OKLAHOMA
State Department
of Health

Delivery via email to: polly.adams@jasmineestatesedmond.com

July 23, 2025

License Number: AL5598

Ms. Pollyette Adams, Administrator
Jasmine Estates Of Edmond
1001 S Bryant Ave
Edmond, OK 73034

RE: Survey Event ID: JXBF11

Dear Ms. Adams:

On **July 15, 2025**, agents from our office concluded a State Licensure survey with complaint investigation 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 **July 15, 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 OSDH.LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Jasmine Estates of Edmond**
Address: **1001 S Bryant Ave.**
City, State, Zip: **Edmond, Ok. 73034**
Provider #: **AL5598**
Complaint #: **OK00084429**
Investigation Date: **07/10/25, and 07/14/25 through 07/15/25**

ALLEGATION(S)
1. The facility failed to ensure residents were free from abuse
2. The facility failed to ensure care was provided for dependent residents.
3. The facility failed to ensure the resident's choice of activities.
4. The facility failed to ensure residents receive three meals per day.

An unannounced on-site investigation was initiated 07/10/2025 at 11:20 a.m.

A sample of three participants, including any identified participants, 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 into the center. Residents were observed for abuse and neglect, personal care, activity and dietary concerns. Staff were observed interacting with residents. Records reviewed included: Residents health records, facility reported incidents, grievances, and police reports. Residents, and staff were asked questions regarding abuse and abuse training, personal care, activities and dietary processes.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 07/17/2025

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	AL5598	A. BUILDING: _____ B. WING _____	C 07/15/2025

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JASMINE ESTATES OF EDMOND	1001 S BRYANT AVE EDMOND, OK 73034

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C 000	INITIAL COMMENTS A relicensure survey with complaint (#OK00084428) was conducted 07/10/25 and 07/14/25 through 07/15/25. Deficiencies were cited as a result of the survey. Facility Census: 35 Listed below are abbreviations that will be used throughout this document: CNA - Certified Nursing Assistant CMA - Certified Medication Aide DD - Dining Director ED - Executive Director OSDH - Oklahoma State Department of Health RN - registered nurse	C 000		
C 391 SS=D	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 facility failed to ensure food items were covered and labeled with the open and use date in 1 of 2 refrigerators observed. The dining director identified 35 residents received nutrition from the kitchen. Findings:	C 391		

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C 391	Continued From page 1 On 07/10/25 at 12:28 p.m., the following items were observed opened or prepared in 1 of 2 refrigerators with no labels to show the open or prepared and use by date: a. two plastic pitchers of prepared juice drink b. one plastic bag containing lunch meat, c. one plastic container of prepared ham salad, d. one plastic container of salad dressing, e. one plastic container of sour cream, f. one uncovered metal bowl, with fruit type contents, g. one uncovered metal pan, with prepared jello, f. one fresh cantaloupe, soft and mushy with dark spots visible, and g. two plastic containers of fresh strawberries with visible mold. A facility policy titled "Food Preparation and Storage Policy," dated May 2025, read in part, "Food will be stored, prepared and served so that the risk of foodborne illness is minimized in accordance with the Oklahoma State Department of Health regulations." On 07/10/25 at 2:45 p.m., the dining director was asked about all items that were spoiled, molded, not covered, labeled or dated. They stated "All items should be fresh, checked regularly, covered if stored in an open container and they should all be labeled and dated."	C 391		
C 910 SS=E	310:663-9-1 NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with	C 910		

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C 910	Continued From page 2 the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to provide sufficient staff to meet the services in the assisted living center's contract for 14 residents identified as not capable of self preservation. The ED identifed 35 residents resided in the center. Findings: On 07/10/25 at 1:45 p.m., an initial tour of the facility was conducted. There were six residents in Broda type chairs in the television room. These residents were dependent on staff or others for mobility of chairs, as they are not able to be	C 910		

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C 910	Continued From page 3	C 910		

moved by the resident, and required two person assistance for placement in and out of the chairs. A resident in main entry area was being assisted up out of a chair to their walker with two staff persons assisting, as they were not strong enough for one staff person to assist out of the chair to stand.

