Delivery via email to: ewhitecloud@oxfordseniorliving.com

April 17, 2025

License Number: AL7239

Ms. Elizabeth Whitecloud, Administrator
Oxford Glen At Owasso
11113 East 103rd Street North
Owasso, OK 74055

RE: Survey Event ID: RMLL11

Dear Ms. Whitecloud:

On **April 9, 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 **April 9, 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
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,

Tempal Killman

Tempal Killman, 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
	AL7239	A. BUILDING: _____ B. WING _____	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 from 04/07/25 through 04/09/25. Deficiencies were cited as a result of the survey. Facility Census: 37 Listed below are abbreviations that will be used throughout this document. FSS - food service supervisor QA - quality assurance RCAL - licensed residential care and assisted living administrator RCD - resident care director Res - resident RN - registered nurse	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 one of two freezers and one of two refrigerators; and b. opened food items were stored in plastic containers with tight fitting lids on 1 of 4 shelf units in the dry storage.	C 391		

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C 391	Continued From page 1 The RCAL identified 37 residents received nutrition from the kitchen. Findings: On 04/07/25 at 1:35 p.m. the following opened food items were not labeled with open and use by date in freezer #1: a. one plastic bag three quarters full of yellow squash slices, and b. one paper freezer bag three quarters full of tater tots. On 04/07/25 at 1:40 p.m., the following opened food items were not labeled with open and use by date in refrigerator #1: a. a 24 oz plastic shaker bottle half full of Kraft grated parmesan cheese, and b. a 32 oz plastic bottle half full of Motts 100% juice. On 04/07/25 at 1:45 p.m., the following food items were opened and not in storage containers with tight fitting lids on shelf #2 in the dry storage: a. one box half full of quick oats. Marked with use by date of 02/19/25, b. one 40 ounce box one third full of Jiffy brand corn muffin mix. Marked with use by date of 02/18/25, and c. one unlabeled medium sized brown box with two packages marked chocolate pudding mix. Marked with use by date of 02/18/25. A facility policy titled "Food Storage," dated 10/25/23, read in part, "All foods will be labeled and dated with an expiration date." A facility policy titled "Food Storage," dated 11/2016, read in part, "Plastic containers with tight fitting lids are acceptable for storage of stable	C 391		

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C 391	Continued From page 2 foods in the pantry." On 04/07/25 at 9:47 a.m., the FSS was asked about the kitchen policies to ensure proper and safe food storage and to ensure all foods are labeled and dated with an expiration date. The FFS stated, "My assistant is new to the position, and is not consistent with proper storage, labeling and dating food yet. I haven't read the policy book. I know from my experience, all open foods should be properly stored, labeled and dated. I will throw the opened items into the trash."	C 391		
C 521 SS=E	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to complete an admission assessment within 30 days before or at the time of admission for 6 (#1, 2, 3, 4, 5, and #7) of 8 sampled residents reviewed for admission assessments. The RCAL identified 37 residents resided at the	C 521		

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C 521	Continued From page 3 facility. Findings: A facility policy titled "Assessment and Service Plan," dated 10/21/23, read in part, "(a) The assisted living center shall complete the admission assessment within (30) days before, or at the time of admission. 1. Res #1 was admitted to the facility on 03/06/25 with diagnoses which included dementia, obesity, and hyperlipidemia. There was no documentation in the health record an admission assessment was completed within 30 days before or at the time of admission. 2. Res #2 was admitted on 01/29/25 with diagnoses which included dementia, hypertension, and repeated falls. There was no documentation in the health record an admission assessment was completed within 30 days before or at the time of admission. 3. Res #3 was admitted on 02/08/25 with diagnoses which included dementia, type 2 diabetes, hyperlipidemia, and anxiety disorder. There was no documentation in the health record an admission assessment was completed within 30 days before or at the time of admission. 4. Res #4 was admitted on 07/01/24 with diagnoses which included Alzheimer's, hypothyroidism, anxiety disorder, and osteoarthritis. There was no documentation in the health record	C 521		

