OKLAHOMA
State Department
of Health

**Delivery via email to: amanda@woodlandgardensal.com; lstanderfer@searchlightcenter.org**

July 16, 2026

License Number: AL3801

Ms. Leigh Standerfer, Administrator
Woodland Gardens Assisted Living
915 North Broadway
Hobart, OK 73651

**Survey Event ID: U8HS11**

Dear Ms. Standerfer:

On **July 7, 2026**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint investigation 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: IDRCoordinator@health.ok.gov
or mail 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 II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA State Department of Health

# INVESTIGATIVE REPORT

**Facility:** **Woodland Gardens Assisted Living**
**Address:** **915 North Broadway**
**City, State, Zip:** **Hobart, OK,73651**
**Provider #:** **AL3801**
**Complaint #:** **OK00091848**
**Investigation Date(s):** **06/30/26 through 07/01/25 and 07/06/26 through 07/07/26**

| ALLEGATION(S) |
|---|
| 1.The center failed to ensure cardiopulmonary resuscitation (CPR) was administered according to physician orders and/or the standard of care. |
| 2.The center failed to ensure medications were not misappropriated. |
| 3.The center failed to ensure residents were free from abuse. |
| 4.The center failed to ensure medications were administered according to the physician orders. |
| 5.The center failed to ensure documentation was not falsified. |
| 6. The center failed to ensure discontinued medications were discarded by qualified staff. |
| 7. The center failed to ensure adequate staff to meet the needs of the residents. |
| 8. The center failed to have and/or implement an effective pest control program. |

An unannounced on-site investigation was initiated 06/30/2026 at 1:30 p.m.

A sample of 4 residents, including 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 on and throughout the survey. The facility was observed for concerns related to abuse and neglect, pest concerns, medications administration and destruction, residents need met regarding staffing, and pest related concerns. Medication carts were observed and narcotics were counted to ensure medication counts were accurate. Records reviewed included employee records, residents' health records, nurses' notes, incident reports, grievances, resident service contracts, service plans, EMS reports, pest management policies, narcotics destruction records, and narcotics counts abuse policies, and cpr policies. Staff records were reviewed for background check, licensing to perform job duties, and training records. Residents and family were asked questions about concerns related to care in the center which included pest, availability of staffing regarding meeting residents 'contractual need, concerns related to medication, concerns related to abuse and misappropriation, and medication administration timeliness. Staff were asked about code status and resident care related to staffing, concerns related to abuse, concerns related to medication administration and destruction.

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: 07/09/2026

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# INVESTIGATIVE REPORT

**Facility:** **Woodland Gardens Assisted Living**
**Address:** **915 North Broadway**
**City, State, Zip:** **Hobart, OK,73651**
**Provider #:** **AL3801**
**Complaint #:** **OK00091923**
**Investigation Date(s):** **06/30/26 through 07/01/25 and 07/06/26 through 07/07/26**

| ALLEGATION(S) |
|---|
| 1. The facility failed to initiate CPR for a resident who had become non-responsive. pest. |

An unannounced on-site investigation was initiated 06/30/2026 at 1:30 p.m.

A sample of 4 residents, including 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 on and throughout the survey. The facility was observed for concerns related to abuse and neglect. Records reviewed included employee records, residents' health records, nurses' notes, incident reports, grievances, resident service contracts, service plans, EMS reports, and center policies. Residents and family were asked questions about concerns related to care in the center. Staff were asked about code status and resident care.