On 07/15/25 at 3:45 p.m., observed a resident being taken via wheelchair from the television area to their room, the family member stated they were helping them to the bathroom.

Facility staff schedules, for a current census of 35 residents in four separate wings, for 06/29/25 thru 07/12/25, showed six staff assigned on the 7 a.m. - 3 p.m. shift; five staff assigned on the 3 p.m. - 11 p.m. shift, and three staff assigned on 11 p.m. - 7 a.m. shift.

A resident condition and overview form, dated 07/10/25, showed 14 residents were not capable of responding to emergency situations without physical assistance from staff of the facility or were not capable of self preservation.

An undated resident evacuation list, effective July 1, 2025 per ED, showed 11 out of 35 residents required two staff person assist for evacuation.

A resident agreement for Resident #7, signed 01/15/24, read in part "Should an emergency evacuation of the building structure occur, community owner, through its staff, shall evacuate all residents."

On 07/14/25 at 11:25 a.m., family member #1 stated the staff frequently left their family member in their room without routine checks - hours at a time. They reported one recent event

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C 910	Continued From page 4 when the family was observing the camera monitoring system and noted that Resident #7 was checked at 6:45 p.m. then nothing until 12:00 a.m., even though they were screaming and yelling. On 07/15/25 at 1:15 p.m., CNA #1 stated staffing during the day seemed good, but they seemed to need more help on the evenings and night shift. They stated when they came in in the morning, there were often times there was still laundry and other tasks that needed to be finished due to other shifts not having time to get it done due to resident care. On 07/14/25 at 2:00 p.m., the ED stated the resident evacuation list was current effective July 1,2025, and showed eleven residents required two staff person assist for transfers from bed to chair if there was a need to evacuate. The ED was asked about staffing related to acuity of residents. The ED stated they did acknowledge they needed more staff available for residents, especially at night,. The ED stated they were working with upper management regarding added staffing. On 07/15/25 at 2:15 p.m., Resident #8 stated there needed to be more staff in the evenings and at night as it took them awhile to find anyone to help when another resident fell and was hollering for help. Resident #8 stated they had to get up and go find someone, and it took awhile to get assistance as the staff were in other residents rooms. On 07/15/25 at 3:45 p.m., a family member in the hallway stated they frequently helped their loved one when they visited, since the staff were often helping other residents.	C 910		

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C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide registered nurse supervision for 8 (#1, #2, #3, #4, #5, #6, #7, and #8), of 8 sampled residents reviewed for skilled nursing interventions. The ED identified 35 residents resided in the facility. Findings: The clinical records for Resident #1 through Resident #8, reviewed from 05/2025 through 07/15/2025, did not contain documentation to indicate fall assessments, elopement risk	C 911		

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C 911	Continued From page 6 assessments, service plans, and dietary notes were conducted by an RN. A facility policy titled "Required Staffing," reviewed May 2025, read in part, "Nurse staffing will comply with the provisions of the Oklahoma Nursing Practice Act and will be provided or arranged as follows: Registered nurse supervision of skilled nursing interventions." On 07/14/25 at 10:50 a.m., CNA #1 was asked about communication with a nurse related to medication concerns. They stated the nurse was off at this time. CNA #1 stated they would take any concerns or issues to the ED. CNA #1 was asked who would assess residents if other issues came up. The CNA stated they were not sure as there was only one nurse they knew of and they were off at this time. On 07/15/25 at 3:30 p.m., the ED was asked about staffing related to RN availability and who was responsible for review of resident service plans and supervision of other skilled nursing interventions. The ED stated they utilize the facility physician for service plan reviews. The ED was asked about supervision of skilled nursing interventions per OSDH requirements. The ED stated they did not have an RN available at this time, but did have one hired and was to start work soon.	C 911		
C 961 SS=E	310:663-9-6(a) MINIMUM STAFF FOR SERVICES (a) The right number of trained staff shall be on duty, awake, and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents and to carry out all the processes listed	C 961		