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C 521	Continued From page 4 an admission assessment was completed within 30 days before or at the time of admission. 5. Res #5 was admitted on 06/21/24 with diagnoses which included dementia, depression, atrial fibrillation, and hypertension. There was no documentation in the health record an admission assessment was completed within 30 days before or at the time of admission. 6. Res #7 was admitted on 02/06/24 with diagnoses which included dementia, hypothyroidism, and major depression. There was no documentation in the health record an admission assessment was completed within 30 days before or at the time of admission. On 04/08/25 at 3:30 p.m., the RCD was asked if there were any assessments for Residents #1, 2, 3, 4, 5, and #7 located somewhere else besides their health record. The RCD stated the admission assessments were not completed within the required timeframe.	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (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.	C 522		

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C 522	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive assessments were completed within 14 days after admission for 4 (#2, 3, 4, and #7) of 8 residents sampled for comprehensive assessments. The RCAL identified 37 residents resided at the facility. Findings: A facility policy titled "Assessment and Service Plan," dated 10/21/23, read in part, "(b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen days after admission of the resident; (2) once every (12) months thereafter; and (3) promptly after a significant change in the residents condition." 1. Res #2 was admitted on 01/29/25 with diagnoses which included dementia, hypertension, and repeated falls. Review of the clinical record showed no comprehensive assessment was completed within 14 days after admission on 01/29/25. 2. Res #3 was admitted on 02/08/25 with diagnoses which included dementia, type II diabetes, hyperlipidemia, and anxiety disorder. Review of the clinical record showed no comprehensive assessment was completed within 14 days after admission on 02/08/25.	C 522		

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C 522	Continued From page 6 3. Res #4 was admitted on 07/01/24 with diagnoses which included Alzheimer's, hypothyroidism, anxiety disorder, and osteoarthritis. Review of the clinical record showed no comprehensive assessment was completed within 14 days after admission on 07/01/24. 4. Res #7 was admitted on 02/18/24 with diagnoses which included dementia, hypothyroidism, and major depression. Review of the clinical record showed no comprehensive assessment was completed within 14 days after admission on 02/18/24. On 04/08/25 at 3:35 p.m., the RCD was asked if there were any comprehensive assessments for Res #2, 3, 4, and #7 located somewhere else besides their health record. The RCD stated the assessment were not completed within the timeframe as required by the Oklahoma State Department of Health.	C 522		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility	C 542		

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C 542	Continued From page 7 failed to ensure assessments were signed and/or coordinated by a RN or physician for 6 (#1, 2, 3, 4, 5, and #7) of 8 sampled residents reviewed for assessments coordinated by a RN or physician. The RCAL identified 37 residents resided at the facility. Findings: 1. Res #1 was admitted to the facility on 03/02/25 with diagnoses which included dementia, obesity, and hyperlipidemia. Res #1's assessment, assessment type box was checked as preadmission, dated 03/06/25, did not show it was signed and/or coordinated by an RN or physician. 2. Res #2 was admitted on 01/29/25 with diagnoses which included dementia, hypertension, and repeated falls. Res #2's 14-day assessment, dated 03/07/25, did not show it was signed and/or coordinated by an RN or physician. 3. Res #3 was admitted on 02/08/25 with diagnoses which included dementia, type II diabetes, hyperlipidemia, and anxiety disorder. Res #3's assessment, assessment type box was checked as preadmission, dated 02/10/25, did not show it was signed and/or coordinated by an RN or physician. 4. Res #4 was admitted on 07/01/24 with diagnoses which included Alzheimer's, hypothyroidism, anxiety disorder, and osteoarthritis.	C 542		

