OKLAHOMA
State Department
of Health

Delivery via email to: cledbetter@aberdeenheights.com

October 27, 2025

License Number: AL7201

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

RE: Survey Event ID: QH0C11

Dear Ms. Ledbetter:

On **October 13, 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 13, 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

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 _____	10/13/2025

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 A relicensure survey was conducted on 10/09/25 and 10/13/25. Facility Census: 52	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, record review, and interview, the facility failed to ensure: a. opened food items were labeled with the open and use by date in 1 of 1 freezer and 1 of 2 refrigerators; b. kitchen employees utilized hairnets and beard covers; and c. the disposal of gloves when beginning a different task. The executive director identified 52 residents received nutrition from the kitchen. Findings: On 10/09/25 at 8:15 a.m., the following food items were observed opened in one of one freezer with no labels to show the open and use by date	C 391		

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C 391	Continued From page 1 a. a plastic bag half full of sweet potato waffle fries, b. a plastic bag three fourths full of frozen cookies, and c. a plastic bag three fourths full of steak fritters. On 10/09/25 at 8:32 a.m., the following food items were observed opened in refrigerator #2 with no label to show the open and use by date: a. a small metal container of pickles, b. a plastic container three fourths full of cottage cheese, c. a plastic container three fourths full of applesauce, d. a plastic container half full of salad mix, e. a plastic bag half full of shredded cheddar cheese, f. a plastic container three fourths full of fresh blueberries, g. a plastic container three fourths full of mandarin oranges, h. a plastic bag half full of whipped topping, i. a plastic container three fourths full of French salad dressing, j. a box three fourths full of vanilla wafer cookies, and k. a plastic bag half full of kettle cooked chips. On 10/09/25 at 8:38 a.m., server #1 was observed with no hairnet on their head while preparing breakfast. They were observed utilizing the same pair of gloves while putting dishes in the dishwasher and making toast. On 10/09/25 at 11:38 a.m., server #2 was observed in the kitchen without a hairnet or beard cover. An untitled, undated policy, read in part, "When to Change Disposable Gloves"..."Before beginning a	C 391		

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	AL7201	A. BUILDING: _____ B. WING _____	10/13/2025

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C 391	Continued From page 2 different task." An undated hair restraint policy, read in part, "all Team Members who work with unpackaged food, clean equipment to wear hair restraints that keep their hair form contacting exposed food; clean equipment." A facility policy titled "Food Storage," dated 07/11/24, read in part, "Most fruits should be used within 3 to 5 days, and all products should be dated when open, and when prepared and use Use-By dates on all food stored in refrigerators." On 10/09/25 at 8:25 a.m., cook #1 stated the food items should be dated when they were opened. They stated their policy was to date, wrap, and label everything they opened. On 10/09/25 at 8:47 a.m., server #1 was asked about the items that were opened in refrigerator #2 without a date or label. They stated staff that opened any items were responsible for putting a date on them. Server #1 stated they were short a cook so right now things were hectic. When server #1 was asked about the usage of hairnets, they stated they were told they did not have to wear a hairnet unless they prepared food. On 10/09/25 at 11:38 a.m., server #2 was asked about wearing hairnets and beard covers. They stated they did not have to wear them unless they were preparing food.	C 391		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following:	C 522		

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 _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 522	Continued From page 3 (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a comprehensive assessment was completed within 14 days of admission for 4 (#1, 2, 6 and #10) of 10 sampled residents whose assessments were reviewed. The administrator identified 52 residents resided in the facility. Findings: A facility policy titled "Resident Evaluation," read in part, "The final resident evaluation should be completed by a licensed nurse or registered nurse if required by state regulation(s):"..."OKLAHOMA - Pre-Assessment-Prior to move- in - Initial - Within 14 days of physical move-in" 1. A diagnoses tab in the electronic record showed Resident #1 had diagnoses which included heart failure, fracture of fourth thoracic vertebra, diabetes, acute and chronic respiratory failure with hypoxia, and anxiety disorder. A profile tab in the electronic record showed Resident #1's physical move in date was	C 522		

