

Delivery via email to: slee@homesteadofweatherford.com

March 31, 2025

License Number: AL2003

Ms. Stacey Lee, Administrator
Homestead Of Weatherford
3601 East Main
Weatherford, OK 73096

Survey Event ID: C42M11

Dear Ms. Lee:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **March 12, 2025**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Respectfully,



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

Enclosure

INVESTIGATIVE REPORT

Facility: Homestead of Weatherford
Address: 3601 East Main
City, State, Zip: Weatherford , Ok, 73096, Custer
Provider #: AL2003
Complaint #: OK00078909
Investigation Date(s):03/12/25

ALLEGATION(S)
The facility failed to provide adequate supervision to prevent elopement.

An unannounced on-site investigation was initiated 03/12/2025 at 10:27am. ,

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:

A tour of the facility was conducted and at various times.

Resident assessments and physician orders were reviewed. Diagnosis, medication and treatment administration record was reviewed. Maintenance policies and procedures were reviewed. Training and staff rosters and schedules were reviewed. Service plans and grievances were reviewed. Maintenance logs and receipts were reviewed.

Resident and staff interactions were observed.

Resident hallways and exits were observed.

Resident were asked if they felt safe and if they had anything to report.

Resident was asked about reporting their concerns.

Staff were asked about exit doors.

Staff were interviewed in relation to monitoring and ensuring the exit doors were locked.

Staff were asked about maintenance reporting.

Staff were asked about policies and procedures of elopement.



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: 03/24/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/12/2025
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF WEATHERFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 3601 EAST MAIN WEATHERFORD, OK 73096		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A complaint investigation (#OK00078909) was conducted on 03/12/25. No deficiencies were cited. Facility Census:39	C 000		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE