OKLAHOMA
State Department
of Health

Delivery via email to: mnetters@oxfordseniorliving.com

July 7, 2025

License Number: AL7206

Ms. Michelle Netters, Administrator
Oxford Springs Tulsa Mc
6022 East 71st Street
Tulsa, OK 74136

Survey Event ID: 89RW11

Dear Ms. Netters:

On **May 22, 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:

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

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

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

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

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

Respectfully,

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 MC**
Address: **6022 East 71st Street**
City, State, Zip: **Tulsa, Okla 74136**
Provider #: **AL7206**
Complaint #: **OK00082262**
Investigation Date(s): **05/19/25 thru 05/22/25**

ALLEGATION(S)

The center failed to ensure adequate supervision to prevent elopement.

An unannounced on-site investigation was initiated 05/19/2025 at 08:30 a.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 Centers for Medicare and Medicaid Services (CMS) 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:

Tours were conducted throughout the facility on arrival and throughout the survey for adequate supervision and safe environment. Staff /resident interactions were observed and interviews with residents, staff and families were conducted.

Residents communicated they felt safe and comfortable within the facility. The sampled residents' clinical records were reviewed. Incident reports, State Reportable incident reports, facility investigations, facility policy/procedures, and facility in-services were reviewed.

Based on observation, record review, and interview, it was determined the center failed to provide adequate supervision to prevent an elopement

The attached CMS 2567 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: 05/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7206	A. BUILDING: _____ B. WING _____	C 05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS TULSA MC	6022 EAST 71ST STREET 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 complaint investigation (#OK00082262) was conducted on 05/19/25 and 05/22/25. Facility Census: 44 Listed below are abbreviations that will be used throughout this document: CMA - certified medication aide CNA - certified nursing assistant EMSA - Emergency Medical Services Authority IJ - immediate jeopardy OSDH - Oklahoma State Department of Health	C 000		
C1512 SS=J	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical	C1512		

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C1512	Continued From page 1 restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: On 05/19/25, an IJ situation was determined to exist when the center failed to provide supervision to prevent an elopement for 1 (#3) of	C1512		

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C1512	Continued From page 2 3 sampled residents reviewed for elopement. On 05/19/25 at 5:30 p.m., the OSDH was notified and verified the existence of the IJ situation. On 05/19/25 at 5:40 p.m., the executive director and director of nurses were notified of the IJ situation related to the elopement of Resident #3. On 05/19/25 at 5:45 p.m., an IJ template was provided and reviewed with executive director and director of nurses. On 05/21/25 at 11:12 a.m., the executive director submitted an updated plan of removal that was accepted by the OSDH. The plan of removal, read in part: "Residents service plan has been updated to reflect redirection of resident when approaching the door /exit seeking to activity of choice or walking a lap around the community"..."Staff have been educated on redirection."..."rug in the entryway was removed and replaced with a smaller floor mat"..."On 5/19 the front entry door to the outside with the alarm was locked and will alarm if opened"..."[local fire protection company] visited on 5/20/2025 At 8:05am to inspect the door and was working on STAT (immediately) return to get alarm added to middle entry door that leads to entry way and outside door." The IJ was removed on 05/22/25 at 2:30 p.m., when all components of the plan of removal were verified as completed: a. Reviewed service plans for residents identified as elopement risks and service plans were updated to reflect redirection of resident when approaching the door /exit seeking to activity of	C1512		

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C1512	Continued From page 3	C1512		

choice or walking a lap around the community.
b. Reviewed education on 05/12/25 and 05/22/25 for staff on the importance of ensuring proper closure of door after entry or exit of visitors and new alarm on door.
c. Rug in entryway was small and not restrictive of door closure.
d. Key code required to open door and alarm on inside exit door working and alarms when left open for over 10 seconds.

On 5/22/25 at 2:21 p.m. Spoke to [local fire protection company] and email received that showed work on alarm for exit door was completed this morning.

On 5/22/25 at 2:25 p.m., walked through front exit doors with the executive director and maintenance director to ensure working order. The inside door code entry locked and alarmed after the door was opened for 10 seconds and the outside door locked with the code exit.

The deficient practice remained at a pattern level with a potential for more than minimal harm.

Based on observation, record review, and interview, the facility failed to provide supervision to prevent an elopement for 1 (#3) of 3 sampled residents reviewed for elopement.

The executive director identified 44 residents resided in the center.

Findings:

On 5/19/25 at 2:20 p.m., Resident #3 was observed wandering in the hallway near the front door they eloped from.