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C 542	Continued From page 8 Res #4's annual assessment, dated 07/12/24, did not show it was signed and/or coordinated by an RN or physician. 5. Res #5 was admitted on 06/21/24 with diagnoses which included dementia, depression, atrial fibrillation, and hypertension. Res #5's annual assessment, dated 02/25/25, did not show it was signed and/or coordinated by an RN or physician. 6. Res #7 was admitted on 02/06/24 with diagnoses which included dementia, hypothyroidism, and major depression. Res #7's annual assessment, dated 02/25/25, did not show it was signed and/or coordinated by an RN or physician. On 04/08/25 at 3:30 p.m., the RCD was asked if there were any assessments signed by the RN or physician, for Res #1, 2, 3, 4, 5, and #7 located somewhere else besides their health record. The RCD stated printed the available assessments from the electronic record. On 04/08/25 at 3:35 p.m., the RCD was asked the reason the assessments were not signed and/or coordinated by an RN or physician. The RDC stated they did not know why the assessments were not signed by the RN or physician.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a	C 543		

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C 543	Continued From page 9 personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive assessments were signed by the resident and/or resident representative for 6 (#1, 2, 3, 4, 5, and #7) of 8 sampled residents reviewed for comprehensive assessments signed by the resident and/or resident representative. The RCAL identified 37 residents resided at the facility. Findings: 1. Res #1 was admitted to the facility on 03/02/25 with diagnoses which included dementia, obesity, and hyperlipidemia. Res #1's comprehensive assessment, dated 03/06/25, did not show the resident and/or personal representative signed the assessment. 2. Res #2 was admitted on 01/29/25 with diagnoses which included dementia, hypertension, and repeated falls. Res #2's comprehensive assessment, dated 03/07/25, did not show the resident and/or	C 543		

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C 543	Continued From page 10 personal representative signed the assessment. 3. Res #3 was admitted on 02/08/25 with diagnoses which included dementia, type II diabetes, hyperlipidemia, and anxiety disorder. Res #3's comprehensive assessment, dated 02/10/25, did not show the resident and/or personal representative signed the assessment. 4. Res #4 was admitted on 07/10/24 with diagnoses which included Alzheimer's, hypothyroidism, anxiety disorder, and osteoarthritis. Res #4's comprehensive assessment, dated 07/12/24, did not show the resident and/or personal representative signed the assessment. 5. Res #5 was admitted on 06/21/24 with diagnoses which included dementia, depression, atrial fibrillation, and hypertension. Res #5's comprehensive assessment, dated 02/25/25, did not show the resident and/or personal representative signed the assessment. 6. Res #7 was admitted on 02/06/24 with diagnoses which included dementia, hypothyroidism, and major depression. Res #7's comprehensive assessment, dated 02/25/25, did not show the resident and/or personal representative signed the assessment. On 04/08/25 at 3:40 p.m., the RCD was asked if there were any comprehensive assessments signed by the resident and/or personal representative for Res #1, 2, 3, 4, 5, and #7 located somewhere else besides their health	C 543		

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C 543	Continued From page 11 record. The RCD said they did not know the resident or representative were required to sign the comprehensive assessments. The RCD stated there were no signed assessments.	C 543		
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to establish a quality assurance committee that met at least quarterly. The RCAL identified 37 residents resided at the facility. Findings: A policy titled "Quality Assurance," dated	C1110		

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C1110	Continued From page 12 10/21/23, read in part, "The Executive Director shall facilitate the organization of a committee, which will meet as often as required by licensing agency, but not less than annually." A black binder labeled "Quality Assurance," had documentation the QA committee met quarterly on 12/09/24 and 03/05/25. There was no documentation the QA committee met quarterly in June 2024 and September 2024. On 04/09/25 at 3:25 p.m., the RCAL was asked if there was documentation the quality assurance committee met quarterly in June 2024 and September 2024. The RCAL stated, "No, the only documents I have are in the binder I gave you."	C1110		

OKLAHOMA
State Department
of Health

Delivery via email to: ewhitecloud@oxfordseniorliving.com

April 23, 2025

License Number: AL7239

Elizabeth Whitecloud, Administrator
Oxford Glen At Owasso
11113 East 103rd Street North
Owasso, OK 74055

RE: Survey Event RMLL11

Dear Ms. Whitecloud:

On **April 9, 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 **May 9, 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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/22/2025** **Facility Name:** Oxford Glen of Owasso **License Number:** AL 7239-7239 **Survey Event ID:** RMLL11 **Date Survey Completed: 4/9/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	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 one of two freezers and one of two refrigerators; and B. opened food items were stored in plastic containers with tight fitting lids on 1 of 4 shelf units in the dry storage.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance.

