OKLAHOMA
State Department
of Health

Delivery via email to: Del Reed <dreed@oxfordseniorliving.com>; mnetters@oxfordseniorliving.com; ebrauer@oxfordseniorliving.com

June 24, 2026

License Number: AL0701

Delbert Reed, Administrator
Oxford Springs Durant Llc
1500 North 19th Street
Durant, OK 74701

RE: Survey Event ID: 4LGG11

Dear Mr. Reed:

On **June 5, 2026**, agents from our office concluded a State Licensure survey with complaint investigations 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 **June 5, 2026**.

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 OSDH.LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Oxford Springs Durant**
Address: **1500 N 19th St**
City, State, Zip: **Durant, OK 74701**
Provider #: **AL0701**
Complaint #: **OK00087002**
Investigation Date(s): **06/01/26 through 06/02/26 and 06/04/26 through 06/05/26**

ALLEGATION(S)
The center failed to ensure there were accurate call light system records.

An unannounced on-site investigation was initiated 06/01/2026 at 11:45 a.m.

A sample of 3 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:

An investigation related to call lights was conducted.

At the time of the survey, staff were observed assisting residents.

At the time of the survey, no residents complained about staff not helping them or answering their call light.

At the time of the survey, staff demonstrated how their call light system worked. They stated if they were providing care to another resident, it could be 15 minutes before they could answer the next call light.

At the time of the survey, there was no deficient practice cited in relation to physical environment.

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: 06/11/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Oxford Springs Durant**
Address: **1500 N 19th St**
City, State, Zip: **Durant, OK 74701**
Provider #: **AL0701**
Complaint #: **OK00091382**
Investigation Date(s):06/01/26 through 06/02/26, and 06/04/26 through 06/05/26

ALLEGATION(S)
The center failed to protect residents from abuse.

An unannounced on-site investigation was initiated 06/01/2026 at 11:45 a.m.

A sample of 3 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:

An investigation related to abuse, abuse training, personnel files, investigations, staffing, and incident reports were conducted.

At the time of the survey, professional interactions between staff and residents were observed.

At the time of the survey, no residents or family members had a problem with staff.

At the time of the survey, staff expressed an understanding of abuse and who they would report to.

There was no deficient practice cited in relation to resident 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: 06/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0701	A. BUILDING: _____ B. WING _____	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS DURANT LLC	1500 NORTH 19TH STREET DURANT, OK 74701

(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 with complaints (#OK00087002 and #OK00091382) was conducted from 06/01/26 through 06/02/26 and 06/04/26 through 06/05/26. Facility Census: 23 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide OSDH - Oklahoma State Department of Health RCD - resident care director	C 000		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the center failed to notify the Nurse Aide Registry within one business day of an allegation of abuse for 1 (CMA #1) of 2 CMAs reviewed for allegations of abuse.	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0701	A. BUILDING: _____ B. WING _____	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS DURANT LLC	1500 NORTH 19TH STREET DURANT, OK 74701

(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
C1911	Continued From page 1 The RCD identified 23 residents resided in the center. Findings: A policy titled "Reportable Events," dated 02/22/22, read in part, "Procedure"..."Review state regulatory abuse reporting requirements for all reportable events involving abuse." A final incident report, dated 05/13/26, read in part, "private duty care giver"..."witnessed unfair treatment during medication pass [CMA #1 with Resident #1]." There was no documentation CMA #1 was reported to the Nurse Aide Registry within one business day of the allegation. On 06/04/26 at 11:40 a.m., the RCD stated they did not know about the separate notification of Nurse Aide Registry form until another agency was in the center and asked about it. They stated it was sent 06/02/26. On 06/05/26 at 12:12 p.m., the RCD stated they thought once the incident report was submitted to the OSDH it was automatically sent to the Nurse Aide Registry. They stated they were not aware of the Nurse Aide Registry form until another agency came in and asked about it.	C1911		
C1914 SS=D	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form.	C1914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0701	A. BUILDING: _____ B. WING _____	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS DURANT LLC	1500 NORTH 19TH STREET DURANT, OK 74701

