
Delivery via email to: kbolino@veradenlife.com

December 18, 2025

License Number: AL5545

Ms. Kara Bolino, Executive Director
The Veraden
2709 E Danforth Rd
Edmond, OK 73034

RE: Survey Event ID: VHPR11

Dear Ms. Bolino:

On **November 24, 2025**, agents from our office concluded a State Licensure survey with complaints at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **November 24, 2025**.

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

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts

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

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be 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 virtual meeting. The facility shall receive written confirmation of the IDR results.

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

Or mail to:

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

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

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

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

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

Respectfully,

Tempal Killman

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

Enclosure

INVESTIGATIVE REPORT

Facility: The Veraden
Address: 2709 E Danforth Rd
City, State, Zip: Edmond, OK. 73034
Provider #: AL5545
Complaint #: OK00067360
Investigation Date(s): 11/17/25 through 11/20/25 and 11/24/25

ALLEGATION(S)

1. The center failed to ensure a clean, safe and homelike environment.
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An unannounced on-site investigation was initiated 11/17/2025 at 10:30 a.m.

A sample of 10 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.

The facility was observed for concerns related to a clean and sanitary environment. Maintenance and repair records were reviewed. Residents were asked about concerns related to the environment. Staff were asked questions regarding maintenance and repairs maintained at the facility.

The attached Statement of Deficiencies, Form 2567 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: 11/24/2025

INVESTIGATIVE REPORT

Facility: The Veraden
Address: 2709 E Danforth Rd
City, State, Zip: Edmond, OK. 73034
Provider #: AL5545
Complaint #: OK00075063
Investigation Date(s): 11/17/25 through 11/20/25 and 11/24/25

ALLEGATION(S)

- | |
|--|
| 1. The center failed to ensure residents were provided care as ordered by the physician and/or according to the resident's |
| 2. The center failed to ensure residents did not exceed the level of care the center could provide. |
| 3. The center failed to ensure a plan of accommodation was in place and/or implemented when a resident was above the level of care the center could provide. |

An unannounced on-site investigation was initiated 11/17/2025 at 10:30 a.m.

A sample of 10 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 in the facility for standards of care. Resident and family representatives were asked questions regarding the care of residents. Staff were asked questions regarding resident care and meeting contractual obligations. Resident records reviewed included third party provider sheets, physician orders, service plans, resident contracts, and facility policies.

The attached Statement of Deficiencies, Form 2567 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: 11/24/2025

INVESTIGATIVE REPORT

Facility: The Veraden
Address: 2709 E Danforth Rd
City, State, Zip: Edmond, OK. 73034
Provider #: AL5545
Complaint #: OK00068032
Investigation Date(s): 11/17/25 through 11/20/25 and 11/24/25

ALLEGATION(S)

1. The center failed to ensure a clean, safe and homelike environment.
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An unannounced on-site investigation was initiated 11/17/2025 at 10:30 a.m.

A sample of 10 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.

The facility was observed for concerns related to a clean and sanitary environment. Maintenance and repair records were reviewed. Residents were asked about concerns related to the environment. Staff were asked questions regarding maintenance and repairs maintained at the facility.

