OKLAHOMA
State Department
of Health

Delivery via email to: anna@countrysideltc.com

December 4, 2025

License Number: AL6102

Ms. Anna Franklin, Administrator
Countryside At Belfair
802 Windsong Way
McAlester, OK 74501

RE: Survey Event ID: 4LOI11

Dear Ms. Franklin:

On **November 20, 2025**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **November 20, 2025**.

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

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

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

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

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

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

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record, and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

Or mail to:

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

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

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

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

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

Respectfully,

Tempal Killman

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Countryside at Belfair
Address: 802 Windsong Way
City, State, Zip: McAlester, OK, 74501
Provider #: AL6102
Complaint #: OK00079532
Investigation Date(s): 11/17/25 through 11/20/25

ALLEGATION(S)
The facility failed to assess, monitor, and/or intervene in a timely manner after residents had a fall.
The center failed to notify the resident representative or responsible party after a change in condition.

An unannounced on-site investigation was initiated 11/17/2025 at 11:00 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation: Upon entrance and throughout the survey staff were observed assisting residents with activities of daily living. Staff were observed assisting residents with mobility and transfers.

The residents stated the staff checked on them often and were available if needed. The residents stated they had alert wristbands or necklaces if they needed staff. The residents stated the staff notify their family with any changes or concerns. The staff stated if a resident had a fall the resident would be assessed and the physician, family, and administrator would be notified immediately.

Policies and procedures, resident assessments, physician orders, progress notes, incident reports, and resident contract/agreements were reviewed.

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: 11/30/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Countryside at Belfair
Address: 802 Windsong Way
City, State, Zip: McAlester, OK, 74501
Provider #: AL6102
Complaint #: OK00081756
Investigation Date(s): 11/17/25 through 11/20/25

ALLEGATION(S)
The facility failed to ensure residents were free from abuse.
The facility failed to ensure adequate supervision to prevent accidents.

An unannounced on-site investigation was initiated 11/17/2025 at 11:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:
Upon entrance and throughout the survey observations were made of resident and staff interaction. Staff were observed assisting residents with activities of daily living. Staff were observed interacting with residents in a calm and pleasant manner. There were no residents with visible bruises noted.

Residents stated the staff assisted them with mobility and were available if needed for assistance. The residents expressed no fear or verbalized any abuse. The staff stated resident abuse was not tolerated.

Policies and procedures, resident assessments, physician orders, care plans, progress notes, incident reports, staff in-services/training, and staff schedules were reviewed.

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: 11/30/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Countryside at Belfair
Address: 802 Windsong Way
City, State, Zip: McAlester, OK, 74501
Provider #: AL6102
Complaint #: OK00084087
Investigation Date(s): 11/17/25 through 11/20/25

ALLEGATION(S)
The facility failed to provide adequate supervision and assistive devices to prevent falls with injuries.

An unannounced on-site investigation was initiated 11/17/2025 at 11:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:
Upon entrance and throughout the survey residents were observed using assistive devices such as walkers and wheelchairs for mobility. Staff were observed assisting residents with transfers and mobility.

Residents stated staff assisted them with mobility and were available if needed. Families stated the staff provided good care for their family members. Staff stated residents are monitored every two hours and some more often for assistance.

Policies and procedures, resident assessments, care plans, physician orders, progress notes, incident reports, staff schedules, and employee in-services/training were reviewed.

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: 11/30/2025

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
	AL6102	A. BUILDING: _____ B. WING _____	C 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE AT BELFAIR	802 WINDSONG WAY MCALESTER, OK 74501

(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 (#OK00079532, OK00081756, and #OK00084087) was conducted from 11/17/25 through 11/20/25. Deficiencies were cited as a result of the survey. Facility Census: 65 Listed below are abbreviations that will be used throughout this document. CNA - certified nurse aide OSDH - Oklahoma State Department of Health RN - registered nurse	C 000		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6102	A. BUILDING: _____ B. WING _____	C 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE AT BELFAIR	802 WINDSONG WAY MCALESTER, OK 74501

(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
C1911	Continued From page 1	C1911		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to report an allegation of abuse to the OSDH within one business day for 1 (#2) of 2 sampled residents reviewed for abuse.

The administrator identified two allegations of abuse from 01/01/25 through 11/17/25.

Findings:

An undated document titled "Facility Policy and Procedure Resident Abuse/Neglect," read in part, "In compliance with Oklahoma Department of Health, Special Health Services, the Belfair identifies and reports suspected abuse, neglect, exploitation, and misappropriation cases."

1. An undated admission record showed Resident #2 had diagnoses which included dementia with behavioral disturbances and unspecified psychosis.