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?	On 4/08/2025 Executive Director reviewed policy and procedure with Dining Services Director about food storage. Executive Director and Dining Service Director reviewed food items for dates and proper storage and labeled all food items. Foods that were past date were removed immediately.
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?	On 4/10/2025 inservice was completed with all dining staff on food storage, preparation and service. Executive Director to audit three times weekly for four weeks to ensure compliance. Weekly audits thereafter.
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.	Executive Director to audit three times weekly for four weeks to ensure compliance. Weekly audits thereafter. Executive Director to audit three times weekly for four weeks to ensure compliance. Weekly audits thereafter. Specific discussion added to Quality Assurance minute meetings. Special Quality Assurance meeting to be held by end of April. Quarterly thereafter. Continue to review in Quarterly Assurance meeting until substantial compliance is met and no evidence of errors recurring.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/17/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Elizabeth WhiteCloud, RCAL	**Date 4/22/2025**

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			
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: 4/22/2025** **Facility Name:** Oxford Glen at Owasso **License Number:** AL 7239-7239 **Survey Event ID:** RMLL11 **Date Survey Completed: 4/9/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C521	Based on: record review and interview, it was determined the facility failed to complete an admission assessment within 30 days before or at the time of admission for 6 (#1, 2, 3, 4, 5, and #7) of 8 sampled residents reviewed for admission assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance.

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?	Executive Director immediately inserviced Resident Care Director on policy and procedure for assessment timeframes for these assessments to be completed on admission day.
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 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?	Executive Director or designee will audit on admission to ensure completion of assessment. Audit to be completed for 30 days. Monthly thereafter.
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.	New admission checklist to be completed to ensure assessments completed in a timely manner. New admission checklist to be completed to ensure assessments completed in a timely manner. Specific discussion added to Quality Assurance meeting minutes. Executive Director or designee will audit on admission to ensure completion of assessment. Audit to be completed for 30 days. Monthly thereafter. . Continue to review in Quarterly Assurance meeting until substantial compliance is met and no evidence of errors recurring.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Elizabeth WhiteCloud, RCAL** OAC 310:663-25-4(F)	**Date 4/22/2025**

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.
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OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/22/2025** **Facility Name:** Oxford Glen at Owasso **License Number:** AL 7239-7239 **Survey Event ID:** RMLL11 **Date Survey Completed: 4/9/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522	Based on: record review and interview, the facility failed to ensure comprehensive assessments were completed within 14 days after admission for 4 (#2,3,4, and #7) of 8 residents sampled for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged defiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance.

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?	Executive Director immediately inserviced Resident Care Director on policy and procedure for assessment timeframes for these assessments to be completed on 14th day after admission and annually thereafter. 14 day assessments completed on resident # 2, 3 were updated. However resident # 4, 7 was prior to resident care director time period and unable to update. Both #4, 7 are up to date on current assessment timelines.
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 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?	Executive Director or designee will audit for 14th day assessment to ensure completion of assessment. Audit to be completed for 30 days. Monthly thereafter.
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.	Executive Director or designee will audit for 14th day assessment to ensure completion of assessment. Audit to be completed for 30 days. Monthly thereafter. Executive Director or designee will audit for 14th day assessment to ensure completion of assessment. Audit to be completed for 30 days. Monthly thereafter. Specific discussion added to Quality Assurance meeting minutes. Executive Director or designee will audit for 14th day assessment to ensure completion of assessment. Audit to be completed for 30 days. Monthly thereafter. . Continue to review in Quarterly Assurance meeting until substantial compliance is met and no evidence of errors recurring.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/9/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Elizabeth WhiteCloud, RCAL OAC 310:663-25-4(F)			**Date 4/22/2025**
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.			
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OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/22/2025** **Facility Name:** Oxford Glen at Owasso **License Number:** AL 7239-7239 **Survey Event ID:** RMLL11 **Date Survey Completed: 4/9/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C542	Based on: record review and interview, the facility failed to ensure assessments were signed and/or coordinated by a RN or physician for 6 (#1,2,3,4,5 and #7) of 8 sampled residents reviewed for assessments coordinated by a RN or physician.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance.