The attached Statement of Deficiencies, Form 2567 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: 11/24/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5545	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/24/2025
NAME OF PROVIDER OR SUPPLIER THE VERADEN		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 E DANFORTH RD EDMOND, OK 73034		
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C 000	INITIAL COMMENTS A relicensure survey with complaints (#OK00067360, OK00068032, OK00075063, and #OK00079137) was conducted from 11/17/25 through 11/18/25 and on 11/24/25. Deficiencies were cited as a result of the survey. Facility Census: 97 Listed below are the abbreviations that will be used throughout this document. CMA - certified medication aide MAR - medication administration record med- medication MOR- medication omission record rep - representative QA/QI - quality assurance	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to; a. ensure a sanitary and clean kitchen was maintained during 1 of 2 observations made for a clean and sanitary kitchen, and b. ensure food items that were expired were disposed of during 1 of 2 kitchen observations.. The executive director identified 97 residents received nutrition from the kitchen.	C 391		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5545	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/24/2025
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C 391	Continued From page 1 Findings: On 11/17/25 at 10:30 a.m., a tour of the kitchen was conducted. The following observations were made: a. the top of the ice machine and ice machine scoop holder was covered with a sticky residue, dust, and debris; b. a shelf in the server drinks station that bagged cereal was stored on had food debris on the shelf; c. three kitchen trash cans did not have lids on them and were open near food prep areas; d. hamburger patties, dated 11/11/25, were stored under the salad bar in a metal pan; e. dust and debris were hanging from the ceiling over the salad bar area; f. food debris, grease, and unknown sticky substance were under the dish area equipment, on the floor, and on the pipes; g. the walls behind the food preparation area and food service lines had food debris, grease, and dirt under and behind all equipment; h. the floor drains in the prep area and the dish area contained food debris and were soiled with grease and residue; i. the top of the dish machine had food debris; and A centers policy titled "Culinary Standard Operating Procedures," dated 11/07/19, read in part, "All areas of the culinary department must always be clean and sanitary. This includes, but is not limited to, floors, ceilings, walls, base boards, vents, countertops, cupboards, drawers, storage racks, hood vents, equipment used for production and food storage, window treatments, chairs and table bases." On 11/17/25 at 10:45 a.m., the culinary director	C 391		

Oklahoma State Department of Health

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C 391	Continued From page 2 stated the hamburger patties were left in the salad bar by mistake because someone did not pay attention to the dates on the patties. The culinary director stated the kitchen had a cleaning schedule but it was hit or miss if it was followed. They stated the walls, the floors, under the equipment, and the floor drains were unsanitary and needed to be cleaned. On 11/17/25 at 12:00 p.m., the executive director was shown the above list of kitchen observations. The executive director stated the kitchen was not clean and sanitary.	C 391		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure assessments were signed by a registered nurse or physician for 3 (#4, 7, and #9) of 10 residents sampled for assessments coordinated by a registered nurse or physician. The executive director identified 97 residents resided in the center. Findings: A centers policy titled "Resident Evaluation," dated 12/10/21, read in part, "The final resident evaluation should be completed by a licensed nurse or registered nurse if required by state regulation (s):"..."Evaluations should be entered into the software program and the original forms	C 542		

Oklahoma State Department of Health

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C 542	Continued From page 3 are to be signed by a community representative, and a resident/responsible party. The signed forms are to be placed in the resident record." 1. Resident #4's initial assessment, dated 06/17/25, showed their cognition was impaired and required memory care services. The assessment showed they had diagnoses which included stroke, agitation, and post mastectomy lymphedema syndrome. The assessment was not signed by a registered nurse or physician. 2. Resident #7's change of condition assessment, dated 03/24/25, showed their cognition was impaired and required memory care level of service. The assessment showed they had diagnoses which included cognitive disorder, urinary incontinence, and agitation. The assessment was not signed by a registered nurse or a physician. 3. Resident #9's annual assessment, dated 06/27/25, showed their memory was fair and required memory care level of service. The assessment showed they had diagnoses which included diabetes and dementia. The assessment was not signed by a registered nurse or a physician. On 11/20/25 at 3:59 p.m., the resident service coordinator provided the above assessments and stated the assessments were not signed by a registered nurse or a physician. On 11/24/25 at 1:43 p.m., the director of resident services was asked about the assessments not signed by a registered nurse or a physician. The director of resident services stated the assessments were not signed or the center misplaced the signed assessments.	C 542		

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C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure assessments contained a resident and/or resident representative signature for 3 (#4, 7, and #9) of 10 residents sampled for assessments signed by a resident and/or resident representative. The executive director identified 97 residents resided in the center. Findings: A centers policy titled "Resident Evaluation," dated 12/10/21, read in part, "The final resident evaluation should be completed by a licensed nurse or registered nurse if required by state regulation (s):"... "Evaluations should be entered into the software program and the original forms are to be signed by a community representative, and a resident/responsible party. The signed forms are to be placed in the resident record." 1. Resident #4's initial assessment, dated 06/17/25, showed their cognition was impaired and required memory care services. The assessment showed they had diagnoses which included stroke, agitation, and post mastectomy lymphedema syndrome. The assessment was not	C 543		

