OKLAHOMA
State Department
of Health

Delivery via email to: mnetters@oxfordseniorliving.com

November 19, 2025

License Number: AL7205

Ms. Michelle Netters, Administrator
Oxford Springs Tulsa Al Llc
8231 South Mingo Road
Tulsa, OK 74133

Survey Event ID: MGZ111

Dear Ms. Netters:

On **November 5, 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.

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. 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 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:

OKLAHOMA
State Department
of Health

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

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

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

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

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

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **OXFORD SPRINGS TULSA AL LLC**
Address: **8231 SOUTH MINGO Road**
City, State, Zip: **Tulsa, OK, 74133**
Provider #: **AL7205**
Complaint #: **OK00087136**
Investigation Dates: **10/27/25, 10/28/25 and 11/05/25**

ALLEGATION
The facility failed to ensure residents were provided care according to their plan of care to prevent falls with injuries.

An unannounced on-site investigation was initiated 10/27/2025 at 2:30 p.m.

A sample of three 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:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs.

Residents were interviewed regarding treatment by staff and promptness of care. Staff were interviewed regarding use of mechanical lifts.

Grievance reports, resident council minutes, policies and procedures, and facility investigations were reviewed. Resident records 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: 11/12/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **OXFORD SPRINGS TULSA AL LLC**
Address: **8231 SOUTH MINGO Road**
City, State, Zip: **Tulsa, OK, 74133**
Provider #: **AL7205**
Complaint #: **OK00087314**
Investigation Date(s): **10/27/25, 10/28/25 and 11/05/25**

ALLEGATION
The center failed to ensure resident were safely transferred.

An unannounced on-site investigation was initiated 10/27/2025 at 2:30 p.m.

A sample of three 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:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs.

Residents were interviewed regarding treatment by staff and promptness of care. Staff were interviewed regarding use of mechanical lifts.

Grievance reports, resident council minutes, policies and procedures, and facility investigations were reviewed. Resident records 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: 11/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7205	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS TULSA AL LLC	8231 SOUTH MINGO ROAD TULSA, OK 74133

(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 (#OK00087314 and #OK00087136) were conducted on 10/27/25 through 10/28/25 and 11/05/25. Deficiencies were cited as a result of the survey. Facility Census: 35 Listed below are abbreviations that will be used throughout this document. CNA - certified nursing assistant ED - executive director	C 000		
C 910 SS=G	310:663-9-1 NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged:	C 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7205	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS TULSA AL LLC	8231 SOUTH MINGO ROAD TULSA, OK 74133

(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 910	Continued From page 1 This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to provide adequate nursing supervision to ensure safe transfer needs were met for facility residents for 1 (#1) of 3 sampled residents reviewed for safe transfers. The ED identified 35 residents resided in the facility. Findings: On 10/27/25 at 4:40 p.m., Resident #1 was observed resting in bed. A sit-to-stand mechanical lift was observed in the resident's room. An undated service plan detail showed Resident #1 required staff assistance with transfers utilizing either a gait belt or a sit to stand device. A policy titled, "Transfer/Mechanical lift," dated 02/22/22, showed two staff were required for all transfers. A medical diagnoses record, dated 10/31/22, showed Resident #1 had diagnoses which included macular degeneration, cerebral infarction and generalized muscle weakness. A "Resident Assessment" form, dated 06/03/25, showed Resident #1 required assistance from staff for transfers and used a sit-to-stand mechanical lift for transfers.	C 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7205	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS TULSA AL LLC	8231 SOUTH MINGO ROAD TULSA, OK 74133

(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 910	Continued From page 2 A progress note, dated 10/18/25, showed CNA#2 was transferring Resident #1 without assistance and without the aid of a gait belt. A hospital record, dated 10/24/25, showed Resident #1 was admitted to the hospital with diagnoses which included a mechanical fall prior to admission with head trauma, acute subdural hematoma (bleeding between the brain and the membrane around the brain) on the left side, and acute left frontal intraparenchymal hemorrhage (bleeding inside the brain tissue). A facility reported incident form, dated 10/28/25, showed on 10/18/25 Resident #1 fell while being transferred with only one staff assisting with the transfer. The incident form showed the resident required hospitalization for head injuries. A progress note, dated 10/27/2025 showed Resident #1 returned to the center from the hospital, resumed hospice services. Resident was on comfort measures. A progress note, dated 11/04/2025 at 3:21 p.m., showed the resident had expired. On 11/05/25 at 1:14 p.m., the resident care director stated Resident #1 was a two person assist with transfers. On 11/05/25 at 3:15 p.m., ED stated it was the center's policy to have all transfers assisted by two staff. The ED stated CNA #2 did not follow the center's policy which required two staff for all assisted transfers. The ED stated CNA #2 was terminated.	C 910		

OKLAHOMA
State Department
of Health

Delivery via email to: mnetters@oxfordseniorliving.com

December 15, 2025

License Number: AL7205

Ms. Michelle Netters, Administrator
Oxford Springs Tulsa Al Llc
8231 South Mingo Road
Tulsa, OK 74133

Survey Event ID: MGZ111

Dear Ms. Netters:

On **November 5, 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 **December 31, 2025**.