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 _____	10/13/2025

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

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C 522	Continued From page 4 09/26/25. An assessment tab in the electronic record showed Resident #1's 14 day assessment was completed on 10/13/25. 2. A diagnoses tab in the electronic record showed Resident #2 had diagnoses which included Alzheimer's disease, and deep vein thrombosis. A profile tab in the electronic record showed Resident #2 was admitted to the facility on 05/19/25. An assessments tab in the electronic record showed Resident #2's initial pre-move in assessment was completed on 06/23/25. 3. A diagnoses tab in the electronic record showed Resident #6 had diagnoses which included essential (primary) hypertension, type II diabetes mellitus without complications, paroxysmal atrial fibrillation, other specified anxiety disorders, and depression. A profile tab in the electronic record showed Resident #6 was admitted to the facility on 01/08/25. An assessments tab in the electric record showed the initial pre-move in assessment was completed 01/13/25. 4. A diagnoses tab in the electronic record showed Resident #10 had diagnoses which included chronic kidney disease stage 3, divert of both small and large intestine with perforation and abscess without bleeding, and hypertension. A profile tab in the electronic record showed	C 522		

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 _____	10/13/2025

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C 522	Continued From page 5 Resident #10 was admitted to the facility on 02/27/25. An assessments tab in the electronic record showed Resident #10's initial pre-move in assessment was completed 03/06/25. On 10/13/25 at 1:35 p.m., the director of nursing reviewed the residents electronic records and stated the dates in the electronic record were incorrect for Residents #1, 2, 6, and #10.	C 522		

OKLAHOMA
State Department
of Health

Delivery via email to: cledbetter@aberdeenheights.com

November 12, 2025

License Number: AL7201

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

RE: Survey Event QH0C11

Dear Ms. Ledbetter:

On **October 13, 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 13, 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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/10/2025** **Facility Name:** Aberdeen Heights Assisted Living **License Number:** AL7201 **Survey Event ID:** QH0C11 **Date Survey Completed: 10/13/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391 SS E	Based on: observation, record review, and interview, the facility failed to ensure: opened food items were labeled with the open and use by date in 1 of 1 freezer and 1 of 2 refrigerators; kitchen employees utilized hairnets and beard covers; and the disposal of gloves when beginning a different task.

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 labeling and food safety requirements, hair restraint use, and glove protocol is conducted for all kitchen staff within 10 days. Attendance will be documented in the education log.
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?	Culinary Director or designee will monitor compliance with random weekly audits. These audits will be conducted for 3 weeks to ensure compliance with labeling and food safety, hair restraint use and glove protocol is being followed. The findings will be documented in the QA meeting.
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 wil be re-inserviced on regulation and company policy regarding labeling and food safety requirements, hair restraint use, and glove protocol. Culinary director or designee will complete random audits weekly for 3 weeks to ensure all staff are consistently following regulation and policy. 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?	12/11/2025

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date** Enter a date of signature. 11/10/25	
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	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: 11/10/2025** **Facility Name:** Aberdeen Heights Assisted Living **License Number:** AL7201 **Survey Event ID:** QH0C11 **Date Survey Completed: 10/13/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 522 SS D	Based on: record review and interview, the facility failed to ensure a comprehensive assessment was completed within 14 days of admission for 4(#1, 2, 6 and #10) of 10 sampled residents whose assessments were reviewed.

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?	The missing 14-day admission assessments for Residents #1, #2, #6, and #10 are completed by **11/15/2025**. All new admissions now receive a documented comprehensive assessment within 14 days of move in.
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?	All licensed nursing staff receive refresher training on assessment timelines according to State Regulations. Attendance will be documented in the staff education log. The Director of Nursing will monitor pending assessments weekly and present a report at the QA meeting. The Director of Nursing or designee will select a random sample of resident records bi-weekly for 2 months to verify compliance with the 14-day assessment timeline requirement. Results are documented in the QA log.
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 licensed nursing staff will be re-inserviced on assessment timelines and documentation to ensure all assessment timelines are being met in accordance with regulation. The director of nursing or designee will monitor pending assessments weekly, perform random audits bi-weekly for 2 months. 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?	12/11/2025		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date** Enter a date of signature.	11/10/25
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	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: cledbetter@aberdeenheights.com

December 17, 2025

License Number: AL7201
Survey Event ID: QH0C12

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

Dear Ms. Ledbetter:

On **December 17, 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 13, 2025,** have now been corrected and your facility is in compliance with licensure standards effective **December 11, 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
	AL7201	A. BUILDING: _____ B. WING _____	R 12/17/2025

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

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 12/17/25. 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