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C 543	Continued From page 5 signed by the resident and/or the resident representative showing they participated in the assessment. 2. Resident #7's change of condition assessment, dated 03/24/25, showed their cognition was impaired and required memory care level of service. The assessment showed they had diagnoses which included cognitive disorder, urinary incontinence, and agitation. The assessment was not signed by the resident and/or the resident representative showing they participated in the assessment. 3. Resident #9's annual assessment, dated 06/27/25, showed their memory was fair and required memory care level of service. The assessment showed they had diagnoses which included diabetes and dementia. The assessment was not signed by the resident and/or the resident representative showing they participated in the assessment. On 11/20/25 at 3:59 p.m., the resident service coordinator provided the above assessments and stated the assessments were not signed by the resident and/or a resident representative showing they participated in the assessment. On 11/24/25 at 1:43 p.m., the director of resident services was asked about the assessments not signed by a resident/resident representative. The director of resident services stated the assessments were not signed or the center misplaced the signed assessments.	C 543			
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE	C1110			

Oklahoma State Department of Health

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C1110	Continued From page 6 (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure a quality assurance committee meeting was held quarterly. The executive director identified 97 residents resided in the center. Findings: A document titled "QA/QI," dated 08/2025 through 10/2025, showed a QA meeting was conducted on 10/31/25. QA documentation was reviewed from 03/31/24 through 10/31/25. There was no documentation showing QA meetings were held in the following months: a. 06/2024; b. 09/2024; c. 12/2025; e. 03/2025; and f. 06/2025. On 11/24/25 at 1:02 p.m., the executive director stated the last QA meeting documentation they had prior to the QA meeting on 10/31/25 was held on 03/31/24. The executive director stated the center missed five opportunities for QA meetings.	C1110		

Oklahoma State Department of Health

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C1110	Continued From page 7 On 11/24/25 at 1:43 pm , the director of resident services stated they could not locate any documentation showing QA meetings were held after 03/31/24 so they went ahead and had a QA meeting on 10/31/25.	C1110		
C1120 SS=D	310:663-11-2 QUALITY ASSURANCE REPRESENTATIVES The quality assurance committee shall include at least the following: (1) registered nurse or physician if a medical problem is to be monitored or investigated; (2) assisted living center administrator; (3) direct care staff person or a staff person who has responsibility for administration of medications; and (4) pharmacist consultant if a medication problem is to be monitored or investigated. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure a direct care staff was on the QA committee for 1 of 1 QA meetings reviewed. The executive director identified 97 residents resided in the center. Findings: A center document titled "QA/QI," dated 08/2025 through 10/2025, showed a quality assurance meeting was conducted on 10/31/25. The document showed the following individuals attended the QA meeting on 10/31/25; a. director of resident services' b. sales and marketing;	C1120		

Oklahoma State Department of Health

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C1120	Continued From page 8 c. resident services coordinator; d. culinary director; e. executive director; f. business director; and g. life styles director. The document did not show a direct care staff was present for the QA meeting on 10/31/25. On 11/24/25 at 1:02 p.m., the executive director stated the last QA meeting documentation they had prior to the QA meeting on 10/31/25 was held on 3/31/24. The executive director stated the center missed five opportunities for QA meetings. The executive director stated there was not a direct care staff present for the QA meeting held on 10/31/25. On 11/24/25 at 1:43 p.m., the director of resident services stated they could not locate any documentation showing QA meetings were held after 03/31/24. The resident services director stated there was not a direct care staff on the QA committee held on 10/31/25.	C1120			
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were not administered to a resident without an order for 1 (#3) of 10 residents sampled for medication administration.	C1921			