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C 961	Continued From page 7 in the continuum of care facility's, or assisted living center's, written emergency and disaster preparedness plan for fires and other natural disasters. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure sufficient staff to meet the needs of the facilities written emergency disaster policy for 35 of 35 residents who resided in the facility. The ED identified 35 residents resided in the facility. Findings: The Resident Agreement, signed 01/15/25 for Resident #7, read in part, "Facility Evacuation. Should an emergency evacuation of the building structure occur, community owner, through its	C 961		

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C 961	Continued From page 8 staff, shall evacuate all residents." An undated "Emergency/Disaster" policy, read in part, "Staff will be responsible for transferring residents" A resident condition and overview form, dated 07/10/25, showed 14 residents were not capable of responding to emergency situations without physical assistance from staff of the facility or were not capable of self-preservation. An undated resident evacuation list showed 11 out of 35 residents required two persons to assist for evacuation. The ED stated the list was current effective July 1, 2025. Facility staff schedules, dated 06/29/25 through 07/12/25, for the current census of 35 residents in four separate wings showed: a. six staff on the 7 a.m. - 3 p.m. shift, b. five on the 3 p.m. - 11 p.m. shift, and c. three on 11 p.m. - 7 a.m. shift. On 07/14/25 at 2:00 p.m., the ED was asked about staffing related to the acuity of residents. The ED stated they did acknowledge they needed more staff available for residents, especially at night, and were talking with upper management regarding staffing. The ED was asked if they felt like the staff they currently had could evacuate the building if needed. The ED stated they could not.	C 961		
C1922 SS=D	310:663-19-2(a)(2) MEDICATION ADMINISTRATION (2) The person responsible for administering medications shall personally prepare the dose,	C1922		

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C1922	Continued From page 9 observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour prior to administration. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure the correct preparation for non crushable medications for 1 (#3) of 2 sampled residents who were reviewed for medication administration. The administrator reported 35 residents resided in the center. Findings: A Medication Administration Report, dated July 2025, showed Resident #3 was admitted to the center on 11/13/24 with diagnoses which included Alzheimer's disease, dementia, hypertension and moderate episodes of recurrent major depressive disorders. A facility policy "Medication Administration, Crushing of Medications," read in part, "Medications which are enteric coated, extended release or otherwise noted by manufacturer as inappropriate for crushing, may not be crushed." A Physician's Order Report, dated 06/01/25, for Resident #3, read in part, "Divalproex Sodium Oral Tablet Delayed Release [An anticonvulsant medication] 125 MG [milligram]..."ADMINISTER 1 Tab [tablet] BY MOUTH EVERY 12 HOURS "DO NOT CRUSH"..."Gabapentin Oral Capsule 100 MG..."ADMINISTER 1 CAP [capsule] BY MOUTH TWICE DAILY "DO NOT CRUSH"..."buPROPion HCl [medication for	C1922		

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C1922	Continued From page 10 depression] ER [extended release] (SL) Oral Tablet Extended Release 24 Hour 150 MG." On 07/14/25 at 10:50 a.m., CMA #2 was observed to insert the Bupropion, Divalproex, and Gabapentin into a plastic sleeve, which was used to hold medications while crushing. As CMA #2 was about to begin crushing the medications, they were asked if all the medications in the sleeve were able to be crushed. The CMA stated they did not know the medications were not crushable, and did not see the notes in the medication administration record or on the packaging the medications came in from the pharmacy. CMA #2 was asked what they would do if the resident could not swallow medications identified as non-crushable. CMA #2 stated they would ask the nurse. On 07/14/25 at 10:55 a.m., CMA #1 was asked if they were aware of special instructions on the medication packaging and medication administration record. CMA #1 stated they had not noticed them before, but knew they should not crush extended release medications. CMA #1 stated packaging was often not looked at as it was a plastic bag that listed the medications in the package. The CMA stated the medications were in individual containers and that was what they used to reference when preparing medications to be given to the resident. CMA #1 stated they did not have comments on them, only what was in them. CMA #1 was asked if they had education regarding medications that were not crushable and the process to take if they were identified. CMA #1 stated they had not had education at this facilty they were aware of, and they would go to the nurse if they had questions or concerns.	C1922		