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: 07/09/2026

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | AL3801 | A. BUILDING: _____ B. WING _____ | C 07/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WOODLAND GARDENS ASSISTED LIVING | 915 NORTH BROADWAY HOBART, OK 73651 |

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| C 000 | INITIAL COMMENTS<br><br>Complaint investigations (#OK00091848 and #OK00091923) were conducted from 06/30/26 through 07/01/26 and 07/06/26 through 07/07/26. Deficiencies were cited.<br><br>Facility Census: 21<br><br>Listed below are the abbreviations that will be used throughout this document.<br><br>ACMA - advanced certified medication aide<br>CMA - certified medication aide<br>CPR - cardiopulmonary resuscitation<br>DNR - do not resuscitate<br>DON - director of nursing<br>EMS - emergency medical services<br>IJ - immediate jeopardy<br>RN - registered nurse<br>QAPI - quality assurance performance improvement | C 000 | | |
| C 522 SS=D | 310:663-5-2(b) ASSESSMENT TIMEFRAMES<br><br>(b) The assisted living center shall complete the comprehensive assessment in accordance with the following:<br>(1) within fourteen (14) days after admission of the resident;<br>(2) once every twelve (12) months thereafter; and<br>(3) promptly after a significant change in the resident's condition.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the center failed to ensure a comprehensive fourteen day assessment was completed after admission for 1 | C 522 | | |

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| C 522 | Continued From page 1<br>(#2) of 4 sampled residents reviewed for fourteen day comprehensive assessments.<br><br>The community manager identified 21 residents resided in the center.<br><br>Findings:<br><br>A policy titled "Evaluation Period," dated 06/2018, read in part, "6. The comprehensive assessment will be done within 14 days of admission."<br><br>A preadmission assessment for Resident #2, dated 03/17/26, showed they had diagnoses which included coronary artery disease, hypertension, and congestive heart failure. The assessment showed Resident #2 was confused at times with fair judgment and ambulated without assistance.<br><br>A service contract for Resident #2, dated 03/17/26, showed the resident was admitted on 04/01/26.<br><br>Resident #2's health record was reviewed. There was no documentation to show a fourteen day comprehensive assessment had been completed.<br><br>On 07/07/26 at 10:30 a.m., the community manager stated Resident #2 was admitted to the center on 04/01/26. They stated the center could not locate a comprehensive fourteen day assessment to confirm it had been completed. | C 522 | | |
| C1505 SS=J | 310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care<br><br>Each assisted living center and its staff shall be familiar with and shall observe all resident rights | C1505 | | |

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| C1505 | Continued From page 2<br>and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B<br><br>63 O.S. 1-1918.(B)(5)<br>(5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the center failed to ensure CPR was performed on a resident that was a full code and found unresponsive for 1 (#2) of 3 sampled residents reviewed for code status.<br><br>Resident #2 was admitted on 04/01/26 with a diagnosis of congestive heart failure and was full code status. On 04/27/26, Resident #2 was found unresponsive without a pulse by staff. CPR was not initiated by staff in attempts to resuscitate Resident #2. EMSA responded and the resident was found to have been expired. | C1505 | | |

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| C1505 | Continued From page 3<br>The community manager identified 13 residents were full code status.<br><br>On 07/01/26 an immediate jeopardy (IJ) situation was determined to exist related to the center's failure to ensure CPR was attempted to resuscitate Resident #2 who was a full code when the resident was found unresponsive.<br><br>On 07/01/26 at 4:21 p.m., the Oklahoma State Department of Health was notified and verified the existence of an IJ situation related to the center's failure to initiate CPR.<br><br>On 07/01/26 at 4:25 p.m., the administrator and community manager were verbally notified of the IJ existence and provided the IJ template.<br><br>On 07/02/26 at 5:02 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal read in part,"<br>1. Immediate action for affected Resident<br>Action: Immediate clinical and administrative response to the specific incident.<br>Implementation date: 07/01/2026.<br>Specific interventions:<br>The administrator was notified the evening of 06/30/2026 of the ACMA's failure to initiate CPR on full code resident. The advanced certified medication aid (ACMA) involved was terminated on 07/01/2026.<br>Adult Protective Services was also notified via phone (R-327864)<br>The support staff involved (CNA and Community Manager) received a written warning and placed on 90 day probationary status.<br><br>2. Identification of All Potentially Vulnerable Residents | C1505 | | |