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER THE VERADEN		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 E DANFORTH RD EDMOND, OK 73034		
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C1921	Continued From page 9 The executive director identified 97 residents received medication from the center. Findings: A center policy titled "Medication Assistance and MARs/ MORs," dated 12/09/19, read in part, "Medication assistance will be provided in accordance with state regulations. Medication assistance includes reminding, assisting, supervising or administration of resident medications and treatment's according to physician orders." Resident #3's "Move in Physician Assessment," dated 12/11/24, showed they were admitted to assisted living with diagnoses which included chronic kidney disease, moderate dementia, and atrial fibrillation. The assessment showed Resident #3 required staff to administer medications. Resident #3's assessment titled "Saint Louis University Mental status Examination," dated 12/13/24, showed their cognition was severely impaired with a score of 12. Resident #3's service plan, dated 12/13/24, did not document Resident #3 had orders for nitroglycerine medication. Resident #3's hospice physician orders, dated 12/31/24, showed Resident #3 did not have an order for nitroglycerin medication. A facility document titled "Medication Error Report, dated 01/03/25, read in part, "[CMA #1] prepared and administered medications for [Resident #3]. Nitrostat (antianginal) 0.4 mg SL (sublingual) was administered. CMA was made	C1921		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5545	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/24/2025
NAME OF PROVIDER OR SUPPLIER THE VERADEN		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 E DANFORTH RD EDMOND, OK 73034		
(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
C1921	Continued From page 10 aware by [Resident #3's] Hospice nurse and the medication was removed from [Resident #3] mouth whole and intact and discarded. [Resident #3] only received/swallowed medications ordered by [their] physician. CMA was removed from med cart and education provided." The document showed, the summary of the medication error was due to the wrong resident, the wrong medication, misread the order, and failure to identify the resident. Resident #3's nursing note, dated 01/13/25, read in part,"late entry for date of service 01/03/25. [CMA #1] prepared and administered medications for this resident. Nitroglycerine was administered in error. When the CMA was made aware of this by hospice nurse at bedside, the whole tablet was removed from the residents mouth and discarded. Only physician ordered medications were being taken by the resident. CMA was removed from the medication cart for this resident and Med error discussed with CMA along with medication administration education." On 11/19/25 at 10:39 a.m., family representative #1 stated, on 01/03/25, they were notified CMA #1 gave Resident #3 a nitroglycerine pill that was not prescribed. Family representative #1 stated the hospice nurse made the CMA aware Resident #3 could not swallow pills and the pill was removed from the residents mouth and discarded. On 11/20/25 at 10:29 a.m., CMA #1 stated they were a new employee and gave the medication to the wrong resident due to being new and not being familiar with the residents. CMA #1 stated the medication was removed from the residents mouth after hospice nurse made them aware of the error.	C1921		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5545	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/24/2025
NAME OF PROVIDER OR SUPPLIER THE VERADEN		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 E DANFORTH RD EDMOND, OK 73034		
(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
C1921	Continued From page 11 On 11/20/25 at 9:38 a.m., the divisional director was asked about the medication error on 01/03/25. The divisional director stated Resident #3 was admitted with nitroglycerine pills from a previous order that was not active. The divisional director stated Resident #3 never had an active order for nitroglycerine medication while at the center. On 11/20/25 at 10:13 a.m., the executive director stated they were given the pill from family rep #1 on 01/03/25 after the hospice nurse saw CMA #1 give the resident the medication. The executive director stated they were told CMA #1 was supposed to give a resident pain medication but they gave the wrong pill. On 11/20/25 at 10:23 a.m., hospice nurse #1 stated Resident #3 was actively dying and could not swallow. Hospice nurse #1 stated a CMA came into the residents room and stated they were there to administer medications for chest pain and tried to give the resident a pill. Hospice nurse #1 stated the CMA gave Resident #3 the pill then took it out of the residents mouth when they were told the resident could not swallow.	C1921		
C1951 SS=D	310.663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice.	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5545	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/24/2025
NAME OF PROVIDER OR SUPPLIER THE VERADEN		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 E DANFORTH RD EDMOND, OK 73034		
(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
C1951	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to document a skin tear for 1 (#3) of 10 residents sampled for documenting treatments. The executive director identified 97 residents resided in the center. Findings: Resident #3's "Move in Physician Assessment," dated 12/11/24, showed they were admitted to the assisted living with diagnoses which included chronic kidney disease, moderate dementia, and atrial fibrillation. Resident #3's assessment titled "Saint Louis University Mental status Examination," dated 12/13/24, showed their cognition was severely impaired with a score of 12. An undated facility policy titled "Skin Integrity," read in part, "1. Within 24 hours of move-in, or the first appearance of an open area, A Skin Observation form should be completed, and the information will be entered into the Resident EHR [electronic health record] by a [name of corporation withheld] nurse." A review of Resident #3's nurses notes and health records did not document a skin tear on 12/16/25. On 11/19/25 at 10:39 a.m., family representative #1 stated on 12/16/24 around 10:00 a.m., they went to the facility to visit Resident #3 and found blood on the residents sheets caused from a skin tear. On 11/20/25 at 9:38 a.m., the divisional director	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5545	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/24/2025
NAME OF PROVIDER OR SUPPLIER THE VERADEN		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 E DANFORTH RD EDMOND, OK 73034		
(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
C1951	Continued From page 13 was asked about Resident #3's skin tear on 12/16/24. The divisional director stated there was no documentation of the skin tear in Resident #3's health record. The divisional director stated the centers policy was not followed due to no documentation of the skin tear. On 11/20/25 at 10:13 a.m., the executive director was asked about Resident #3's skin tear and the blood on Resident #3's sheet on 12/16/24. The executive director stated they became aware of the blood from a skin tear during the morning medication pass around 8:00 a.m. The executive director stated they did basic first aide and did not document anything related to the incident. On 11/20/25 at 11:48 a.m., CMA #2 stated they provided medications to the resident on 12/16/24 in the morning and saw the blood from a skin tear. CMA #2 stated they notified a nurse and basic first aide was provided.	C1951		

