OKLAHOMA
State Department
of Health

Delivery via email to: caryl@milestoneretirement.com

November 7, 2025

License Number: AL5591

Ms. Caryl Ridgeway, Administrator
The Mansion At Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

RE: Survey Event ID: MEQN11

Dear Ms. Ridgeway:

On **October 23, 2025**, agents from our office concluded a State Licensure survey with complaint investigations 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 **October 23, 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
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,

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: **The Mansions at Waterford**
Address: **6110 North Penn Avenue**
City, State, Zip: **Oklahoma City. OK, 73112**
Provider #: **AL5591**
Complaint #: **OK00066063**
Investigation Date(s): **10/21/25 through 10/23/25**

ALLEGATION(S)

1. The center failed to ensure residents were not falsely billed according to the contract, the assessment and the care plan.

An unannounced on-site investigation was initiated 10/21/2025 at 9:00 a.m.

A sample of 12 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.

Resident records were reviewed including assessments, physician orders, nursing notes, 30 day notices, treatment records, and contracts. Residents and family representatives were interviewed about facility policy, billing practices and procedures. Staff were interviewed regarding rate increases and billing practices.

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: 10/29/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **The Mansions at Waterford**
Address: **6110 North Penn Avenue**
City, State, Zip: **Oklahoma City. OK, 73112**
Provider #: **AL5591**
Complaint #: **OK00066116**
Investigation Date(s): **10/21/25 through 10/23/25**

ALLEGATION(S)

1. The center failed to ensure residents were notified of rate increases according to the contract and State Law.

An unannounced on-site investigation was initiated 10/21/2025 at 9:00 a.m.

A sample of 12 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.

Resident records were reviewed including assessments, physician orders, nursing notes, 30 day notices, treatment records, and contracts. Residents and family representatives were interviewed about facility policy, billing practices and procedures. Staff were interviewed regarding rate increases and billing practices.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

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INVESTIGATIVE REPORT

Facility: **The Mansions at Waterford**
Address: **6110 North Penn Avenue**
City, State, Zip: **Oklahoma City. OK, 73112**
Provider #: **AL5591**
Complaint #: **OK00066810**
Investigation Date(s): **10/21/25 through 10/23/25**

ALLEGATION(S)

1. The center failed to ensure residents or resident representatives were informed prior to the facility completing a bank.

An unannounced on-site investigation was initiated 10/21/2025 at 9:00 a.m.

A sample of 12 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.

Resident records were reviewed including assessments, physician orders, nursing notes, 30 day notices, treatment records, and contracts. Residents and family representatives were interviewed about facility policy, billing practices and procedures. Staff were interviewed regarding rate increases and billing practices.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

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Facility: **The Mansions at Waterford**
Address: **6110 North Penn Avenue**
City, State, Zip: **Oklahoma City. OK, 73112**
Provider #: **AL5591**
Complaint #: **OK00075842**
Investigation Date(s): **10/21/25 through 10/23/25**

ALLEGATION(S)

1. The center failed to ensure medication was administered as ordered by the physician.
2. The center failed to ensure residents were not verbally or psychosocially abused or neglected.

An unannounced on-site investigation was initiated 10/21/2025 at 9:00 a.m.

A sample of 12 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.

Resident records were reviewed including assessments, physician orders, nursing notes, 30 day notices, treatment records, grievances, medication administration records, incidents, abuse policy, medication administration policy, and contracts. Residents and family representatives were interviewed about facility policy, abuse concerns and medication administration concerns. Staff were interviewed regarding abuse policies, medication administration, and documentation.

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: 10/29/2025

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INVESTIGATIVE REPORT

Facility: **The Mansions at Waterford**
Address: **6110 North Penn Avenue**
City, State, Zip: **Oklahoma City. OK, 73112**
Provider #: **AL5591**
Complaint #: **OK00080237**
Investigation Date(s): **10/21/25 through 10/23/25**

ALLEGATION(S)

1. The facility failed to ensure residents were free from abuse.

An unannounced on-site investigation was initiated 10/21/2025 at 9:00 a.m.