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/1/2025** **Facility Name:** Oxford Springs Tulsa Assisted Living **License Number:** AL7205 **Survey Event ID:** MGZ111 **Date Survey Completed: 11/5/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C910	Based on: Based on observation, record review, and interview, the center failed to provide adequate nursing supervision to ensure safe transfer needs were met for facility residents for 1 (#1) of 3 sampled residents reviewed for safe transfers.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

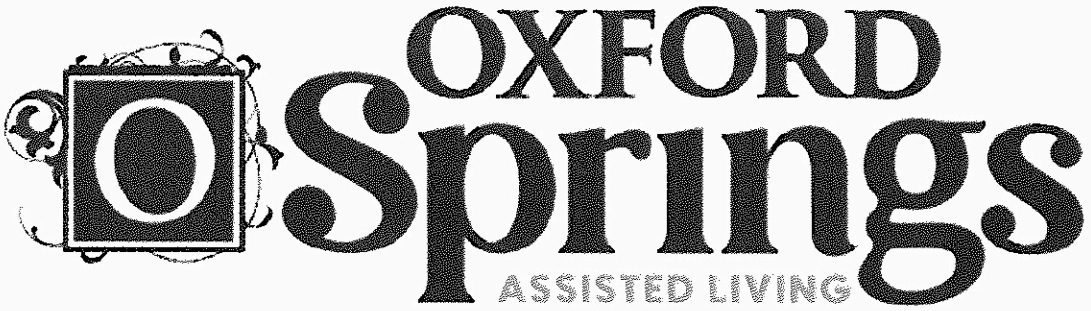
REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Cited resident's care plan was reviewed immediately to ensure it reflected current needs. Nursing staff responsible for incident was immediately terminated and re-education/competencies were completed with all direct care staff. Compliance was verified through direct nurse observation.
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 that require assistance with transfer of 1 or 2 staff members have the potential to be affected. Interdisciplinary team reviewed resident care plans to ensure all interventions were correct and being followed as written by direct care staff; discrepancies in care plans were immediately corrected and staff notified of any changes. Resident care plans reviewed by all direct care staff and acknowledged via signature.
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?	Transfer policy, competency and a safety observation sheet will be completed on all new hires prior to floor assignment; this to be completed with nurse. Safety observation forms to be completed for all direct care staff members by a nurse each month.
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.	Nurse will observe all 2 person transfers with and without lifts 3x week for 2 weeks and then nurse will observe all 2 person transfers with and without lifts 1x week for 2 weeks. Monthly safety observations will be completed on all direct care staff by nurse on duty. QA meeting will occur 1x monthly x3 months to specifically discuss transfers and education. Documentation of above observation forms will be

	maintained in state ready book for review.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	12/31/2025		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date 12/1/2025**	
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.			

** INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY **

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
December 5, 2025 at 12:05:39 PM CST		153	3	Received

From: 12/05/2025 12:55 #439 P.001/003



Oxford Springs Tulsa Assisted Living
8231 S Mingo Rd.
Tulsa, OK 74133
Phone: 918-600-0924
Fax: 539-666-2682
Michelle Netters, LPN/Executive Director

To:	Lisa Calvin	Date:	12/5/25
Company:		Pages:	
Fax #:	405-900-7683	Phone:	

From:	Michelle Netters, ED
Subject:	POC for Oxford Springs Tulsa Assisted Living #MGZ111

OKLAHOMA
State Department of Health

FINAL DETERMINATION NOTICE
USPS Tracking # 9589 0710 5270 2318 8397 82

January 13, 2026

License Number: AL7205

Ms. Michelle Netters, Administrator
Oxford Springs Tulsa Al, Llc
8231 South Mingo Road
Tulsa, OK 74133

Survey Event ID: MGZ112

Dear Ms. Netters:

A revisit conducted **January 12, 2026**, revealed that your facility corrected deficiencies effective **December 31, 2025**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me at (405) 426-8200.

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

Respectfully,

Lisa Calvin

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

Enclosure:

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7205	A. BUILDING: _____ B. WING _____	R-C 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS TULSA AL LLC	8231 SOUTH MINGO ROAD TULSA, OK 74133

(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 revisit was conducted on 01/12/26. All deficiencies from the 11/05/25 survey were cleared	{C 000}		

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