INVESTIGATIVE REPORT

Facility: The Veraden
Address: 2709 E Danforth Rd
City, State, Zip: Edmond, OK. 73034
Provider #: AL5545
Complaint #: OK00079137
Investigation Date(s): 11/17/25 through 11/20/25 and 11/24/25

ALLEGATION(S)

- | |
|--|
| 1. The center failed to ensure medications were administered according to the physicians' orders. |
| 2. The center failed to ensure adequate supervision was provided according to the plan of care/contract. |
| 3. The center failed to ensure refunds were issued in a timely manner according to the contract. |

An unannounced on-site investigation was initiated 11/17/2025 at 10:30 a.m.

A sample of 10 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 in the facility for standards of care. Resident and family representatives were asked questions regarding the care of residents. Staff were asked questions regarding resident care and meeting contractual obligations. Resident records reviewed included third party provider sheets, physician orders, service plans, resident contracts, and facility policies.

The attached Statement of Deficiencies, Form 2567 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: 11/24/2025

Delivery via email to: kbolino@veradenlife.com

January 9, 2026

License Number: AL5545

Ms. Kara Bolino, Executive Director
The Veraden
2709 E Danforth Rd
Edmond, OK 73034

RE: Survey Event VHPR11

Dear Ms. Bolino:

On **November 24, 2025**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and in a timely manner. **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 **February 16, 2026**.

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

Respectfully,

Tempal Killman

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

Enclosure

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/7/2026	
	Facility Name: The Veraden	
	License Number: AL5545	
	Survey Event ID: VHPR11	
Date Survey Completed: 11/24/2025		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C391	Based on: observation, record review, and interview, the center failed to; a. ensure a sanitary and clean kitchen was maintained during 1 of 2 observations made for a clean and sanitary kitchen, and b. ensure food items that were expired were disposed of during 1 of 2 kitchen observations.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements in this document, we have outlined specific actions in response to each allegation(s) or finding.		
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?	Culinary Director and/or designee to provide in-service training to all culinary team members to review and train on the implementation of Culinary expectations and guidelines regarding the kitchen cleaning schedules.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Culinary Director and/or designee to track and monitor weekly, with the Executive Director reviewing weekly cleaning schedules/checklists during monthly kitchen check.	
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?	Executive Director and/or designee to conduct random audits to ensure on-going compliance with weekly/monthly kitchen cleaning schedules/checklists.	
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Enter methods to ensure corrections are sustained: Culinary Director to track and monitor weekly, monthly kitchen cleaning schedules/checklists. Executive Director and/or designee to conduct random reviews over the next three months to ensure schedules/checklist are in place and being completed. Cleaning schedules/checklists to be brought to quarterly QA meetings for review and to ensure on-going compliance.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	2/16/2026	
OSDH Response: Element accepted Yes ☐ No ☐		

Administrator's Signature <i>Kara Bolino</i> OAC 310:663-25-4(F)		Date 1/7/2026	
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	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/7/2026

Facility Name: The Veraden

License Number: AL5545

Survey Event ID: VHPR11

Date Survey Completed: 11/24/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C542

Based on: record review and interview, the center failed to ensure assessments were signed by a registered nurse or physician for 3 (#4, 7, and #9) of 10 residents sampled for assessments coordinated by a registered nurse or physician.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements in this document, we have outlined specific actions in response to each allegation(s) or finding.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Kara Bolino

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident Services Director and/or designee specifically to conduct a current assessment for resident #4, #7 and #9 and have it reviewed and signed off by a registered nurse or a physician.

