPR [and] First Aid Training"..."Failure to maintain required training	C 954		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 954	Continued From page 1 may result in removal from the work schedule until compliance is achieved." Review of CNA #3's employee file showed they were hired on 11/05/24 and there was no documentation of CPR and first aid training. On 03/04/26 at 12:19 p.m., the ED stated CNA #3 did not have CPR and first aid training documentation in their employee file. On 03/04/26 at 12:21 p.m., the ED stated CNA #3 had no in-service on CPR and first aid training.	C 954		
C1512 SS=D	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical	C1512		

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C1512	Continued From page 2 restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents were free from physical restraints for 2 (#6 and #7) of 4 sampled residents reviewed for restraints. The regional maintenance director identified 33 residents resided in the facility.	C1512		

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C1512	Continued From page 3 Findings: An undated "Resident Care and Services" policy, read in part, "Community owner prohibits administering to a Resident any physical restraints"..."A physical restraint is any method, device, materials, or equipment that cannot remove by the resident and/or that restrict freedom of movement or normal access one's body." 1. On 03/03/26 at 12:20 p.m., Resident #6 was observed in the East dining room sitting at the table having lunch in a geriatric chair with all four wheels locked. A "Change of Condition" assessment for Resident #6, dated 10/08/25, showed the resident had diagnosis which included Alzheimer's dementia. 2. On 03/03/26 at 12:21 p.m., Resident #7 was observed in the East dining room sitting at the table having lunch in a geriatric chair with the left rear wheel locked. An "Annual" assessment for Resident #7, dated 05/05/25, showed the resident had diagnosis which included dementia. On 03/03/26 at 12:51 p.m., CNA #1 stated the center policy on resident chairs being locked while pushed up to the table was a restraint. On 03/03/26 at 12:53 p.m., CNA #1 stated Resident #6 and Resident #7's chairs were locked. CNA #1 stated if Resident #7's chair was not locked they would push away from the table. On 03/03/26 at 2:36 p.m., the wellness director stated chairs being locked while at the dining	C1512		

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C1512	Continued From page 4 table was considered a restraint. They stated neither Resident #6 nor Resident #7 were able to unlock or move their chairs without assistance.	C1512		
C1917 SS=D	310:663-19-(g) REPORTS TO THE DEPARTMENT (g) Content of Incident Report (1) The preliminary report shall at the minimum include: (A) who, what, when, and where; and (B) measures taken to protect the resident(s) during the investigation. (2) The follow-up report shall at the minimum include: (A) preliminary information; (B) the extent of the injury or damage if any; and (C) preliminary findings of the investigation. (3) The final report shall, at the minimum, include preliminary and follow-up information and: (A) a summary of the investigative actions; (B) investigative findings and conclusions based on findings; (C) corrective measures to prevent future occurrences; and (D) if items are omitted, why the items are omitted and when they will be provided. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain documentation of investigative findings and conclusion of an abuse investigation for 1 (#4) of 3 sampled residents reviewed for abuse. The regional maintenance director identified 33 residents resided in the facility.	C1917		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1917	Continued From page 5 Findings: A "Abuse and Neglect" policy, dated 04/2023, read in part, "The abuse and/or neglect of our residents, or the misappropriation of their property, is absolutely prohibited."..."The facility will maintain documentation." An undated facesheet for Resident #4 showed they had diagnoses which included senile degeneration of brain and anxiety. On 11/11/25 at 1:49 p.m., the Oklahoma State Department of Health received a "Final Incident Report." The report, read in part, "Care giver services were initiated for the resident by [home care service] on 11/1/25 - 11/2/25, 7a-7p shift. The caregiver's relief did not show up and the caregiver was in the facility until 12:30pm, 11/02/25. The administrator of Jasmine Estates was watching live video footage of the community from home and noticed that the caregiver had two guest in the building from 9:30am to 10:30am."..."Upon closer inspection of the camera footage on 11/3/25 with the caregiver's employer from [name withheld] present, it was determined that the conduct of the caregiver and [sex withheld] was inappropriate and violated the residents rights/HIPPA [Health Insurance Portability and Accountability Act] privacy."..."The [family member] of the caregiver used the back of the residents shirt to pull [them] back down in the wheel chair."..."The resident tried to get up again and was physically pushed back down into the chair by the guest."... "APS [Adult Protective Services] has recommended contacting law enforcement. [ED] will follow up with their assessment of the incident."..."Law enforcement notified and [case # withheld] created on	C1917		