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C1922	Continued From page 11 On 07/14/25 at 11:15 a.m., the ED was asked about the medication administration process related to medications identified as non crushable on the medication packaging, as well as the medication administration record where the CMA's document administration of medications. The ED stated they should be following the specific instructions and reporting to the nurse if there were concerns or issues. The ED stated they were not sure of education or the process for observation of medication passes by nursing director.	C1922		
C1972 SS=D	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure staff were educated on abuse within 90 days of hire for 2 (CMA #2, and housekeeper #1) of 5 sampled employees whose records were reviewed for trainings. The ED identified 35 residents resided in the center. Findings:	C1972		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5598	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF EDMOND	1001 S BRYANT AVE 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
C1972	Continued From page 12 1. The employee handbook, staff training reports, and employee files showed CMA #2 was hired on 01/12/24, and there was not any documentation of abuse training provided. 2. The employee handbook, staff training reports, and employee files showed housekeeper #1 was hired on 11/15/24, and there was not any documentation of abuse training provided. A policy titled "Abuse and Neglect," reviewed May 2025, read in part, "All employees, within ninety (90) days of employment, will be trained in identification of abuse and neglect of residents." On 07/15/25 at 3:30 p.m., the ED was asked about abuse and neglect training for employees. The ED stated there was not any documentation of abuse training for CMA #2 or housekeeper #1. The ED stated they were aware the training was to be completed within ninety days of hire, and they encourage the training to be completed before staff are assigned to work with residents.	C1972		
C6000 SS=E	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the	C6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5598	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF EDMOND	1001 S BRYANT AVE 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
C6000	Continued From page 13 following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor	C6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5598	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF EDMOND	1001 S BRYANT AVE EDMOND, OK 73034

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C6000	Continued From page 14 to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services. This Rule is not met as evidenced by: Based on record review and interview, the center failed to conduct registry screening and background checks for staff upon hire for 2 (housekeeper #1 and CNA #3) of 5 sampled personnel files reviewed. The administrator identifed 35 residents resided in the center. Findings: 1. The personnel file for housekeeper #1 showed they were hired on 11/15/24. Review of employee records showed the criminal history background check was completed on 11/25/24.	C6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5598	A. BUILDING: _____ B. WING _____	C 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF EDMOND	1001 S BRYANT AVE 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
C6000	Continued From page 15 2. The personnel file for CNA #3 showed they were hired on 01/17/25. Review of the employee records showed the criminal history background check was completed on 04/16/25. On 07/15/25 at 3:30 p.m., the ED was interviewed regarding the registry screening and background check completion process when employees were hired. The ED stated they were in the process of updating the policies and employee handbook for the new hire process and were aware they needed to be completed.	C6000		

OKLAHOMA
State Department of Health

Delivery via email to: polly.adams@jasmineestatesedmond.com

August 6, 2025

License Number: AL5598

Ms. Pollyette Adams, Administrator
Jasmine Estates Of Edmond
1001 S Bryant Ave
Edmond, OK 73034

RE: Survey Event JXBF11

Dear Ms. Adams:

On **July 15, 2025**, a Licensure inspection with complaint investigation 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 **August 6, 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: 7/28/2025** **Facility Name:** Jasmine Estates of Edmond **License Number:** AL5598 **Survey Event ID:** JXBF11 **Date Survey Completed: 7/15/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 391	Based on: observation, record review and interview, the facility failed to ensure food items were covered and labeled with the open and use date in 1 of 2 refrigerators 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?	All food coverage/dating guidelines have been reviewed with staff. Inservice is scheduled for 08/01/2025 for full company education of regulations.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Continued monitoring by Exec. Chef to ensure compliance. Continued education will be conducted quarterly to maintain knowledge of regulatory expectations.
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?	Continued monitoring by Exec. Chef to ensure compliance. Continued education will be conducted quarterly to maintain knowledge of regulatory expectations.
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.	Monthly department audits conducted by Chef. Review of monthly audits during quarterly QA meeting. Through review of monthly audits during quarterly QA meeting, continued attendance by Exec. Chef. Monthly audit tool will be maintained for review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/1/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Pollyette Adams** OAC 310:663-25-4(F)	**Date 7/28/2025**