Resident Services Director and/or designee to conduct a audit of all current resident assessments and ensure they have been reviewed and signed off by a registered nurse or a physician.

Resident Service Director and/or designee to bring a list of the assessments completed each month to quarterly QA meeting for review of signatures by registered nurse or physician.

Enter methods to ensure corrections are sustained:

Resident Services Director and/or designee to conduct a monthly audit of all resident assessments completed each month to ensure each are signed by a registered nurse or physician.

Monthly audit of those resident assessments completed each month to be brought to the quarterly QA meeting for review and to ensure on-going compliance.

2/16/2026

Date 1/7/2026

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

Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

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



Oklahoma State
Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/7/2026

Facility Name: The Veraden

License Number: AL5545

Survey Event ID: VHPR11

Date Survey Completed: 11/24/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C543

Based on: record review and interview, the center failed to ensure assessments contained a resident and/or resident representative signature for 3 (#4, 7, and #9) of 10 residents sampled for assessments signed by a resident and/or resident representative.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements in this document, we have outlined specific actions in response to each allegation(s) or finding.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Lara Bolino

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident Services Director and/or designee specifically to conduct a current assessment for resident #4, #7 and #9 and have it reviewed and signed by the resident and/or resident representative.

Resident Services Director and/or designee to conduct a audit of all current resident assessments and ensure that they have been reviewed and signed off by the resident and/or resident representative.

Resident Service Director and/or designee to bring a list of the assessments completed each month to quarterly QA meeting for review of signatures by the resident and/or resident representative.

Enter methods to ensure corrections are sustained:

Resident Services Director and/or designee to conduct a monthly audit of all resident assessments completed each month to ensure each are signed by the resident and/or resident representative.

Monthly audit of those resident assessments completed each month to be brought to the quarterly QA meeting for review and to ensure on-going compliance.

2/16/2026

Date 1/7/2026

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	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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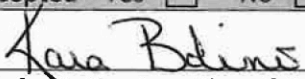
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Facility in Compliance by: [Click here to enter a date.](#)

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/7/2026	
	Facility Name: The Veraden	
	License Number: AL5545	
	Survey Event ID: VHPR11	
Date Survey Completed: 11/24/2025		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1110	Based on: record review and interview, the center failed to ensure a quality assurance committee meeting was held quarterly.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements in this document, we have outlined specific actions in response to each allegation(s) or finding.		
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?		Executive Director and Resident Services Director to review and refamiliarize themselves with the rules and regulations stated in Chapter 663, subchapter 11 regarding Quality Assurance Committee meetings. In addition, to planning these meetings for the year for the same time, each quarter both on our personal calendars and a computer reminder in Outlook.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Executive Director and Resident Services Director to review and refamiliarize themselves with the rules and regulations stated in Chapter 663, subchapter 11 regarding Quality Assurance Committee meetings. In addition, to planning these meetings for the year for the same time, each quarter both on our personal calendars and a computer reminder in Outlook.
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?		Executive Director and Resident Services Director to review and refamiliarize themselves with the rules and regulations stated in Chapter 663, subchapter 11 regarding Quality Assurance Committee meetings. In addition, to planning these meetings for the year for the same time, each quarter both on our personal calendars and a computer reminder in Outlook.
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		Enter methods to ensure corrections are sustained: Executive Director and Resident Services Director to review and refamiliarize themselves with the rules and regulations stated in Chapter 663, subchapter 11 regarding Quality Assurance Committee meetings. In addition, to planning these meetings for the year for the same time, each quarter both on our personal calendars and a computer reminder in Outlook.

correction.			
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/2/2026	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) 		Date 1/7/2026	
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	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/7/2026

Facility Name: The Veraden

License Number: AL5545

Survey Event ID: VHPR11

Date Survey Completed: 11/24/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1120

Based on: record review and interview, the center failed to ensure a direct care staff was on the QA committee for 1 of 1 QA meetings reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements in this document, we have outlined specific actions in response to each allegation(s) or finding.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Executive Director and Resident Services Director to review and refamiliarize/retrain themselves with the rules and regulations stated in Chapter 663, subchapter 11 Quality Assurance Representatives. This will allow us to ensure we know who all is required as representatives to attend our quarterly QA meetings.

