OKLAHOMA
State Department
of Health

Delivery via email to: cledbetter@sagora.com

July 31, 2025

License Number: AL7201

Ms. Cherylann Ledbetter, Administrator
Aberdeen Heights Assisted Living Community
7220 South Yale
Tulsa, OK 74136

Survey Event ID: 4V5C11

Dear Ms. Ledbetter:

On **July 16, 2025, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.**

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the 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. 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 will be completed for each violation; and
(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 a 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: Aberdeen Heights AL
Address: 7220 S Yale
City, State, Zip: Tulsa, OK, 74136
Provider #: AL7201
Complaint #: OK00064169
Investigation Date(s): 07/14/25-07/16/25

ALLEGATION(S)
The center failed to ensure residents/representatives were treated with dignity and respect and failed to ensure resident's representatives were notified of a change in condition.
The center failed to ensure services were billed according to the contract.
enter text
enter text
enter text

An unannounced on-site investigation was initiated 07/14/2025 at 1:15 p.m.

A sample of four 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:
Upon entrance into the facility and throughout the three days staff members were observed interacting with residents treating them with respect and dignity. Observations were made of residents' rooms being cleaned, no foul odor detected throughout the facility. Records reviewed include electronic health records, physician orders, and facility policies. Interviews were conducted with residents, family members, and employees.

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

OKLAHOMA
State Department
of Health

Date report completed: 07/17/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Aberdeen Heights AL
Address: 7220 S Yale
City, State, Zip: Tulsa, OK, 74136
Provider #: AL7201
Complaint #: OK00084310
Investigation Date(s): 07/14/25-07/16/25

ALLEGATION(S)
The center failed to provide a clean, comfortable, and homelike environment.
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 07/14/2025 at 1:15 p.m.

A sample of four 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:
Upon entrance into the facility and throughout the three days staff members were observed interacting with residents treating them with respect and dignity. Observations were made of residents' rooms being cleaned, no foul odor detected throughout the facility. Records reviewed include electronic health records, physician orders, and facility policies. Interviews were conducted with residents, family members, and employees.

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Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 07/17/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Aberdeen Heights AL
Address: 7220 S Yale
City, State, Zip: Tulsa, OK, 74136
Provider #: AL7201
Complaint #: OK00084525
Investigation Date(s): 07/14/25-07/16/25

ALLEGATION(S)
The center failed to ensure residents were not verbally or psychosocially abused.
The center failed to ensure the resident and resident's POA had the right to refuse treatment.
The center failed to maintain a clean, comfortable, and homelike environment.
The center failed to ensure the resident's POA was notified when the resident had a change in condition.
The center failed to ensure food was palatable.

An unannounced on-site investigation was initiated 07/14/2025 at 1:15 p.m.

A sample of four 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:
Upon entrance into the facility and throughout the three days staff members were observed interacting with residents treating them with respect and dignity. Observations were made of residents' rooms being cleaned, no foul odor detected throughout the facility. Records reviewed include electronic health records, physician orders, and facility policies. Interviews were conducted with residents, family members, and employees.

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

OKLAHOMA
State Department
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INVESTIGATIVE REPORT

Facility: Aberdeen Heights AL
Address:7220 S Yale
City, State, Zip: Tulsa, OK, 74136
Provider #: AL7201
Complaint #: OK00084607
Investigation Date(s): 07/14/25-07/16/25

ALLEGATION(S)
The center failed to ensure residents were not abused.
The center failed to assess, monitor, and/or intervene when a resident had a change in condition.
The center failed to provide a safe, clean, comfortable homelike atmosphere.
The center failed to ensure staffing to meet the needs of the residents.
enter text

An unannounced on-site investigation was initiated 07/14/2025 at 1:15 p.m.

A sample of four 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:
Upon entrance into the facility and throughout the three days staff members were observed interacting with residents treating them with respect and dignity. Observations were made of residents' rooms being cleaned, no foul odor detected throughout the facility. Records reviewed include electronic health records, physician orders, and facility policies. Interviews were conducted with residents, family members, and employees.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7201	A. BUILDING: _____ B. WING _____	C 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEIGHTS ASSISTED LIVING COMI	7220 SOUTH YALE TULSA, OK 74136