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C1917	Continued From page 6 11/10/25."..."Law enforcement will take the case from here." On 03/03/26 at 10:02 a.m., the ED stated they had no documentation of the investigation and their investigation was watching the video. 03/03/26 at 2:28 p.m., the ED stated, "I didn't document any interviews with staff."	C1917		

OKLAHOMA
State Department of Health

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

April 24, 2026

License Number: AL5543

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

Survey Event ID: QPCE11

Dear Ms. Leehan:

On **March 5, 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:

- **C954** – The plan of correction did not address in-service for person responsible for tracking CPR certifications/training. QA is not addressed.
- **C1512** – How does the facility plan to track the monitoring? QA is not addressed in the plan of correction.
- **C1917** – How does the facility plan to track the monitoring? QA is not addressed in the plan of correction.

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

Respectfully,

Lisa Calvin

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

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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 Complaint investigations (#OK00086031, OK00087523, OK00087637, OK00088710, and #OK00089673) were conducted on 03/03/36 through 03/05/26 . Deficiencies were cited as a result of the survey. Facility Census: 33 Listed below are abbreviations that will be used throughout this document. CNA - certified nursing assistant CPR - cardiopulmonary resuscitation ED - executive director	C 000	POC response to C 954 The Executive Director conducted an audit of all personnel files and identified any missing or incomplete CPR/First Aid training documentation. Those identified as well as staff members due for CPR/First Aid renewal have successfully completed their training and remain in compliance. To ensure ongoing compliance, a CPR/First Aid tracking binder has been implemented. The ED or designee will conduct routine audits to ensure continued adherence to CPR/First Aid training requirements.	4/10/26
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff were trained in CPR and first aid for 1 (CNA #3) of 5 sampled direct care staff reviewed for required staff training. The regional maintenance director identified 33 residents resided in the facility. Findings: An undated "Staff Training" policy, read in part, "Prior to beginning floor training or working independently, all new hires must complete and document the following"..."CPR [and] First Aid Training"..."Failure to maintain required training	C 954	CNA #3 has completed CPR/First Aid training.	4/10/26

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Leehan, ED

TITLE: Executive Director

(X6) DATE: 04/16/2026

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 03/05/2026

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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C 954	Continued From page 1 may result in removal from the work schedule until compliance is achieved." Review of CNA #3's employee file showed they were hired on 11/05/24 and there was no documentation of CPR and first aid training. On 03/04/26 at 12:19 p.m., the ED stated CNA #3 did not have CPR and first aid training documentation in their employee file. On 03/04/26 at 12:21 p.m., the ED stated CNA #3 had no in-service on CPR and first aid training.	C 954	The Executive Director provided the surveyor with a CPR/First Aid in-service training attendance sheet dated 5/28/25. The attendance record included CNA #3, and the ED verified participation by highlighting the employee's name. Attendance of CPR/First Aid in-service dated 5/28/25 (OKCFD) A yearly update CPR/First Aid training has been scheduled with the OKC Fire Department.	5/28/26
C1512 SS=D	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical	C1512	POC response to C1512 An all staff in-service was conducted of Residents Rights Residents rights posters are hung in the employee break room and the front entrance of the building	4/9/26 4/14/26

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1512	Continued From page 2 restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents were free from physical restraints for 2 (#6 and #7) of 4 sampled residents reviewed for restraints. The regional maintenance director identified 33 residents resided in the facility.	C1512	An all staff in-service was conducted on restraints - Recognizing and reporting	4/9/26

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C1512	Continued From page 3 Findings: An undated "Resident Care and Services" policy, read in part, "Community owner prohibits administering to a Resident any physical restraints"..."A physical restraint is any method, device, materials, or equipment that cannot remove by the resident and/or that restrict freedom of movement or normal access one's body." 1. On 03/03/26 at 12:20 p.m., Resident #6 was observed in the East dining room sitting at the table having lunch in a geriatric chair with all four wheels locked. A "Change of Condition" assessment for Resident #6, dated 10/08/25, showed the resident had diagnosis which included Alzheimer's dementia. 2. On 03/03/26 at 12:21 p.m., Resident #7 was observed in the East dining room sitting at the table having lunch in a geriatric chair with the left rear wheel locked. An "Annual" assessment for Resident #7, dated 05/05/25, showed the resident had diagnosis which included dementia. On 03/03/26 at 12:51 p.m., CNA #1 stated the center policy on resident chairs being locked while pushed up to the table was a restraint. On 03/03/26 at 12:53 p.m., CNA #1 stated Resident #6 and Resident #7's chairs were locked. CNA #1 stated if Resident #7's chair was not locked they would push away from the table. On 03/03/26 at 2:36 p.m., the wellness director stated chairs being locked while at the dining	C1512	POC Response to C 1512 Cont: A restraints policy addendum has been created and added to the policy & procedures binder. Dining room and common areas will be monitored regularly by Ed and Wellness Director. If wheelchair and/or Broda chairs are discovered to be locked the ED and/or Wellness Director will unlock the brake/s immediately, identify the aide responsible, and educate immediately, followed by written disciplinary action if necessary. Signage has been placed in the dining room service area.	4/10/26 effective as of 3/6/26 4/14/26