A sample of 12 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.

Resident records were reviewed including assessments, physician orders, nursing notes, 30 day notices, treatment records, grievances, medication administration records, incidents, abuse policy, medication administration policy, and contracts. Residents and family representatives were interviewed about facility policy, and abuse concerns. Staff were interviewed regarding abuse policies and concerns.

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: 10/29/2025

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INVESTIGATIVE REPORT

Facility: **The Mansions at Waterford**
Address: **6110 North Penn Avenue**
City, State, Zip: **Oklahoma City. OK, 73112**
Provider #: **AL5591**
Complaint #: **OK00086605**
Investigation Date(s): **10/21/25 through 10/23/25**

ALLEGATION(S)

1. The facility failed to protect residents from resident to resident abuse.

An unannounced on-site investigation was initiated 10/21/2025 at 9:00 a.m.

A sample of 12 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.

Resident records were reviewed including assessments, physician orders, nursing notes, 30 day notices, treatment records, grievances, medication administration records, incidents, abuse policy, medication administration policy, and contracts. Residents and family representatives were interviewed about facility policy, and abuse concerns. Staff were interviewed regarding abuse policies and concerns.

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: 10/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5591	A. BUILDING: _____ B. WING _____	C 10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANSION AT WATERFORD	6110 NORTH PENN AVENUE OKLAHOMA CITY, OK 73112

(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 with complaints (#OK00066063, OK00066116, OK00066810, OK00075842, OK00080237, and #OK00086605) was conducted from 10/21/25 through 10/23/25. Deficiencies were cited as a result of the survey. Facility Census: 109 Listed below are abbreviations that will be used throughout this document. ACMA - advanced certified medication aide ACT - actuation calc/mag - calcium and magnesium carb/levo - carbidopa levodopa DM - dietary manager ER - extended release EX - extended release mg - milligram ml - milliliter ppm - parts per million SPR - spray STR - strength tab - tablet	C 000		
C 391 SS=F	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	C 391		

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C 391	Continued From page 1 interview, the center failed to ensure the sanitizer solution in the dishwasher was maintained according to recommended ppm levels for the sanitization of dishware. The vice president of quality assurance identified 109 residents received nutrition from the kitchen. Findings: On 10/21/25 at 9:25 a.m., kitchen staff #1 was observed testing the sanitizer solution in the dishwasher. The test strip had a reading below 50 ppm. On 10/21/25 at 9:26 a.m., kitchen staff #2 was observed testing the sanitizer in the dishwasher. The test strip had a reading below 50 ppm. On 10/21/25 at 9:27 a.m., the DM was observed testing the sanitizer in the dishwasher. The test strip had a reading below 50 ppm. An undated policy titled "Recording of Dishmachine Temperatures," read in part," The concentration of the sanitary solution during the rinse cycle is 50 -100 ppm with Chlorine sanitizer." On 10/21/25 at 9:28 a.m., the dietary manager stated the sanitizer in the dishwasher was reading below 50 ppm. On 10/21/25 at 12:23 p.m., the DM stated they did not have a manufacturer's policy.	C 391		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that	C 543		

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C 543	Continued From page 2 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 resident assessments included a personal interview between the resident and/or the residents representative for 2 (#1 and #3) of 12 sampled residents reviewed for comprehensive assessments. The administrator identified 109 residents resided in the center. Findings: A policy titled "AS01-Resident Assessments," dated 06/20/25, read in part, "Assessments are completed and updated as frequently as necessary to ensure they reflect current resident care needs and preferences." 1. Resident #3's significant change assessment, dated 07/31/25, showed they were admitted on 11/07/23 with diagnoses which included lymphoma, cerebral vascular disease, and memory loss. The assessment showed Resident #3 was alert and oriented times one and had confusion. The assessment was not signed by the resident and/or resident representative.	C 543		