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C1512	Continued From page 4 A "Service Plan Report," with admission date of 07/21/22, and "as of" date of 05/19/25, showed a diagnosis of unspecified dementia, psychotic mood disturbance, anxiety, and major depressive disorder. The report showed Resident #3 had an elopement risk initiated 02/03/24 with an intervention to "observe location in the community approximately every 2 hours." An "Elopement Risk assessment," dated 02/25/25, showed Resident #3 was at risk for elopement. On 05/13/25 at 12:51 p.m., OSDH received an incident report which read in part, "CMA noticed the middle door to community was caught on new floor mat and left the door ajar. Leadership notified and began process of head count on all residents, the local police department contacted the facility during the elopement process with report there was a resident at the local grocery store and EMSA was on site." The incident report showed the resident was Resident #3. On 05/19/25 at 11:00 a.m., the maintenance director was asked if they were aware of Resident #3's elopement. They stated they were, a carpet got stuck under the inside exit door and did not allow it to close all the way. The maintenance director was asked about the alarm system for exit doors. They stated, "The door that did not close did not have a working alarm on it. The maintenance director was asked about the outside door alarm. They stated it was only turned on at night due to an issue with the contact on the magnets on the door. On 05/19/25 at 11:35 a.m., CNA #1 was asked what elopement training they had before the incident. They stated they check on all residents	C1512		

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C1512	Continued From page 5	C1512		

every two hours. The CNA stated if they identified there was someone missing, they started the elopement check process of checking rooms, doors, and making sure everyone was accounted for. CNA #2 was asked about alarms on exit doors. They stated they beep and there were announcements overhead that told them which door it was.

On 05/19/25 at 11:40 a.m., CNA #2 was asked if they were aware of the recent elopement. The CNA stated they were. CNA #2 was asked about training. The CNA stated if a door alarm went off, they were to check on their residents and make sure everyone was accounted for. CNA #2 was asked about the front door alarms. The CNA stated they did not know why the alarm did not go off.

On 05/19/25 at 11:55 a.m., a family member of Resident #3 was asked if they were aware of Resident #3's elopement from facility on 05/12/25. The family member stated they were aware. The family member stated, "They have always been a wanderer and they are in the facility due to wandering." The family member was asked if they were aware of any previous elopement incidents at the facility. They stated they were not.

On 05/19/25 at 12:50 p.m., executive director was asked about recent incident of resident elopement. They stated the resident went out through the front door when a rug got caught under the door and it did not allow the door to completely close. The executive director was asked which door was involved and if there were alarms on the door. They stated it was the inside exit door going into a breezeway and was not alarmed. The executive director was asked about

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C1512	Continued From page 6 the outside door of the breezeway. They stated the alarm on the outside door was only on at night due to a magnet on the door. The executive director was asked how they identified residents at risk for elopement. They stated elopement risk assessments, and if identified they did a service plan with interventions. The executive director was asked about Resident #3's service plan. They stated before the incident, the intervention was to check every two hours.	C1512		

OKLAHOMA
State Department of Health

Delivery via email to: mnetters@oxfordseniorliving.com; astuart@oxfordseniorliving.com

July 14, 2025

License Number: AL7206

Mr. Aaron Stuart, Executive Director
Oxford Springs Tulsa Mc
6022 East 71st Street
Tulsa, OK 74136

Survey Event ID: 89RW11

Dear Mr. Stuart:

On **May 22, 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 **July 12, 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: 7/9/2025

Facility Name: Oxford Springs Tulsa Memory Care

License Number: AL7206

Survey Event ID: 89RW11

Date Survey Completed: 5/22/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1512	Based on: On 05/19/25,visit an IJ situation was determined to exist when the center failed to provide supervision to prevent an elopement for 1 (#3) of 3 sampled residents reviewed for elopement.

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?	All Service Plans reviewed and updated for those that are at risk for Elopement. Inservice staff on importance of proper door closesure of entry and exit. Rug in entry was changed to smaller mat in foyer. New alarm was added with code with mag locks on foyer and exit doors.
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 elopement risk residents have the risk 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?	Staff inserviced regarding proper closure of doors, not to give codes to families or residents, redirections of residents that may be near exits.Exit doors are checked routinely to ensure doors are properly functioning.
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.	Reviewing Service Plans semi annual and Change of condition, routine checks on exits amd educating staff on any new residents that may be at risk for elopement. Will incorporate monthly elopement drills to ensure staff are knowledgeable regarding policy and procedure for 3 months. Added to Quaterly QA meeting Binder to be kept in ED office drills and inservices that pertain to Elopement procedures.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/12/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. **Date** Enter a date of signature. 7/10/25

OAC 310:663-25-4(F)

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

OKLAHOMA
State Department of Health

FINAL DETERMINATION NOTICE
USPS Tracking #7021 2720 0002 0354 1792

August 8, 2025

License Number: AL7206

Aaron Stewart, Administrator/Executive Director
Oxford Springs Tulsa Mc
6022 East 71st Street
Tulsa, OK 74136

Survey Event ID: 89RW12

Dear Mr. Stewart:

A revisit conducted **August 6, 2025**, revealed that your facility corrected deficiencies effective **July 12, 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:

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{C 000}	INITIAL COMMENTS A revisit was conducted on 08/06/25. All deficiencies from the 05/22/25 survey were cleared.	{C 000}		

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