(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
C1914	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the center failed to notify the OSDH of a reportable incident for 1 (#11) of 3 sampled residents reviewed for reportable incident reports. The RCD identified 23 residents resided in the center. Findings: A final incident report, dated 04/14/26, read in part, "Upon staff making rounds, resident [#11] was observed lying on floor in bathroom. Resident [#11] stated [they] was transferring [themselves] to the wheelchair from the toilet. Resident [#11] is on blood thinners and was complaining of increased left leg pain; denied hitting head"..."sent to local emergency room for evaluation"..."Resident [#11] had a left lateral condyle fracture [leg] and was hospitalized for 4 days"..."came back from the hospital with left leg immobilizer." There was no documentation the incident was reported to the Oklahoma State Department of Health. On 06/04/26 at 11:39 a.m., the RCD stated state reportable incidents should be sent to the OSDH the next business day. On 06/05/26 at 3:10 p.m., the regional director of operations stated they had been having problems with their server and fax machine during the time the incident had not been received by the OSDH.	C1914		

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Delivery via email to: Del Reed <dreed@oxfordseniorliving.com>; mnetters@oxfordseniorliving.com; ebrauer@oxfordseniorliving.com

July 15, 2026

License Number: AL0701

Delbert Reed, Administrator
Oxford Springs Durant Llc
1500 North 19th Street
Durant, OK 74701

RE: Survey Event 4LGG11

Dear Mr. Reed:

On **June 5, 2026**, a Licensure inspection with complaints 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 **July 3, 2026**.

We will conduct a revisit for 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: 6/26/2026** **Facility Name:** Oxford Springs Durant AL **License Number:** AL 0701 **Survey Event ID:** 4LGG11 **Date Survey Completed: 6/5/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1911	Based on: This Rule is not met as evidenced by:C1911Based on record review and interview, the centerfailed to notify the Nurse Aide Registry within onebusiness day of an allegation of abuse for 1 (CMA#1) of 2 CMAs reviewed for allegations of abuse.

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?	Regional Director of Operations immediately inservices Resident Care director on 6/1/26 of proper reporting to Nurse aide registery and time lines.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Resident continues to be protected through the communities abuse prevention program, prompt investigations and timely reporting.
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?	Educated staff on abuse/ neglect policy and procedures, Educated Resident Care director on reporting to Nurse aide registery within regulatory time line and implemented State reportable checklist to ensure all required notifications are made with regulatory time frames.
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.	ED or designee will audit reportable checklist are completed Audit findings will be reviewed on monthly basis for 4 weeks Findings will be reviewed and incorporated in all quarterly QA meetings Checklist log will be kept in a state reportable binder along with all state reportables
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/3/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Delbert Reed** OAC 310:663-25-4(F)	**Date 06/26/26**

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. **Facility in Compliance by:** Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/26/2026** **Facility Name:** Oxford Springs Durant AL **License Number:** AL 0701 **Survey Event ID:** 4LGG11 **Date Survey Completed: 6/5/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1914	**Based on:** Click here to enter "Based On" statement which follows "This REQUIREMENT is not met as evidenced by:" in the Summary of Deficiencies column on the STATE FORM.

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?	Regional Director of Operations immediately educated on timely reporting and policy and procedures and alternative methods for reporting.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Resident continues to be protected through the communities abuse prevention program, prompt investigations and timely reporting.
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?	Educated Resident Care Director on reporting within regulatory time line and implemented a tracking log to ensure reports are sent within regulatory time frames. Alternative methods of reporting incidents have been created and will be used in the event faxing is not available.
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.	ED or designee will audit reportable tracking log to ensure incidents are submitted. Audit findings will be reviewed on monthly basis for 4 weeks Findings will be reviewed and incorporated in all quarterly QA meetings Tracking log will be kept in a state reportable binder along with all state reportables
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/3/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Delbert Reed** OAC 310:663-25-4(F)	**Date 06/26/26**

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department
of Health

Delivery via email to: Del Reed <dreed@oxfordseniorliving.com>; mnetters@oxfordseniorliving.com; ebrauer@oxfordseniorliving.com

July 16, 2026

License Number: AL0701

Del Reed, Administrator
Oxford Springs Durant Llc
1500 North 19th Street
Durant, OK 74701

RE: Survey Event 4LGG12

Dear Mr. Reed:

On **July 16, 2026,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your re-licensure survey with complaints on **June 5, 2026,** have now been corrected effective **July 3, 2026.**

If you have any questions concerning the information in this letter, please contact Long Term Care Enforcement 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
	AL0701	A. BUILDING: _____ B. WING _____	R-C 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD SPRINGS DURANT LLC	1500 NORTH 19TH STREET DURANT, OK 74701

(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 07/16/26. All deficiencies from the 06/05/26 survey were cleared.	{C 000}		

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