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 543	Continued From page 3 2. Resident #1's significant change assessment, dated 07/31/25, showed they were admitted on 01/01/25 with diagnoses which included anxiety disorder and abdominal hernia. The assessment showed Resident #1 was alert and oriented times two and confused. The assessment was not signed by the resident and/or resident representative. Resident #1's significant change assessment, dated 10/13/25, showed the resident usually confused with fair judgment. The assessment was not signed by the resident and/or resident representative. On 10/23/25 at 9:30 a.m., family representative #1 for Resident #1 and Resident #3 stated they did not sign or receive a copy of the significant change assessment completed on 07/31/25 for Resident #1 and Resident #3 and on 10/13/25 for Resident #1. On 10/23/25 at 1:30 p.m., the vice president of quality assurance stated all assessments should be signed by the resident and/or resident representative to ensure the resident was involved in the assessment. The vice president of quality assurance was shown Resident #1 and Resident #3 significant change assessments, dated 07/31/25 and the significant change assessment, dated 10/13/25 for Resident #1. The vice president of quality assurance stated the assessments were not signed by the residents and/or the residents representative because it was hard to get family to sign the assessments.	C 543		
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE	C1110		

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C1110	Continued From page 4 (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 maintain an internal quality assurance committee that monitored trends and incidents for 1 of 3 sampled QA meetings held quarterly for 2025. The administrator identified 109 residents resided in the center. Findings: The quality assurance notes, dated 09/15/25, did not show monitoring of trends and incidents in the center. On 10/23/25 at 1:09 p.m., the vice president of quality assurance stated the center did not have the centers incidents included in the quality	C1110		

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C1110	Continued From page 5 assurance meeting held on 09/15/25.	C1110		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to administer medications as ordered by the physician for 1 (#5) of 12 sampled residents reviewed for medication administration. The vice president of quality assurance identified 106 residents were administered medications from the center. Three residents self-administered medications. Findings: A policy titled "MP15-Documenting Medication Pass," dated 06/20/25, read in part, "All medications are administered per physician orders."..."The MARs are signed/initialed at the time the medication is poured."..."If a medication cannot be poured, the MAT/CMA (medication administration training/certified medication aide) will note in the MAR until the problem is rectified." Resident #5's admission assessment, dated 03/25/24, showed they were admitted with diagnoses which included Parkinson's disease, stage 3 kidney disease, and pulmonary hypertension. The assessment showed Resident #5 was alert and oriented times four with fair judgment. A MAR for Resident #5, dated 11/01/24 through 11/30/24, showed the resident did not receive the following medications on 11/09/24: a. acetaminophen EX/STR 500 mg, two tablets by mouth at 7:30 a.m. and 3:30 p.m.; and b. carb/levo tab 25-100 mg. Strength: 25-100 mg.	C1505		