Executive Director and Resident Services Director to review and refamiliarize/retrain themselves with the rules and regulations stated in Chapter 663, subchapter 11 Quality Assurance Representatives. This will allow us to ensure we know who all is required as representatives to attend our quarterly QA meetings.

Executive Director and Resident Services Director to review and refamiliarize/retrain themselves with the rules and regulations stated in Chapter 663, subchapter 11 Quality Assurance Representatives. In addition a attendance list will be implemented listing all those required in attendance to ensure everyone listed on the list is in attendance as required.

Enter methods to ensure corrections are sustained:

Executive Director and Resident Services Director to review and refamiliarize/retrain themselves with the rules and regulations stated in Chapter 663, subchapter 11 Quality Assurance Representatives. In addition a attendance list will be implemented listing all those required in attendance to ensure everyone listed on the list is in attendance as required.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/2/2026	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) 		Date 1/7/2026	
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	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 1/7/2026		
	Facility Name: The Veraden		
	License Number: AL5545		
	Survey Event ID: VHPR11		
Date Survey Completed: 11/24/2025			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C1921	Based on: record review and interview, the facility failed to ensure medications were not administered to a resident without an order for 1 (#3) of 10 residents sampled for medication administration.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: This plan is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements in this document, we have outlined specific actions in response to each allegation(s) or finding.			
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS	
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		Resident # 3 is no longer a resident of the community.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Resident Services Director and/or designee to in-service all Medication Aides on the the seven rights of medication administration.	
OSDH Response: Element accepted Yes ☐ No ☐			
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		Resident Services Director and/or designee to review monthly orders and ensure they match the residents current medication administration record.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		Enter methods to ensure corrections are sustained: Monthly orders audit will be reviewed during quarterly QA meeting along with on-going training for all Medication Aides reviewed during QA as well.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/16/2026	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)		Date 1/7/2026	
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	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.

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



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/7/2026

Facility Name: The Veraden

License Number: AL5545

Survey Event ID: VHPR11

Date Survey Completed: 11/24/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1951

Based on: record review and interview, the facility failed to document a skin tear for 1 (#3) of 10 residents sampled for documenting treatments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements in this document, we have outlined specific actions in response to each allegation(s) or finding.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Lara B. Jones

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident # 3 is no longer a resident of the community.

Resident Services Director and/or designee to in-service care staff in completing skin observations form any time they encounter a resident experiencing any type of skin care issue/concern or when staff must perform basic first aide. These forms will be turned into the Resident Services Director for further review and follow-up of resident's skin care issue/concern.

Resident Services Director and/or designee to bring a monthly list of those residents that are experiencing any type of skin care issues/concerns to quarterly QA for review and follow-up.

Enter methods to ensure corrections are sustained:

Resident Services Director and/or designee to bring a monthly list of those residents that are experiencing any type of skin care issues/concerns to quarterly QA for review and follow-up.

2/16/2026

Date 1/7/2026

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

Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

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

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.

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

Delivery via email to: kbolino@veradenlife.com

February 23, 2026

License Number: AL5545

Ms. Kara Bolino, Executive Director
The Veraden
2709 E Danforth Rd
Edmond, OK 73034

Survey Event ID: VHPR12

Dear Ms. Bolino:

On **February 23, 2026**, an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your survey on **November 24, 2025**, have now been corrected effective **February 16, 2025**.

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

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5545	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 02/23/2026
NAME OF PROVIDER OR SUPPLIER THE VERADEN		STREET ADDRESS, CITY, STATE, ZIP CODE 2709 E DANFORTH RD EDMOND, OK 73034		
(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 An offsite/paper revisit was conducted on 02/23/26. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE