OKLAHOMA
State Department
of Health

Delivery via email to: ewhitecloud@oxfordseniorliving.com

June 10, 2025

License Number: AL7239

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

Survey Event ID: 2XKT11

Dear Ms. Whitecloud:

On **May 29, 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

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 Glen Owasso AL
Address: 11113 E 103rd Street N
City, State, Zip: Owasso, OK, 74055
Provider #: AL7239
Complaint #: OK00081826
Investigation Date(s): 05/28/25 and 05/29/25

ALLEGATION(S)
enter text The center failed to assess, monitor, and intervene in a timely manner for a change in condition.
enter textThe center failed to ensure care and treatment was provided according to the assessment, plan of care, contract, and/or the standard of care
enter text enter textThe center failed to ensure adequate supervision was provided to prevent accidents
enter text enter textThe center failed to ensure adequate staff to meet the needs of the residents
enter text

An unannounced on-site investigation was initiated 05/28/2025 at 9:17 a.m.

A sample of three residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation: Upon entrance into the facility and throughout the two-day complaint investigation staff was observed treating residents with dignity and respect. Staff were interacting with residents. Staff was being attentive to residents to prevent any accidents and to meet their needs. Records reviewed included incident reports, monthly work schedule, care plans, assessments. Interviews were conducted with residents, family members and employees.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

OKLAHOMA
State Department
of Health

Date report completed: 05/30/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Oxford Glen Owasso AL
Address: 11113 E 103rd Street N
City, State, Zip: Owasso, OK, 74055
Provider #: AL7239
Complaint #: OK00082927
Investigation Date(s): 05/28/25 and 05/29/25

ALLEGATION(S)
The center failed to ensure residents were not abused.
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 05/28/2025 at 9:17 a.m.

A sample of three residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation: Upon entrance into the facility and throughout the two-day complaint investigation there was no observance of residents being physically, verbally or psychosocially abused. Staff were interacting with residents treating them with respect and dignity. Records reviewed included incident reports, electronic records, in service training and policy and procedures. Residents, employees and family members were interviewed regarding any allegation of abuse.

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: 05/30/2025

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 _____	C 05/29/2025

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 A complaint survey (#OK00082927 and #OK00081826) was conducted on 05/28/25 through 05/29/25. Deficiencies were cited as a result of the survey. Facility Census: 39 Listed below are the abbreviations that will be used throughout this document. CMA- certified medication aide ED- executive director Res- resident	C 000		
C1512 SS=G	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		

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 _____	C 05/29/2025

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
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: Based on record review and interview, the facility failed to ensure a resident was free from abuse for 1 (#3) of 3 sampled residents reviewed for	C1512		

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 _____	C 05/29/2025

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
C1512	Continued From page 2 abuse. The ED identified 39 residents resided in the facility. Findings: A facility policy titled "Abuse, Neglect, or Exploitation," dated 11/2016, read in part, "It is the policy of Oxford Management Group to ensure all residents have the right to be free from abuse, neglect, and exploitation." An undated facesheet for Res #3 showed they were admitted on 09/18/24 with diagnoses which include Alzheimer's disease with late onset, heart failure, hypertension, and atherosclerotic heart disease. An "Incident Investigation Report," dated 05/21/25, read in part, "[CMA #5] was yelling and cussing at the residents of the house." The report showed CMA #5 was immediately placed on suspension on 05/21/25, pending further investigation of the allegations. The report showed in Part B it was determined through staff interviews CMA #5 had verbally, and psychosocially abused Res #3. The derogatory language used by CMA #5 resulted in sadness, isolation, and fear of retaliation to Res #3. CMA #5 was notified by phone of their termination being effective immediately on 05/23/25. On 05/29/25 at 10:33 a.m., the ED was asked about the allegation of abuse by CMA #5. The ED stated they were informed by the activity director on 05/21/25 about the abuse allegation and immediately they reported it to their direct supervisor. The ED stated CMA #5 was suspended immediately pending further	C1512		

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 _____	C 05/29/2025

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
C1512	Continued From page 3 investigation of the allegation. The ED stated on 05/23/25 CMA #5 was terminated for the allegation of abuse to Res #3.	C1512		
C1916 SS=D	310:663-19-1(f) REPORTS TO THE DEPARTMENT (f) Each continuum of care facility and assisted living center shall report allegations and occurrences of resident abuse, neglect, or misappropriation of resident's property by a nurse aide to the Nurse Aide Registry by submitting a completed "Notification of Nurse Aide Abuse, Neglect, Mistreatment or Misappropriation of Property" form (ODH Form 718), which requires the following: (1) facility/center name, address and telephone; (2) facility type; (3) date; (4) reporting party name or administrator name; (5) employee name and address; (6) employee certification number; (7) employee social security number; (8) employee telephone number; (9) termination action and date (if applicable); (10) other contact person name and address; and (11) the details of the allegation or occurrence of abuse, neglect, or misappropriation of resident property. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify the Nurse Aide Registry of an allegation of abuse involving CMA #5 for 1 (#3) of	C1916		

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 _____	C 05/29/2025

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
C1916	Continued From page 4 3 sampled residents reviewed for abuse. The ED identified 39 residents resided in the facility. Findings: A facility policy titled "Reportable Events," dated 11/2016, read in part "Review applicable state regulatory abuse reporting requirements for all reportable events involving abuse, neglect, or misappropriation of resident property." An undated electronic facesheet for Res #3 showed they were admitted on 09/18/24 with diagnoses which include Alzheimer's disease with late onset, heart failure, hypertension, and atherosclerotic heart disease. An "Incident Investigation Report," dated 05/21/25, read in part "[CMA #5] was yelling and cussing at the residents of the house." The report showed CMA #5 was immediately placed on suspension on 05/21/25, pending further investigation of the allegations. An initial "Incident Investigation Report," dated 05/21/25, did not show notification was made to the Nurse Aide Registry. A final "Incident Investigation Report," dated 05/23/25, did not show notification was made to the Nurse Aide Registry. On 05/29/25 at 10:33 a.m., the ED was asked about the allegation of abuse from CMA #5. The ED stated they were informed by the activity director on 05/21/25. The ED was asked if CMA #5 was reported to the Nurse Aide Registry for the allegation of abuse. They stated, "No."	C1916		

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 _____	C 05/29/2025

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

OKLAHOMA
State Department
of Health

Delivery via email to: ewhitecloud@oxfordseniorliving.com

June 19, 2025

License Number: AL7239

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

Survey Event ID: 2XKT11

Dear Ms. Whitecloud:

On **May 29, 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 **June 1, 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: 6/18/2025** **Facility Name:** Oxford Glen at Owasso **License Number:** AL 7239-7239 **Survey Event ID:** 2XKT11 **Date Survey Completed: 5/29/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1512	Based on: record and interview, the facility failed to ensure a resident was free from abuse for 1 (#3) of 3 sampled residents reviewed for abuse.

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 suspended employee on 05/21/2025 due to allegation of abuse/mistreatment and after conclusion of investigation employee was terminated from employment on 05/23/2025. Family of resident (#3) was notified immediatiely of allegation and of employee suspension and termination.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All staff required to complete relias abuse and neglect training upon hiring and annually. In person in-service held 06/05/2025. Policy and procedure to be followed when investigating allegations of abuse/mistreatment.
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.	Continuing education to be provided to staff about reporting allegations of abuse/mistreatment immediately to Direct Supervisors. All reports of abuse/mistreatment to be investigated immediately to ensure resident safety. Policy and Procedure to be followed to ensure compliance. Specific discussion to be added to Quality assurance meeting minutes to ensure compliance. All reports of abuse/mistreatment to be investigated immediately to ensure resident safety. Policy and Procedure to be followed to ensure compliance. Review in Quality Assurance meeting to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/1/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Elizabeth WhiteCloud, RCAL	**Date 6/18/2025**

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: 6/18/2025** **Facility Name:** Oxford Glen at Owasso **License Number:** AL 7239-7239 **Survey Event ID:** 2XKT11 **Date Survey Completed: 5/29/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1916	Based on: record review and interview, the facility failed to notify the Nurse Aide Registry of an allegation of abuse involving CMA #5 for 1 (#3) of 3 sampled residents reviewed for abuse.

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 05/29/2025 a late report was sent to Nurse Aide Registry for allegation of abuse on CMA #5.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All reports submitted to the department regarding allegations of abuse/mistreatment involving staff will be reported to the department immediately upon discovery and Nurse Aide registry to be notified of allegation of abuse/mistreatment.
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 ensure all reports are made to the Department and Nurse Aide Registry per regulations. Executive Director was also in-serviced by Regional Director of Operations on reporting to Nurse Aid Registry timely. Created checklist to ensure all components of investigation and reporting are completed. Specific discussion to be added to Quality Assurance meeting minutes. Will review in QA to ensure that following policy and procedures of reporting.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/1/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Elizabeth WhiteCloud, RCAL** OAC 310:663-25-4(F)	**Date 6/18/2025**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department of Health

FINAL DETERMINATION NOTICE
USPS Tracking # 7021 2720 0002 0354 1808

July 31, 2025

License Number: AL7239

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

Survey Event ID: 2XKT12

Dear Ms. Whitecloud:

A revisit conducted **July 29, 2025**, revealed that your facility corrected deficiencies effective **June 1, 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
	AL7239	A. BUILDING: _____ B. WING _____	R-C 07/29/2025

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 A revisit was conducted on 07/29/25. All deficiencies from the 05/29/25 survey were cleared.	{C 000}		

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