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THE MANSION AT WATERFORD	6110 NORTH PENN AVENUE OKLAHOMA CITY, OK 73112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 7 One tablet by mouth at 7:00 a.m. The MAR documented five missed doses of medications on 11/09/24. A MAR for Resident #5, dated 12/01/24 through 12/31/24, showed the resident did not receive the following medications on 12/07/24: a. acetaminophen EX/STR 500 mg, two tablets by mouth at 7:30 a.m. and 3:30 p.m.; b. carb/levo tab 25-100 mg tablet by mouth at 7:00 a.m., 11:30 a.m., and 4:30 p.m.; c. calc/mag 1000/310 MG/5 MG. 2 ml (One dose); e. calcitronin SPR 200/ACT. One spray in the nostril daily; f. esomepra mag capsule 20 mg. Take one capsule by mouth daily; g. lidocaine pad 4%. Apply patch to the lower back every morning; h. nebivolol tablet 10 mg. Take one table by mouth; and i. oxybutynin tablet 10 mg ER. Take one tablet by mouth daily. There was a total of 13 missed opportunities for medications administered on 12/07/24. A center document for Resident #5 titled "Physician Order Review," dated 12/02/24, showed Resident #5 had the following orders: a. acetaminophen EX/STR 500 mg tablet, dated 10/22/24, take two tabs (1000 mg) by mouth twice daily (7:30 am and 3:30 pm); b. carb/levo tab 25-100 mg., dated 09/30/24, take one tablet by mouth three times a day; c. calc/mag 1000/310 mg/5 mg., dated 11/05/24, give 2 ml by mouth daily; d. calcitronin SPR 200/ACT, dated 10/22/24, One spray in nostril daily and alternate nostrils each day; e. docusate sodium 50 mg/8.6 mg. The order	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5591	A. BUILDING: _____ B. WING _____	C 10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANSION AT WATERFORD	6110 NORTH PENN AVENUE OKLAHOMA CITY, OK 73112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 8 was dated 09/30/24 to take one tablet by mouth daily for constipation and hold for loose stools; f. esomepra mag capsule 20 mg delayed release, dated 09/30/24, take one capsule by mouth every morning; g. lidociane pad 4 %, dated 11/27/24, apply one patch topically to the lower back every morning. On for 12 hours and off for 12 hours; h. nebivolol tab 10 mg., dated 09/30/24, take one tablet by mouth; and i. oxybutynin tab 10 mg ER, dated 11/08/24, take one tablet by mouth daily. On 10/22/25 at 1:33 p.m., ACMA #1 stated they were the medication aide passing medications on 11/09/24 and on 12/07/24. ACMA #1 stated when medications were not administered, there should be a reason charted. ACMA #1 was shown the MAR for Resident # 5 dated 11/01/24 through 12/31/24. They were asked what was charted on 11/09/24 and 12/07/24. ACMA #1 stated the medication listed above were not charted as administered on 11/09/24 and 12/07/24. ACMA #1 stated there was no documentation on 11/09/24 and 12/07/24 showing why the medications were not administered. On 10/22/25 at 1:54 p.m., the vice president of quality assurance was shown the MAR for Resident #5 dated 11/01/24 through 12/31/24. The vice president of quality assurance stated the above medications listed were not administered on 11/09/24 and on 12/07/24. The vice president of quality assurance stated there was no documentation showing why the medications were not administered on 11/09/24 and on 12/07/24.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: caryl@milestoneretirement.com

November 21, 2025

License Number: AL5591

Mr. Caryl Ridgeway, Administrator
The Mansion At Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

RE: Survey Event MEQN11

Dear Mr. Ridgeway:

On **October 23, 2025**, a Licensure inspection with complaint investigations 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 **December 18, 2025**.

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement 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: 11/19/2025** **Facility Name:** The mansion at Waterford **License Number:** AL5591 **Survey Event ID:** MEQN11 **Date Survey Completed: 10/23/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 391	Based on: Observation, record review and interview, the center failed to ensure the sanitizer solution in the dishwasher was maintained according to recommended ppm levels for the sanitization of dishware.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law

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?	Sanatizer solution was replaced and the PPM levels were adjusted to meet the department requirements.
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 review was conducted of dishwashing and sanitization records from the previous 30 days to identify any time periods when PPM levels were out of range. Residents who received nutrition day of survey during those times PPM levels were out of range were considered to have the potential to be affected. No residents affected.
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?	Dietary staff will receive re-education on proper dishwashing sanitization including how to test PPM levels. A daily monitoring log will be verified. Weekly preventative maintenance schedule implemented to ensure sanitizing dispenser is functioning properly.
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.	Daily monitoring log checked daily by Dietary Director or Designee Sanitizer PPM log reviews PPM log for 30 days and then weekly for 60 days to ensure effectiveness. Random audits to be conducted there after. The QA team will review sanitizer PPM logs, Audit findings, staff competency results and any reported infection control concerns related to dish sanitization. DCS will do random checks herself on the numbers to assure accurate. The PPM Log will be completed and signed off by staff at start and end of shift. The log will include date and time of testing. PPM readings, initials of staff performing tests and corrective action being taken when levels are out of

	range. Dietary supervisor will review and initial and store logs in a binder in supervisors office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/18/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Caryl Ridgeway** OAC 310:663-25-4(F)	**Date 11/19/2025**