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: 7/28/2025** **Facility Name:** Jasmine Estates of Edmond **License Number:** AL5598 **Survey Event ID:** JXBF11 **Date Survey Completed: 7/15/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 910	Based on: observation, record review, and interview, the center failed to provide sufficient staff to meet the services in the assisted living center's contract for 14 residents identified as not capable of self preservation.

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?	An additional staff member has been added to evening and overnight shift to ensure care of residents according to contractual services.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Staffing will continue to be overseen by ED during nursing transition to ensure compliance based on acquity in consideration of care of residents according to contractual services.
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?	RE-evaluation of staffing plan to meet care needs of residents care according to contractual services. Continued monitoring conducted by ED to ensure compliance.
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.	Through staffing schedule, and review of care of residents according to contractual services during quarterly QA meetings. Through audit of staffing for care of residents according to contractual services during quarterly QA meetings. Through audit of staffing for care of residents according to contractual services during quarterly QA meetings. Staffing schedules are maintained for staffing record, care plans of residents, for documented high acquity residents.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/28/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Pollyette Adams** OAC 310:663-25-4(F)	**Date 7/28/2025**

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/28/2025** **Facility Name:** Jasmine Estates of Edmond **License Number:** AL5598 **Survey Event ID:** JXBF11 **Date Survey Completed: 7/15/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 911	Based on: observation, record review andinterview, the facility failed to provide registered nurse supervision for 8 (#1, #2, #3, #4, #5, #6,#7, and #8), of 8 sampled residents reviewed for skilled nursing interventions.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: We ask that it be noted that our pursuit of contracting with the Medical Director was that of a pure intention to exceed the expectation of the RN by supplying a higher level of oversight for our residents, their families and our staff. Our medical director is contracted to provide training and support at a higher level than that of just providing signatures as required. We now have a better understanding of the regulatory requiement and have aggressively moved forward to ensure full compliance.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	RN Supervisor/Wellness Director has been hired for start date of 8/6/25.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	RN supervisor will continue to be employed to monitor skilled nursing interventions moving forward.
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?	RN has been placed in the Wellness Director role to ensure all skilled nursing interventions, as well as daily nursing functions are completed within the single role.
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.	RN Supervisor will continue to be part of community staff. Through the oversight of skilled nursing interventions conducted by the RN. RN is appointed to be an active member of the QA team. Through employment record of RN, through signed documentation of skilled nursing interventions.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/6/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Pollyette Adams** OAC 310:663-25-4(F)	**Date 7/28/2025**

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/28/2025** **Facility Name:** Jasmine Estates of Edmond **License Number:** AL5598 **Survey Event ID:** JXBF11 **Date Survey Completed: 7/15/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 961	Based on: record review and interview, the center failed to ensure sufficient staff to meet the needs of the facilities written emergency disaster policy for 35 of 35 residents who resided in the facility.

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?	An additional staff member has been added to evening and overnight shift to ensure safety of residents in emergent situations.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Staffing will continue to be overseen by ED during nursing transition to ensure compliance based on acquity in consideration of emergent situations.
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?	RE-evaluation of staffing plan to meet safety for residents in emergent situations. Continued monitoring conducted by ED to ensure compliance.
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.	Through staffing schedule,care plan review, and review of emergency planning for evacuation during quarterly QA meetings in the event of emergent situation. Through audit of care plans, scheduling audit, and evacuation planning for those unable to mobilize themselves in an emergent situation. Review of evacuation plan for noted 2 person assist will be conducted at each quarterly QA meeting. Staffing schedules are maintained for staffing record, care plans of residents, as well as emergency plan for documented high acquity residents.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/28/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Pollyette Adams**  OAC 310:663-25-4(F)	**Date 7/28/2025**