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| C1505 | Continued From page 4<br>Action: Audit. 100% of current residents to ensure clear, accessible identification of their resuscitation preferences.<br>Implementation date: must be completed within 24 hours of IJ notification by 07/02/2026<br>Specific interventions:<br>Code Status Audit: The director of nursing (DON) reviewed 100% of current resident's charts to verify and reconcile physician orders for CPR/ Code Status. (Full Codes versus Do Not Resuscitate/ DNAR).<br>Visual Identification: Validated that Oklahoma do not resuscitate (DNR) forms or Full Code identifiers are clearly flagged in the electronic health record (EHR), the resident's binder, and visible clues that alert staff, (yet are discreet to the public and protect the resident's privacy) inside the resident's apartment doorway. Additionally, all direct care staff will now wear on their person a card that contains all residents with a red or green indicator, notifying direct care staff who is a Full Code (green) and who is DNR (red).<br>Emergency Roster: A master "Emergency Code Status Roster" was generated, verified for accuracy, and placed at the nurses desk in emergency binders for instant staff access during a crisis.<br><br>3. Immediate: Systemic Mitigations, (stopping the immediate threat)<br>Action: Ensure that no staff members work a shift without verified competency in emergency CPR initiation.<br>Implementation Date: 07/02/2026- must be ongoing prior to next shift worked<br>Specific Interventions:<br>"No- Work" Mandate: Each staff member's (including CMA's, certified nurse aides, and licensed nurses) who has not completed the immediate emergency competency training | C1505 | | |

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| C1505 | Continued From page 5<br>(detailed in Section 4 ) will be removed from the schedule and not permitted to provide direct care until trained.<br>Emergency Binders: Placed. Laminated. "Emergency response protocols, end quotes. At every medication cart in nursing station, detailing the exact steps a CMA/ CNA must take if a resident is found unresponsive.<br><br>4. Mandatory Staff Education and Competency Verification.<br>Action: Immediate, Mandatory training for all direct care staff regarding Oklahoma Assisted Living. Regulations on emergency care, CPR execution, and scope of practice.<br>Implementation Date: Commenced on 07/02/2026 at 5:30 AM 100% Completion of scheduled staff required by 07/02/2026 at 10:00 PM.<br>Specific Interventions:<br>Immediate Huddle/ Training: The DON conducted mandatory education for all available staff covering:<br>Policy on "Emergency Resident Resuscitation and CPR."<br>The legal and ethical obligation of CMA's and all direct care staff to immediately initiate CPR on a "Full Code" resident.<br>How to instantly verify code status during an emergency.<br>Competency Check: Every direct care staff member passed a return dash demonstration competency check, including:<br>Locating a resident's code status in under 30 seconds.<br>Simulating the immediate activation of EMS ( 911 ).<br>Demonstrating correct chest compression/ CPR response.<br>Scope of Practice Clarification: Re- Educated | C1505 | | |

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| C1505 | Continued From page 6<br>CMA's that while they cannot assess medical stability, they must initiate emergency life dash saving measures. (CPR) immediately for an unresponsive full code resident while 911 is in route.<br>Escalating Communication to Administrator: All staff, both technical (direct care) and non-technical were informed via. Connectteam on 07/02/2026 (Staff Communication portal) and in person (beginning 07/02/2026 through 07/03/2026 ) of the importance of always escalating all emergent situations along with all pertinent details to the Administrator as soon as they occur- minimum reporting time is for such designated by the facility to be 2 hours within the time of the incident.<br><br>5. Monitoring, Auditing, and Quality Assurance (QAPI)<br>Action: Rigorous auditing to prove the facility remains compliant and staff retain this knowledge.<br>Implementation date: 07/02/2026.<br>Specific Interventions:<br>Shift-Level audits: The DON, Administrator, or Community Manager will conduct random verbal. "Pop quizzes" and code status drills with at least one direct care staff member every shift. (Day, Evening, Night) daily for 14 days, then weekly for three months.<br>New Hire Auditing: 100% of new direct care staff will undergo this exact code status and CPR initiation competency check during day-one orientation before being allowed to floor shifts.<br>QAPI Oversight: Audit results and drill performance metrics will be submitted directly to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for 6 months. The committee will determine if further root cause analysis. For ongoing training is | C1505 | | |

