OKLAHOMA
State Department
of Health

Delivery via email to: tellis@shawneememorycare.com

October 29, 2025

License Number: AL6304

Ms. Teri Ellis, Administrator
Shawnee Memory Care
1723 N Airport Drive
Shawnee, OK 74804

RE: Survey Event ID: HIL711

Dear Ms. Ellis:

On **October 22, 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 **October 22, 2025**.

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

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

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

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

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

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

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

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

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

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

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

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

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

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;

- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

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

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

Respectfully,

Clorissa Nubine

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Shawnee Memory Care**
Address: **1723 Airport Drive**
City, State, Zip: **Shawnee, OK. 74804**
Provider #: **AL6304**
Complaint #: **OK00064156**
Investigation Date(s): **10/20/25 – 10/22/25**

ALLEGATION(S)
The center failed to ensure assistance with activities of daily living was provided and timely manner and according to the contract and the plan of care.
The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 10/20/2025 at 9:15 a.m.

A sample of 8 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 throughout the survey. Residents were observed to be clean, dressed appropriately, and free of odors. Staff were observed assisting residents with activities of daily living and as needed.

Resident records, i.e. service contracts, care plans, assessments, and physician orders were reviewed. Staffing schedules were reviewed. Grievances were reviewed.

Residents and staff were interviewed regarding care being provided timely and according to the plan of care and activities of daily living. Staff and residents wee interviewed regarding having adequate staff to provide care for residents.

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: 10/23/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Shawnee Memory Care**
Address: **1723 Airport Drive**
City, State, Zip: **Shawnee, OK. 74804**
Provider #: **AL6304**
Complaint #: **OK00084535**
Investigation Date(s): **10/20/25 – 10/22/25**

ALLEGATION(S)
The center failed to ensure residents were free from abuse and neglect.
The center failed to provide adequate supervision for dependent/vulnerable residents.
The center failed to ensure three meals were served daily.
The center failed to ensure adequate staff to provide care for dependent residents.

An unannounced on-site investigation was initiated 10/20/2025 at 9:15 a.m.

A sample of 8 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 throughout the survey. Residents were observed to be clean, dressed appropriately, and free of odors. Staff were observed assisting residents during meals and after meals. Staff were observed taking meal trays to residents' rooms. Staff were observed assisting residents with activities of daily living and as needed.

Resident records were reviewed. Resident meal percentages and diets were reviewed. Staff schedules were reviewed. Incident reports with investigations were reviewed. Grievances were reviewed.

Residents were interviewed regarding meals, adequate staff, and activities of daily living. Staff were interviewed regarding meals, adequate staff, and providing care to residents timely.

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

OKLAHOMA
State Department
of Health

Long Term Care Service

Date report completed: 10/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	C 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE MEMORY CARE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 (#OK00064156 and #OK00084535) was conducted from 10/20/25 through 10/22/25. Deficiencies were cited as a result of the survey. Facility Census: 43	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure the kitchen floors were kept clean The dietary manager reported 43 residents received meals from the kitchen. Findings: On 10/20/25 at 12:30 p.m., the floor in the cooking area of the kitchen was observed to have a dark buildup of debris and grease under the cooking appliances. On 10/22/25 at 12:08 p.m., the floors under the cooking appliances were observed to have a dark buildup of debris and grease under the cooking appliances. On 10/22/25 at 12:23 p.m., the dietary manager	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	C 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE MEMORY CARE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 391	Continued From page 1 reported the kitchen floors under the appliances were last cleaned about three weeks ago.	C 391		
C 711 SS=D	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an annual fire marshal inspection was conducted on 2025. The executive director reported 43 residents resided in the center. Findings: A document titled "Inspection Report", dated 03/21/24, showed a fire marshal inspection date of 03/21/24.	C 711		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	C 10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE MEMORY CARE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 711	Continued From page 2 On 10/22/25 at 1:00 p.m., the executive director reported they had been trying to get in touch with the fire marshal to schedule an inspection, but had not been able to.	C 711		

OKLAHOMA
State Department
of Health

Delivery via email to: tellis@shawneememorycare.com

November 10, 2025

License Number: AL6304

Ms. Teri Ellis, Administrator
Shawnee Memory Care
1723 N Airport Drive
Shawnee, OK 74804

RE: Survey Event HIL711

Dear Ms. Ellis:

On **October 22, 2025**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **November 30, 2025**.

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

Respectfully,

Clorissa Nubine

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

Enclosure

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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/4/2025

Facility Name: Shawnee Memory Care

License Number: AL6304

Survey Event ID: HIL711

Date Survey Completed: 10/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391	Based on: observation and interview, the center failed to ensure the kitchen floors were kept clean.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

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 large kitchen equipment (that was removeable) was removed and pressured washed, including all casters. All grease and debri buildup was removed from under the appliances and the floors were cleaned On 10/23/2025
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The Excicetive Director or designee will Inservice All Dietary staff w 11/10/25 on Floor and Equipment cleanliness.
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?	A daily cleaning log / checklist will be used with the staff member intialing after checklist is completed and the Dietary Manager siguature satification completion on Monday and Fridays.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The QA team will review all cleaning logs/checklist to ensure the monitoring is completed. The Excutive Director or Designee will monitor all logs/checklist weekly to ensure completion.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/11/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Teri Ellis** OAC 310:663-25-4(F)	**Date 11/4/2025**

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: 11/4/2025** **Facility Name:** Shawnee Memory Care **License Number:** AL6304 **Survey Event ID:** HIL711 **Date Survey Completed: 10/22/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 711	Based on: the failed to ensure an annual fire marshal inspection was conducted on 2025

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

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 Executive Director has made multiple attempts to have the Fire Marshall inspection completed. The Excutive Director will continue to call and leave voice mails until the inspection report is completed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The Executive Director has made multiple attempts to have the Fire Marshall inspection completed. The Excutive Director will continue to call and leave voice mails until the inspection report is completed.
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 Executive Director has made multiple attempts to have the Fire Marshall inspection completed. The Excutive Director will continue to call and leave voice mails until the inspection report is completed.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The QA team will review the firemarshall report and ensure the attempts to have a 2025 report received are made.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/30/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Teri Ellis** OAC 310:663-25-4(F)	**Date 11/4/2025**

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: tellis@shawneememorycare.com

December 8, 2025

License Number: AL6304
Survey Event ID: HIL712

Ms. Teri Ellis, Administrator
Shawnee Memory Care
1723 N Airport Drive
Shawnee, OK 74804

Dear Ms. Ellis:

On **December 4, 2025**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **October 22, 2025,** have now been corrected and your facility is in compliance with licensure standards effective **November 30, 2025**.

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

Respectfully,

Clorissa Nubine

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	R-C 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE MEMORY CARE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 12/04/25. 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