(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 Complaint investigations (#OK00064169, OK00084310, OK00084525, and #OK00084607) were conducted on 07/14/25 through 07/16/25. Deficiencies were cited as a result of the survey. Facility Census: 49 Listed below are abbreviations that will be used throughout this document. ED- executive director LPN- licensed practical nurse POA- power of attorney	C 000		
C 940 SS=E	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure food prepared for one of one meal observation was consistent with a written and planned menu prepared by a dietary consultant. The ED identified 49 residents resided in the center. Findings: On 07/15/25 at 11:15 a.m., the lunch meal was observed. Cream spinach soup, house salad, roasted chicken, fried fish nuggets, collard	C 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7201	A. BUILDING: _____ B. WING _____	C 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEIGHTS ASSISTED LIVING COMI	7220 SOUTH YALE TULSA, OK 74136

(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 940	Continued From page 1 greens, macaroni and cheese, and orange cake was served to the residents. A policy titled "Culinary Procedures," dated 11/07/23, read in part, "it is up to the Culinary Director at each community to alter this menu." The week at a glance menu for week one approved by the registered dietitian, dated 04/18/25, showed white bean and kale soup, grilled salmon with dill butter, chicken cordon bleu, brown rice pilaf, green beans with lemon and parsley, whole grain roll, and orange chiffon cake were to be served to the residents. The daily feature menu, dated 07/15/25, showed cream spinach soup, house salad, roasted chicken, fried fish nuggets, collard greens, macaroni and cheese, and orange cake was served to the residents. On 7/15/25 at 9:25 a.m., cook #1 was asked why were there changes to the menu. They stated they did not have enough food items to cook and the cooks do not know how to do the ordering. Cook #1 stated the kitchen manager was out on leave. They stated a cook from another community came in and made the menu for the items they had in the kitchen.	C 940		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5)	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7201	A. BUILDING: _____ B. WING _____	C 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEIGHTS ASSISTED LIVING COMI	7220 SOUTH YALE TULSA, OK 74136

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 2 (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to notify a resident's POA of a change in condition for 1 (#3) of 8 sampled residents reviewed for change in condition. The ED identified 49 residents resided in the center.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7201	A. BUILDING: _____ B. WING _____	C 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEIGHTS ASSISTED LIVING COMI	7220 SOUTH YALE TULSA, OK 74136

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 3 Findings: A policy titled "Change of Condition," dated 09/09/20, read in part, "The physician and legally responsible party will be notified of the residents change in condition." On 07/14/25 at 3:12 p.m., the POA stated they were notified via text message from the hospital that Resident #3 was at the hospital. On 07/16/25 at 11:07 a.m., LPN #2 stated on 07/03/25 Resident #3 had a change in condition and they called the resident's provider. LPN #2 stated Resident #3 wanted to go to the emergency room due to being in distress. They stated the center failed to notify the POA the resident was transported to the hospital.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: cledbetter@sagora.com

August 13, 2025

License Number: AL7201

Ms. Cherylann Ledbetter, Administrator
Aberdeen Heights Assisted Living Community
7220 South Yale
Tulsa, OK 74136

Survey Event ID: 4V5C11

Dear Ms. Ledbetter:

On **July 16, 2025,** a complaint investigation was conducted at your Assisted Living Center. 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 **September 5, 2025**.

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

Respectfully,

Clorissa Nubine

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

Enclosure

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 8/9/2013
	Facility Name: Aberdeen Heights Assisted Living
	License Number: AL7201
	Survey Event ID: 4V5C11
	Date Survey Completed: 7/16/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505 SS D	Based on: Based on record review and interview, the center failed to notify a resident's POA of a change in condition for 1 (#3) of 8 sampled residents reviewed for change in condition.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuary and regulatory requirements. In this document, we have outlined specific actions in response to each finding. We have not presented all contrary factual or legal arguments or have we identified mitigation factors.

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 direct care team members which also incudes Resident Service team members were re-inserviced on Resident Righs to include notifications made to resident's POAs of changes in condition. Resident #3's medical record was reviewed and confirmation was made that correct and current POA contact information is reflected in their record verified by POA with Resident Services Director or designee.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	ED or designee will ensure correct and current contact information is recorded in the resident's health record
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.	Resident Services Director will re-inservice all resident services team members on Resident Rights to also include notifying POA of any changes to reident's health condition.The ED or designee will conduct an audit of contact information that the residents have listed for the correct and current POA contact information. Any discrepancies identified will be updated in the resident's health record to reflect the correct information. ED or designee will ensure compliance. Review of the audit will be incorporated into the QA meeting and any need for additional interventions will be put into place Record of the documentation will be kept with the QA minutes

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		9/5/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date 8/12/2025**
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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 8/9/2013
	Facility Name: Aberdeen Heights Assisted Living
	License Number: AL7201
	Survey Event ID: 4V5C11
	Date Survey Completed: 7/16/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 940 SS E	Based on: Observation, record review, and interview, the center failed to ensure food prepared for one of one meal observation was consistent with a written and planned menu prepared by a dietary consultant.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuary and regulatory requirements. In this document, we have outlined specific actions in response to each finding. We have not presented all contrary factual or legal arguments or have we identified mitigation factors.