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| C1505 | Continued From page 7<br>required."<br><br>On 07/06/26 at 5:01 p.m., the IJ was lifted, effective 07/06/26, when all components of the plan of removal had been verified as completed. Staff in various departments and shifts were interviewed regarding facility measures for CPR and clinical protocol for identifying resident's code status. All staff interviewed were knowledgeable on the education and training provided. The plan of removal records including the facility's measures for CPR, code status policy, clinical protocol for identifying resident code status, staff in-service training, and QAPI monitoring were reviewed.<br><br>The deficiency remained at an isolated level with the potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings:<br><br>A policy titled "Resuscitation Status (Full Code/DNR) Training and Emergency Response," dated 07/08/18, showed five steps staff should complete in the event a resident was found unresponsive. The five steps included the following:<br>a. to assess and call for help;<br>b. activate EMS and locate emergency gear;<br>c. initiate CPR;<br>d. EMS arrival and transfer of care; and<br>e. post and submit documentation and notification.<br><br>An American Red Cross certificate, dated 11/12/24, showed ACMA #3 was CPR certified. .<br><br>American Red Cross certificates, dated 02/28/25, showed ACMA #1, housekeeper #1, the | C1505 | | |

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| C1505 | Continued From page 8 | C1505 | | |

community manager assistant, and the community manager were CPR certified.

A preadmission assessment for Resident #2, dated 03/17/26, showed they had diagnoses which included coronary artery disease, hypertension, and congestive heart failure. The assessment showed Resident #2 was confused at times with fair judgment and ambulated without assistance.

A physician order for Resident #2, dated 03/18/26, showed they were full code status which indicated resuscitation measures should be taken.

A "Prehospital Care Report" for Resident #2, dated 04/27/26, showed EMS responded to an emergency call on 04/27/26 at 8:58 a.m.. The report showed Resident #2 was found seated on a couch near a door and slouched over. The report showed Resident #2 was last seen approximately one hour prior. The report showed the resident was pulseless, had no respirations, skin was pale and cool to the touch, pupils were fixed and dilated, and no neurological function was present. The report showed the cardiac monitor showed asystole in two leads, and lividity was noted in the extremities.

An incident form, dated 07/01/26, showed a combined intital and final report was submitted to the Oklahoma State Department of Health. The form showed upon investigation, ACMA #1 was terminated for not performing CPR on Resident #2 on 04/27/26 who was a full code when they were found unresponsive.

On 07/01/26 at 10:11 a.m., ACMA #1 stated they saw Resident #2 on 04/27/26 around 7:30 a.m. in

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL3801 | A. BUILDING: _____ B. WING _____ | C 07/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WOODLAND GARDENS ASSISTED LIVING | 915 NORTH BROADWAY HOBART, OK 73651 |

| (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 |
|---|---|---|---|---|
| C1505 | Continued From page 9 | C1505 | | |

their room and passed medications to the resident around 8:00 a.m.. ACMA #1 stated they were alerted by housekeeper #1 around 8:30 a.m., that Resident #2 was seated on a couch in a common area with their head back and unresponsive. ACMA #1 stated they yelled for help. ACMA #1 stated Resident #2 did not have a pulse, was blue, and did not respond to stimuli. ACMA #1 stated ACMA #3, the community manager, and assistant community manager responded to the call for help. ACMA #1 stated they did not start CPR because there was no pulse and they did not know the code status of Resident #2.