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	Jasmine Estates Memory Care 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
C1512	Continued From page 4 table was considered a restraint. They stated neither Resident #6 nor Resident #7 were able to unlock or move their chairs without assistance.	C1512		
C1917 SS=D	310:663-19-(g) REPORTS TO THE DEPARTMENT (g) Content of Incident Report (1) The preliminary report shall at the minimum include: (A) who, what, when, and where; and (B) measures taken to protect the resident(s) during the investigation. (2) The follow-up report shall at the minimum include: (A) preliminary information; (B) the extent of the injury or damage if any; and (C) preliminary findings of the investigation. (3) The final report shall, at the minimum, include preliminary and follow-up information and: (A) a summary of the investigative actions; (B) investigative findings and conclusions based on findings; (C) corrective measures to prevent future occurrences; and (D) if items are omitted, why the items are omitted and when they will be provided. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain documentation of investigative findings and conclusion of an abuse investigation for 1 (#4) of 3 sampled residents reviewed for abuse. The regional maintenance director identified 33 residents resided in the facility.	C1917	An all staff in-service has been conducted on incident reporting according to state standards. Please Note: The In-Service was combined with "Guest & Visitor security & monitoring." An incident reporting & Documentation cheat sheet will be posted in all Care staff charting stations. The cheat sheet will be added to the new hire orientation training going forward.	4/9/26 4/13/26

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C1917	Continued From page 5 Findings: A "Abuse and Neglect" policy, dated 04/2023, read in part, "The abuse and/or neglect of our residents, or the misappropriation of their property, is absolutely prohibited."..."The facility will maintain documentation." An undated facesheet for Resident #4 showed they had diagnoses which included senile degeneration of brain and anxiety. On 11/11/25 at 1:49 p.m., the Oklahoma State Department of Health received a "Final Incident Report." The report, read in part, "Care giver services were initiated for the resident by [home care service] on 11/1/25 - 11/2/25, 7a-7p shift. The caregiver's relief did not show up and the caregiver was in the facility until 12:30pm, 11/02/25. The administrator of Jasmine Estates was watching live video footage of the community from home and noticed that the caregiver had two guest in the building from 9:30am to 10:30am."..."Upon closer inspection of the camera footage on 11/3/25 with the caregiver's employer from [name withheld] present, it was determined that the conduct of the caregiver and [sex withheld] was inappropriate and violated the residents rights/HIPPA [Health Insurance Portability and Accountability Act] privacy."..."The [family member] of the caregiver used the back of the residents shirt to pull [them] back down in the wheel chair."..."The resident tried to get up again and was physically pushed back down into the chair by the guest."... "APS [Adult Protective Services] has recommended contacting law enforcement. [ED] will follow up with their assessment of the incident."..."Law enforcement notified and [case # withheld] created on	C1917		

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C1917	Continued From page 6 11/10/25."..."Law enforcement will take the case from here." On 03/03/26 at 10:02 a.m., the ED stated they had no documentation of the investigation and their investigation was watching the video. 03/03/26 at 2:28 p.m., the ED stated, "I didn't document any interviews with staff."	C1917	POC response to C 1917 Following the incident on 11/2/25, The ED documented findings from camera footage on state form 283. The ED informed surveyor that the only staff interaction with the guests of the caregiver was to open the front door and let them in. An additional statement was requested from the care providers agency and given to surveyor. A policy on "Guest & Visitor security & monitoring" has been created and will be added to the facility policy & Procedure binder as well as the new hire packets going forward. An In-Service was conducted on "Guest & Visitor Security and monitoring. Please note: This training was combined with the "Incident Documentation" training.	4/13/26 3/19/26

OKLAHOMA
State Department
of Health

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

May 13, 2026

License Number: AL5543

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

Survey Event ID: QPCE11

Dear Ms. Leehan:

On **March 5, 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 8, 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: 5/3/2026** **Facility Name:** Jasmine Estates Memory Care **License Number:** AL5433 **Survey Event ID:** QPCE11 **Date Survey Completed: 3/5/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 954	Based on: Based on record review and interview, the facility failed to ensure direct care staff were trained in CPR and first aid for 1 (CNA #3) of 5 sampled direct care staff reviewed for required staff training.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The center acknowledges the deficient practice identified related to CPR and First Aid training requirements for direct care staff and will ensure compliance with all applicable state regulations and company policies.