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 dietary staff will be re-inserviced on the requirements that food is prepared and consistent with a written and planned menu prepared by a dietary consultant, follow the approved dietary consultant menu and the proper protocol for substitutions, including documentation and prior approval if time allows.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The dietary manager or designee will review daily meal preparations against approved menu 1 hour before meal service. The dietary manager or designee will complete random weekly audits. These audits will be conducted for 3 weeks to compare actual meals served against the planned menu for accuracy. The findings will be documented and reviewed in QA 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.	All dietary staff will be re-inserviced on regulation and company policy regarding preparing and serving planned meals that have been approved by dietary consultant Dietary Manager or designee will complete random audits for 3 weeks to ensure meals that are being served are consistent with the dietary consultants approved menu Audit results will be reviewed in QA and any identified areas of improvement that is observed will be documented and corrected. Audit results and any recommendations will be kept as a part of the QA minutes.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		9/5/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date 8/12/2025**
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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7201	A. BUILDING: _____ B. WING _____	C 07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEIGHTS ASSISTED LIVING COMI	7220 SOUTH YALE TULSA, OK 74136

(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 Complaint investigations (#OK00064169, OK00084310, OK00084525, and #OK00084607) were conducted on 07/14/25 through 07/16/25. Deficiencies were cited as a result of the survey. Facility Census: 49 Listed below are abbreviations that will be used throughout this document. ED- executive director LPN- licensed practical nurse POA- power of attorney	C 000		
C 940 SS=E	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure food prepared for one of one meal observation was consistent with a written and planned menu prepared by a dietary consultant. The ED identified 49 residents resided in the center. Findings: On 07/15/25 at 11:15 a.m., the lunch meal was observed. Cream spinach soup, house salad, roasted chicken, fried fish nuggets, collard	C 940		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEIGHTS ASSISTED LIVING COMI	7220 SOUTH YALE TULSA, OK 74136

(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 940	Continued From page 1 greens, macaroni and cheese, and orange cake was served to the residents. A policy titled "Culinary Procedures," dated 11/07/23, read in part, "it is up to the Culinary Director at each community to alter this menu." The week at a glance menu for week one approved by the registered dietitian, dated 04/18/25, showed white bean and kale soup, grilled salmon with dill butter, chicken cordon bleu, brown rice pilaf, green beans with lemon and parsley, whole grain roll, and orange chiffon cake were to be served to the residents. The daily feature menu, dated 07/15/25, showed cream spinach soup, house salad, roasted chicken, fried fish nuggets, collard greens, macaroni and cheese, and orange cake was served to the residents. On 7/15/25 at 9:25 a.m., cook #1 was asked why were there changes to the menu. They stated they did not have enough food items to cook and the cooks do not know how to do the ordering. Cook #1 stated the kitchen manager was out on leave. They stated a cook from another community came in and made the menu for the items they had in the kitchen.	C 940		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5)	C1505		

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
	AL7201	A. BUILDING: _____ B. WING _____	C 07/16/2025

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C1505	Continued From page 2 (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to notify a resident's POA of a change in condition for 1 (#3) of 8 sampled residents reviewed for change in condition. The ED identified 49 residents resided in the center.	C1505		

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C1505	Continued From page 3 Findings: A policy titled "Change of Condition," dated 09/09/20, read in part, "The physician and legally responsible party will be notified of the residents change in condition." On 07/14/25 at 3:12 p.m., the POA stated they were notified via text message from the hospital that Resident #3 was at the hospital. On 07/16/25 at 11:07 a.m., LPN #2 stated on 07/03/25 Resident #3 had a change in condition and they called the resident's provider. LPN #2 stated Resident #3 wanted to go to the emergency room due to being in distress. They stated the center failed to notify the POA the resident was transported to the hospital.	C1505		