A state reportable, with an incident date of 04/29/25, showed an allegation of abuse. The report showed Resident #2 pushed Resident #9 to the floor. The report showed Resident #9 was sent to the emergency room, sustained a left hip fracture, and a skin tear to the right ring finger during the encounter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6102	A. BUILDING: _____ B. WING _____	C 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE AT BELFAIR	802 WINDSONG WAY MCALESTER, OK 74501

(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
C1911	Continued From page 2 A fax transmittal sheet showed a state reportable for an allegation of abuse on 04/29/25 regarding Resident #2 was sent to the OSDH on 05/06/25 at 5:12 p.m. On 11/19/25 at 4:45 p.m., the administrator viewed the state reportable sent to the OSDH for the incident dated 04/29/25 of an allegation of abuse. The administrator stated the allegation of abuse was not reported within one business day to the OSDH as required. 2. An undated admission record showed Resident #9 had diagnoses which included dementia, bipolar disorder, and anxiety. A state reportable, dated 01/12/25, showed an allegation of abuse. The report showed CNA #3 witnessed Resident #9 punch Resident #3 on the left side of the face. The report showed CNA #3 did not report the incident until 01/13/25. A fax transmittal sheet showed a state reportable for an allegation of abuse on 01/12/25 regarding Resident #9 and Resident #3 was sent to OSDH on 01/14/25 at 5:01 p.m. On 11/19/25 at 4:45 p.m., the administrator stated CNA #3 should have reported the incident immediately and not waited until the next day.	C1911		

OKLAHOMA
State Department
of Health

Delivery via email to: anna@countrysideltc.com

January 5, 2026

License Number: AL6102

Ms. Anna Franklin, Administrator
Countryside At Belfair
802 Windsong Way
McAlester, OK 74501

RE: Survey Event 4LOI11

Dear Ms. Franklin:

On **November 20, 2025**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and in a timely manner. **Our acceptance does not absolve the facility's responsibility for** compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **December 12, 2025**.

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

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/16/2025** **Facility Name:** COUNTRYSIDE AT BELFAIR **License Number:** AL 6102 **Survey Event ID:** 4LOI11 **Date Survey Completed: 11/20/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1911	Based on: RECORD REVIEW AND INTERVIEW, THE FACILITY FAILED TO REPORT AN ALLEGATION OF ABUSE TO THE OSDH WITHIN ONE BUSINESS DAY FOR 1 (#2) OF 2 SAMPLED RESIDENTS REVIEWED FOR ABUSE.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The facility acknowledges that a resident-to-resident abuse incident was not reported within the required 24-hour timeframe. Once the issue was identified, the incident was immediately reported to the appropriate state authorities.

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?	Immediately upon discovery of the reporting failure, the reporting RCC completed the required abuse report & submitted it to OSDH. All involved residents were assessed & any necessary support measures were provided. Documentation was updated to reflect all required information.
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 full review of all incident, grievance, and behavior reports from the year of 2025 was completed to ensure no additional allegations of abuse were missed or reported late. No other unreported or delayed reporting incidents were identified.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	• Mandatory reporting procedures have been reviewed and revised to ensure clarity and compliance with Tag # C1911 requirements. • Refresher training on abuse reporting timelines and protocols was completed for all staff, including leadership. • Written reporting guidelines and flowcharts have been posted in staff areas throughout the building to reinforce expectations. • Leadership will provide immediate oversight for all future incident reports to ensure timely submission.
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;	Beginning Friday, Dec 12, the corrective action plan is complete and actionable compliance set as follows: The community Administrator or Clinical Lead will audit all incident reports weekly for 90 days (through March 13, 2026) to verify that required reports are submitted within 24 hours.

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.	After 90 days (starting April 10), monthly audits will be conducted for an additional three months (through June 12). Findings will be reviewed in quarterly Quality Assurance meetings. Any instance of non-compliance will result in immediate retraining and corrective action, as well as re-starting the aforementioned review schedule. The facility will continue this monitoring process until substantial compliance is achieved and sustained.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/12/2025
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature OAC 310:663-25-4(F) Angela Franklin	**Date** 12/16/25
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	**Submitted by**
Items Below Are For OSDH Use Only	
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Surveyor:	
If Plan of Correction is unacceptable, the reasons are as follows: Facility in Compliance by:	

OKLAHOMA
State Department of Health

Delivery via email to: anna@countrysideltc.com

January 8, 2026

License Number: AL6102

Ms. Anna Franklin, Administrator
Countryside At Belfair
802 Windsong Way
McAlester, OK 74501

RE: Survey Event 4LOI12

Dear Ms. Franklin:

On **January 7, 2026,** an off-site paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 20, 2025,** have now been corrected effective **December 12, 2025.**

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

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6102	A. BUILDING: _____ B. WING _____	R-C 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE AT BELFAIR	802 WINDSONG WAY MCALESTER, OK 74501

(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 01/07/26. The facility was in substantial compliance.	{C 000}		

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