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?	Residents potentially affected by the deficient practice were not harmed. All direct care staff, including CNA #3, identified as missing or having expired CPR/First Aid documentation were issued training packets for completion. The Executive Director, Laura Leehan, who has also completed CPR/First Aid training, oversees onboarding and ensures completion and documentation of all required training. An in-person CPR in-service will be conducted by the OKFD on 5/28/2026, and all training documentation will be maintained in the in-service compliance binder kept in the Executive Directors office.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected by the deficient practice; however, no residents were harmed as a result. Continued compliance with CPR/First Aid training requirements for all new hires is included in the onboarding process. New hire onboarding is conducted by the Executive Director, Laura Leehan, or the Business Office Manager, Michelle Grigsby, to ensure all required documentation is completed prior to providing resident care. Annual CPR/First Aid in-service training is provided by the Oklahoma Fire Department and the Wellness Director to maintain ongoing staff competency and compliance.
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?	To ensure the deficient practice does not recur, the facility has implemented a CPR/First Aid compliance tracking system. Following new hire onboarding, CPR/First Aid documentation will be maintained in a compliance binder located in the Executive Director's office. The Executive Director, Laura Leehan will conduct monthly audits of the

	binder to ensure all certifications remain current and that any approaching or expired trainings are updated immediately.
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 Executive Director, Laura Leehan and/or Wellness Director, RN, Neke Sims will monitor the performance of of the correction by ensuring that all staff are up to date with their CPR/first aid training, including mandatory attendance to the annual In-service, training. a. The correction will be evaluated for effectiveness through monthly audits of CPR/First Aid compliance records. Executive Director, Laura Leehan will verify that all direct care staff maintain current, properly documented training in a CPR/First aid compliance binder to ensure continued compliance with no repeat deficiencies. b. QAIP meeting on 4/30/2026, facilitated by Executive Director, Laura Leehan addressed the deficiency: Quality assurance will be maintained through monthly audits conducted by the Executive Director, Laura Leehan of CPR/First Aid compliance records. Any discrepancies or overdue certifications will be immediately corrected, and staff will be placed out of direct care until compliance is restored. Audit results will be documented, and trends or recurring issues will be addressed through staff retraining or process updates as needed. c. Monitoring records will be maintained by Executive Director, Laura Leehan in a CPR/First Aid compliance binder located in the Executive Director's office. The binder will include training verification and documentation status. All audit results and corrective actions will be documented in the QA file and retained to demonstrate ongoing compliance and evidence of correction.
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 Leehan, Executive Director OAC 310:663-25-4(F)	**Date 5/3/2026**

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	5/3/2026	**Submitted by**	Laura 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: 5/4/2026** **Facility Name:** Jasmine Estates Memmory Care **License Number:** AL5543 **Survey Event ID:** QPCE11 **Date Survey Completed: 3/5/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1512	Based on: Based on observation, record review, and interview, the facility failed to ensure residentswere free from physical restraints for 2 (#6 and#7) of 4 sampled residents reviewed for restraints.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The center has implemented corrective interventions and appropriate changes to ensure residents remain free from restraints in accordance with regulatory standards, with ongoing monitoring to ensure continued 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?	Upon discovery, the brake locks for the two affected residents were immediately disengaged. An in-service on recognizing and reporting restraints was conducted by the Executive Director, Laura Leehan and Wellness Director, RN, Neke Sims on 4/9/26. Signage has been posted in the dining room service area indicating that wheelchair and Broda chair brakes are not to be left locked due to being a restraint.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A tracking sheet will be created by the Wellness Director, RN Neke Sims, to maintain a current log of residents requiring the use of Broda chairs or wheelchairs. These residents will be routinely monitored in the dining room and common areas by the Wellness Director, RN Neke Sims, and Executive Director, Laura Leehan, to ensure brakes are disengaged when the equipment is idle. Identified concerns will be addressed promptly with staff re-education and corrective action as needed.
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 restraint policy has been developed and added to the company Policy & Procedure Manual. A training document has also been incorporated into the new hire orientation process to ensure all staff are educated on recognizing and reporting restraints.
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	The center will monitor the effectiveness of corrective actions to ensure sustained compliance with restraint-free practices and safe wheelchair/Broda chair use through ongoing audits, QAPI oversight, and documented tracking of compliance. a. Effectiveness will be evaluated through routine observational audits by Wellness Director, RN Neke Sims &