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/8/2025

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: MEQN11

Date Survey Completed: 10/23/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 543	Based on: record review and interview, the center failed to ensure resident assessments included personal interview between the resident and/or the residents representative for 2 (#1 and #3) of 12 sampled residents reviewed for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law

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 #1 and #3 assessment will be reviewed and signed with resident representative.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Audit will be conducted to insure comprehensive assessment is signed by the resident and/or resident representative.
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?	VPQA and/or designee will conduct audit for resident and/or resident representative signatures on comprehensive assessments. VPQA and/or designee will monitor for completion of resident and/or resident representative signatures on comprehensive assessments.
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.	VPQA and/or designee will monitor signatures on comprehensive assessments to ensure they are signed per regulations. Comprehensive assessment log will be implemented by VPQA and/or deignee and reviewed weekly for 30 days. Random audits to be conducted to ensure compliance. AED, RCD and/or designee will maintain documentation of comprehensive assessments signed by resident and/or resident representative. Assessements completed will be reported and reviewed during QA meeting.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/18/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Caryl Ridgeway** **Date 11/19/2025**

OAC 310:663-25-4(F)

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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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
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/18/2025

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: MEQN11

Date Survey Completed: 10/23/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1110	Based on: record review and interview, the center failed to maintain an internal quality assurance committee that monitored trends and incidents for sampled QA meetings help quarterly for 2025

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law

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?	QA meetings will be conducted every quarter to ensure monitoring of trends and incidents in our building. No residents were 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?	No residents were affected by the deficient practice due directly to the lack of QA monitoring. A systematic correction has been initiated by re-establishing an active QA/QAPI committee with documented regular meetings, tracking systems, and corrective action follow-through.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The facility has re-establish a quality assurance performance improvement committee that meets quarterly to show monitoring, trends and incidents in the community.
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.	Community will conduct weekly audits for 60 days and then quarterly there after to ensure monitoring of trends and incidents in the community. The administrator or designee will conduct random audits for 30 days to review QA notes to include monitoring of trends and incidents. Incident dashboard will be reviewed monthly. Audit results will be recorded in QA documents. Review of resident incidents will be conducted monthly and results will be recorded in QA documents
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/18/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Caryl Ridgeway** **Date 11/19/2025**

OAC 310:663-25-4(F)

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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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
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Oklahoma State Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/8/2025

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: MEQN11

Date Survey Completed: 10/23/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1505	Based on: record review and interview, the center failed to administer medications as ordered by the physician for 1 (#5) of 12 sampled residents reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law

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 community will administer as ordered by the physician. Resident #5 no longer resides at 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?	VPQA and/or designee will review medication dashboard weekly to ensure medications are administered as ordered by physician.
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?	VPQA and/or designee will monitor medication dashboard weekly. Med techs will be inserviced on medication management.
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.	VPQA, and/or designee will review medication dashboard daily. VPQA, AED and/or designee will review medication dashboard through weekly audits. Weekly audits will be incorporated into the QA system for tracking and trending. Weekly audit will be reported in community QA documents.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/18/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Caryl Ridgeway** **Date 11/19/2025**
OAC 310:663-25-4(F)

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

OKLAHOMA
State Department
of Health

Delivery via email to: Caryl Ridgeway <caryl.ridgeway@milestoneretirement.com>

December 23, 2025

License Number: AL5591

Ms. Caryl Ridgeway, Administrator
The Mansion At Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

RE: Survey Event MEQN12

Dear Ms. Ridgeway:

On **December 23, 2025,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey with complaints on **October 23, 2025,** have now been corrected effective **December 18, 2025.**

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
	AL5591	A. BUILDING: _____ B. WING _____	R-C 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANSION AT WATERFORD	6110 NORTH PENN AVENUE OKLAHOMA CITY, OK 73112

(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 12/23/25. 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