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?	Resident #1, 2,3,4,5 and #7 were signed by RN Consultant on 04/16/2025.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	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?	Executive Director audited for signatures on assessments. Of that audit RN was in on 4/16/2025 and signed assessments. Moving forward when RCD completes assessments. RCD will place assessments in binder for RN to sign monthly.
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.	RCD will have binder with assessments ready to sign by RN and set dates for signatures. ED or designee to audit assessments monthly to ensure signatures are in place. Specific meeting minutes added to Quality Assurance. ED or designee to audit assessments monthly to ensure signatures are in place. . Continue to review in Quarterly Assurance meeting until substantial compliance is met and no evidence of errors recurring.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Elizabeth WhiteCloud, RCAL** OAC 310:663-25-4(F)	**Date 4/22/2025**

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.

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OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/22/2025** **Facility Name:** Oxford Glen at Owasso **License Number:** AL 7239-7239 **Survey Event ID:** RMLL11 **Date Survey Completed: 4/9/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C543	Based on: record review and interview, the facility failed to ensure comprehensive assessments were signed by the resident and/or resident representative for 6 (1,2,3,4,5, and #7) of 8 sampled residents reviewed for comprehensive assessments signed by the resident and/or resident representative.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance.

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?	Executive Director inserviced RCD on resident/resident representative acknowledgement/signature on assessments. Residents 1,2,3,4,5 and 7 reviewed and obtained signatures.
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?	Executive Director audited for signatures on assessments. . Moving forward when RCD completes assessments, RCD will contact the resident/resident representative to gain signature and review assessment.
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.	RCD will put completed assessment in binder for Executive Director or designee to audit monthly. RCD will put completed assessment in binder for Executive Director or designee to audit monthly. Specific discussion added to Quality Assurance Meeting Minutes. Continue to review in Quaterly Quality Assurance meeting until substantial compliance is met and no evidence of errors recurring.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/9/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Elizabeth WhiteCloud, RCAL** OAC 310:663-25-4(F)	**Date 4/22/2025**

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.

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OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 4/22/2025
	Facility Name: Oxford Glen at Owasso
	License Number: AL 7239-7239
	Survey Event ID: RMLL11
	Date Survey Completed: 4/9/2025

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1110	Based on: record review and interview, the facility failed to establish a quality assurance committee that met at least quarterly.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance.

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?	Special Quality Assurance meeting held. Dates set forth for Quartely meetings thereafter.
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 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?	Continue with Quarterly Assurance meetings and all future dates have been planned for the year.
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.	Continue with Quarterly Assurance meetings and all future dates have been planned for the year. All Quarterly Assurance Meeting mInutes will be in a binder in Executive Directors office to ensure compliance. Planned dates and invitations have been sent to all involved with QA meetings. Placing all meeting minutes directly into binder and reviewing all past minutes to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Elizabeth WhiteCloud, RCAL** OAC 310:663-25-4(F)	**Date 4/22/2025**

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.

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Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department of Health

Delivery via email to: ewhitecloud@oxfordseniorliving.com

May 13, 2025

License Number: AL7239

Elizabeth Whitecloud, Administrator
Oxford Glen At Owasso
11113 East 103rd Street North
Owasso, OK 74055

RE: Survey Event RMLL12

Dear Ms. Whitecloud:

On **May 9, 2025,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 9, 2025,** have now been corrected effective **May 9, 2025.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7239	A. BUILDING: _____ B. WING _____	R 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GLEN AT OWASSO	11113 EAST 103RD STREET NORTH OWASSO, OK 74055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 05/09/25. 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