c. How monitoring records will be kept to evidence the correction.	Executive Director, Laura Leehan will be conducted in the dining room and common areas to ensure Broda chair and wheelchair brakes are disengaged when idle. Compliance will be confirmed by direct observation of staff practice and review of the resident Broda/Wheel chair tracking log, with any identified issues used to guide immediate staff re-education and corrective action as needed. b. The restraint citation, corrective actions, and ongoing compliance monitoring were reviewed and incorporated into the facility's QAPI system during the 4/30/2026 meeting facilitated by the Executive Director, Laura Leehan. The issue will remain an active QAPI focus area, with audit results and compliance monitoring reviewed on an monthly basis to ensure sustained correction and system improvement. c. Monitoring records will be maintained Wellness Director, RN Neke Sims through the Broda/wheelchair tracking log, and audit tool, titled "Broda-Wheelchair Restraint Compliance." observation documentation to be completed by the Wellness Director, RN Neke Sims and Executive Director, Laura Leehan on a monthly basis. These records will be filed in the Wellness Director office with copies retained in the centers QAPI documentation system and reviewed during scheduled QAPI meetings to evidence compliance and ensure ongoing compliance and corrective actions.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/8/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Laura Leehan** OAC 310:663-25-4(F)	**Date 5/4/2026**

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	5/4/2026	**Submitted by**	Laura 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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/4/2026** **Facility Name:** Jasmine Estates Memory Care **License Number:** AL5543 **Survey Event ID:** QPCE11 **Date Survey Completed: 3/5/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1917	Based on: Based on record review and interview, the facility failed to maintain documentation of investigative findings and conclusion of an abuse investigationfor 1 (#4) of 3 sampled residents reviewed for abuse.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The center acknowledges the deficiency. Due to the timing of the incident and the resident's passing, the original documentation could not be completed; however, all available supporting information was obtained and provided. Staff were educated on documentation requirements, and a standardized process has been implemented to ensure all investigations are complete and thorough going 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 resident involved has since passed away on 2/15/2026; therefore, no direct resident corrective action is required. Additional supporting documentation was obtained from the contracted caregiver agency (Synergy Homecare), provided to the surveyor, and added to the investigative record.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	To identify any additional residents, all subsequent incidents that may meet criteria for abuse or neglect will be fully investigated and reviewed for compliance. Any incident will include video footage retained in a secure electronic file, collection of witness statements, and documentation in the Alis EHR system. All required reports will be submitted to OSDH, APS will be notified, and law enforcement will be contacted as appropriate. All investigations will be completed and documented by the Executive Director, Laura Leehan and Wellness Director,RN Olaneke Sims.
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?	An all-staff in-service was conducted on 4/9/2026 and facilitated by Executive Director, Laura Leehan, addressing incident reporting, abuse investigation documentation according to state standards, and guest/visitor security and monitoring. An incident reporting and documentation "cheat sheet" has been implemented and posted at all care staff charting stations to reinforce requirements. Executive Director, Laura Leehan and Wellness Director, RN Neke Sims will ensure adherence to these processes to promote consistent and compliant documentation practices. A policy on "Guest & Visitor security &

	monitoring" has been created and will be added to the facility policy & Procedure's as well as the new hire packets going forward.
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 conduct ongoing audits of all incident and abuse investigations for completeness and compliance. Results will be reviewed through the QAPI process, and any identified issues will be addressed promptly to ensure compliance and quality of documentation. a. Effectiveness will be evaluated through audits of all abuse & neglect incident investigations to ensure documentation is complete,accurate, and includes all findings, statements, interventions, and final conclusions. b. This correction was incorporated into the QAIP, which was facilitated by Executive Director Laura Leehan on 4/30/2026. The QAIP included a review of interventions and staff training related to incident reporting and documentation in accordance with state standards, and will continue to be monitored through ongoing QAIP reviews. c. All monitoring records, investigation check list and completed investigation reviews, will be maintained in the Executive Director's office. These records will be overseen and monitored by Executive Director Laura Leehan to ensure ongoing compliance and to evidence sustained correction.
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 Leehan** OAC 310:663-25-4(F)	**Date 5/4/2026**

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	5/4/2026	**Submitted by**	Laua 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

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

June 2, 2026

License Number: AL5543

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

RE: Survey Event QPCE12

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 5, 2026,** have now been corrected effective **April 30, 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 03/05/26 survey were cleared.	{C 000}		

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