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/28/2025** **Facility Name:** Jasmine Estates of Edmond **License Number:** AL5598 **Survey Event ID:** JXBF11 **Date Survey Completed: 7/15/2025**

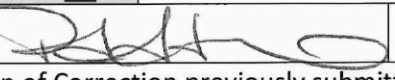
SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1922	Based on: observation, record review, and interview, the center failed to ensure the correct preparation for non crushable medications for 1(#3) of 2 sampled residents who were reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: DON provided a blanket order of 'crush all crushable meds' and should have followed through in ensuring that staff were aware of non-crushable meds.

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?	Pharmacist and Medical Director review of all medications and their orders was conducted 07/22/2025 to adjust orders appropriately. In-service scheduled 7/30/25 to build skills in recognizing crushable and non-crushable medications.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Medical Director and Pharmacist will review medication orders for non-crushable medications quarterly to ensure non-crushable meds are correctly identified. RN will follow through with education to staff administering medications.
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?	Medical Director and Pharmacist will review medication orders for non-crushable medications quarterly to ensure non-crushable meds are correctly identified. RN will follow through with education to staff administering medications.
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.	Through quarterly pharmacy review, monthly physician order review and RN oversight. Through quarterly QA meetings. Review of changing medication orders to ensure compliance and continued audit. Through quarterly QA meetings, and through pharmacy audit.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/30/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Pollyette Adams**  OAC 310:663-25-4(F)	**Date 7/28/2025**

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/28/2025** **Facility Name:** Jasmine Estates of Edmond **License Number:** AL5598 **Survey Event ID:** JXBF11 **Date Survey Completed: 7/15/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1972	Based on: record review and interview, the center failed to ensure staff were educated on abuse within 90 days of hire for 2 (CMA #2, and housekeeper #1) of 5 sampled employees whose records were reviewed for trainings.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Files were audited by incoming ED in April 2025. ED then discovered missing training and completed immediately. No further issues have occurred.

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?	All employee records were audited for Q2 in April 2025, and continued audits are performed each Quarter.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Through continued audits of employee records each quarter. Through continued training through in-service meetings.
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?	Continued audits of employee records each quarter, and continued training through in-service meetings.
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.	Through quarterly QA review of audited files. Through quarterly QA review of audited files. Audit review discussed in quarterly QA meeting. Within quarterly QA reporting.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/28/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Pollyette Adams** OAC 310:663-25-4(F)	**Date 7/28/2025**

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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: 7/28/2025** **Facility Name:** Jasmine Estates of Edmond **License Number:** AL5598 **Survey Event ID:** JXBF11 **Date Survey Completed: 7/15/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C6000	Based on: record review and interview, the center failed to conduct registry screening and background checks for staff upon hire for 2(housekeeper #1 and CNA #3) of 5 sampled personnel files reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Files were audited by incoming ED in April 2025. ED then discovered missing backgrounds and completed immediately. No further issues have occurred.

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?	All employee records were audited for Q2 in April 2025, and continued audits are performed each Quarter.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Through continued audits of employee records each quarter.
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?	Continued audits of employee records each quarter.
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.	Through quarterly QA review of audited files. Through quarterly QA review of audited files. Audit review discussed in quarterly QA meeting. Within quarterly QA reporting.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/28/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Pollyette Adams** OAC 310:663-25-4(F)	**Date 7/28/2025**

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

Delivery via email to: polly.adams@jasmineestatesedmond.com

August 11, 2025

License Number: AL5598

Ms. Pollyette Adams, Administrator
Jasmine Estates Of Edmond
1001 S Bryant Ave
Edmond, OK 73034

RE: Survey Event JXBF12

Dear Ms. Adams:

On **August 11, 2025,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your relicensure survey with complaint on **July 15, 2025,** have now been corrected effective **August 6, 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
	AL5598	A. BUILDING: _____ B. WING _____	R-C 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF EDMOND	1001 S BRYANT AVE 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 08/11/25. 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