OKLAHOMA
State Department
of Health

Delivery via email to: superiorcarehomesofoklahoma@gmail.com; misty.leeson04@gmail.com

May 5, 2025

License Number: AL5556

Ms. Misty Leeson, Administrator
Superior Care Homes Of Oklahoma
8817 Nw 121st
Oklahoma City, OK 73162

RE: Survey Event ID: J1ZB11

Dear Ms. Leeson:

On **April 28, 2025**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **April 28, 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:

IDR Coordinator
IDRCoordinator@health.ok.gov
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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5556	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUPERIOR CARE HOMES OF OKLAHOMA	8817 NW 121ST OKLAHOMA CITY, OK 73162

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted on 04/28/25. Deficiencies were cited as a result of the survey. Facility Census: 5 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for 1 (#1) of 3 residents sampled for comprehensive assessments. The consulting nurse identified five residents resided in the center. Findings: A "Comprehensive Move-in Assessment," dated	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5556	A. BUILDING: _____ B. WING _____	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 522	Continued From page 1 11/19/23, showed Resident #1 was admitted to the center on 11/19/23 with diagnosis of dementia with behaviors. A review of the resident's health records did not show a comprehensive assessment for 2024. On 04/28/25 at 12:12 p.m., the consulting nurse was asked for the most recent comprehensive assessment for Resident #1. They stated, "It's in [Resident #1's] chart." The consulting nurse was asked where the comprehensive assessment was for 2024 and they stated, "Are these supposed to be quarterly? I don't know much about assessments." The consulting nurse was asked how often they conducted comprehensive assessments. They stated, "Only on admission."	C 522		
C1931 SS=F	310:663-19-2(b)(1) MEDICATION ADMINISTRATION (b) An assisted living center may maintain nonprescription drugs for dispensing from a common or bulk supply if all of the following are accomplished. (1) The assisted living center shall have and follow a written policy and procedure to assure safety in dispensing and documenting medications given to each resident. This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to ensure medications were secured inside of an unattended, open medication room for 1 of 1 medication room observed. The consulting nurse identified five residents	C1931		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5556	A. BUILDING: _____ B. WING _____	04/28/2025

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SUPERIOR CARE HOMES OF OKLAHOMA	8817 NW 121ST OKLAHOMA CITY, OK 73162

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C1931	Continued From page 2 resided in the center. Findings: On 04/28/25 at 11:28 a.m., the medication room was observed unattended with the door open. There was no lock on the door for the medication room. A "Medication Handling and Administration Policies and Procedure," dated 02/28/25, read in part, "All medications must be stored in a locked, temperature-controlled area"..."accessible only to authorized personnel." On 04/28/25 at 11:30 a.m., CMA #1 was asked if the medication room was lockable. They stated, "Yes, I left it open on accident." CMA #1 stated, "They replaced the floors Saturday and they switched the door handles. This one is supposed to have a lock on it."	C1931		

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Delivery via email to: superiorcarehomesofoklahoma@gmail.com; misty.leeson04@gmail.com

May 16, 2025

License Number: AL5556

Ms. Misty Leeson, Administrator
Superior Care Homes Of Oklahoma
8817 NW 121st
Oklahoma City, OK 73162

RE: Survey Event J1ZB11

Dear Ms. Leeson:

On **April 28, 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 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 31, 2025**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, 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:5/14/2025** **Facility Name:** Superior Care Homes of Oklahoma **License Number:** AL5556 **Survey Event ID:** 4/28/2025 **Date Survey Completed: 4/28/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: review and interview, it was determined the center failed to provide a comprehensive assessment in accordance with (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a sig**nificant change in the resident's condition.**

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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 corrective action will ensure compliance checks and maintenance of all comprehensive assessments for residents on an annual, quarterly, and as need basis, based on the residents' **needs in the care home.**
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents have the potential to be affected by not having an up-to-date admission, 14 days after admission, annual, and as needed assessments completed. This could **impact the care team's ability to update care plan needs** based on changes identified in the comprehensive assessment.
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?	**All residents' assessments will be reviewed and update** accordingly in addition to the affected resident(s) comprehensive assessment be conducted 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 correction will be evaluated for effectiveness by reviewing all resident comprehensive assessments to ensure state requirements for continual assessments from the time of admission and no later than 14 days, annually, and on an as needed basis. Continuous reviews of resident comprehensive assessments will be conducted to ensure all comprehensive assessments are in compliance with the state of Oklahoma. **Monitoring records will be kept in the care center's q**uality assurance manual.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?	by May 31, 2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Signed by FFEAE821FEA04C7...	**Date** 5/14/2025 Enter date of signature.

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:12/14/2025** **Facility Name:** Superior Care Homes of Oklahoma **License Number:** AL5556 **Survey Event ID:** 04/28/2025 **Date Survey Completed: 04/28/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1931	Based on: record review and interview, the facility failed to ensure medications were secured inside of an unattended, open medication room for 1 of 1 medication room observed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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 corrective action will ensure bulk medications and all medication overflow will be kept in a looked room where a key is kept in a secure location away from all residents.
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 can be affected by having access to bulk medications when medications are not in a secure area, which poses a safety risk for potential harmful outcomes.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The care center will implement a rounding system to ensure staff performs continues checks during the shift and at shift change to ensure all bulk medications are locked in their secured location.
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 correction will be evaluated for effectiveness by monitoring efficiency related to ensuring the medication room is locked by having the nurse consultant check during her rounding with staff. Staff training on the importance of maintaining of a secure location for bulk medications will be provided by the **center's nurse consultant.** Monitoring records will be maintained in the staff quality assurance and training manuals.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Maintenance issues surrounding the unsecured area has been corrected affective 4/29/2025.
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	**Date** 5/14/2025

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐Acceptable ☐Unacceptable Date: Click here to enter a date. Surveyor: Surveyor
If the 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: superiorcarehomesofoklahoma@gmail.com; misty.leeson04@gmail.com

June 5, 2025

License Number: AL5556
Survey Event ID: J1ZB12

Ms. Misty Leeson, Administrator
Superior Care Homes Of Oklahoma
8817 NW 121st
Oklahoma City, OK 73162

Dear Ms. Leeson:

On **June 5, 2025**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **April 28, 2025,** have now been corrected and your facility is in compliance with licensure standards effective **May 31, 2025**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5556	A. BUILDING: _____ B. WING _____	R 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUPERIOR CARE HOMES OF OKLAHOMA	8817 NW 121ST OKLAHOMA CITY, OK 73162

(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 06/05/25. The facility was in substantial compliance.	{C 000}		

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