On 07/01/26 at 11:13 a.m., the community manager assistant stated they were notified on 04/27/26 around 8:30 a.m. by ACMA #3 that Resident #2 was unresponsive. The community manager assistant stated an unidentified staff checked the pulse of Resident #2, an unidentified staff notified RN #1 of the situation by phone, and EMS was called. The community manager assistant stated CPR was never attempted by any of the staff and Resident #2 was deceased when EMS arrived. They stated Resident #2 was sent directly to the funeral home.

On 07/01/26 at 11:25 a.m., ACMA #3 stated on 04/27/26, they heard ACMA #1 yelling for help and responded to the call for assistance. ACMA #3 stated Resident #2 was seated on a couch in a common area, blue in color and unresponsive. ACMA #3 stated the community manager assistant, ACMA #1, and community manager were present. ACMA #3 stated CPR was not attempted by anyone to resuscitate Resident #2.

On 07/01/26 at 12:07 p.m., RN #1 stated they were notified by phone on 04/27/26 at 8:53 a.m.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL3801 | A. BUILDING: _____ B. WING _____ | C 07/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| C1505 | Continued From page 10<br><br>by ACMA #1 that they did not think Resident #2 was alive. RN #1 stated they directed ACMA #1 to check the code status and start CPR. RN #1 stated they arrived at the facility a couple minutes later and Resident #2 was seated on the couch in the common area. RN #1 stated ACMA #1 told them they did not start CPR because ACMA #1 thought it was too late to try and resuscitate Resident #2.<br><br>On 07/01/26 at 1:03 p.m., the community manager stated they were notified Resident #2 was unresponsive on 04/27/26 around 8:30 a.m. by ACMA #1 yelling they needed assistance. The community manager stated they responded to the call for assistance and found Resident #2 seated on a couch unresponsive. They stated ACMA #1 checked the pulse of Resident #2 and ACMA #1 stated Resident #2 had expired. The community manager stated CPR was not attempted to try and resuscitate Resident #2.<br><br>On 07/01/26 at 1:06 p.m., the administrator stated they had not been made aware the staff had not attempted CPR on Resident #2 on 04/27/26. The administrator stated ACMA #1, ACMA #3, the community manager assistant, and the community manager were all CPR certified.<br><br>On 07/01/26 at 3:57 p.m., EMS #1 stated when EMS arrived on 04/27/26, staff were not observed attempting to perform CPR to resuscitate Resident #2 who was a full code. | C1505 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to**: amanda@woodlandgardensal.com; lstanderfer@searchlightcenter.org

July 31, 2026

License Number: AL3801

Ms. Leigh Standerfer, Administrator
Woodland Gardens Assisted Living
915 North Broadway
Hobart, OK 73651

**RE: Survey Event U8HS11**

Dear Ms. Standerfer:

On **July 7, 2026**, a Complaint investigation 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 in a timely manner. **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 have been corrected and you were in substantial compliance by **July 28, 2026.**

We will conduct a revisit to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

**Delivery via email to**: amanda@woodlandgardensal.com; lstanderfer@searchlightcenter.org

July 31, 2026

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Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 7/28/2026**<br>**Facility Name:** Woodland Gardens Assisted Living<br>**License Number:** AL3801<br>**Survey Event ID:** U8HS1107/07/2026<br>**Date Survey Completed: 7/7/2026** |
|---|---|

**SUMMARY OF DEFICIENCY CITED BY OSDH**

| | |
|---|---|
| ID Prefix Tag: C 522 | Based on: Base on record review and interview, the center failed to ensure a comprehensive fourteen day assessment was completed after admission for 1(#2) of 4 sampled residents reviewed for fourteen day comprehensive assessments. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: This plan of correction is not to be constructed as an admission of, or agreement with, the findings and conclusions in the statement of deficiencies, or any related sanctions or fines. Rather it is submittied as a confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to the delivery of quality health service and will continue to make changes and improvements to satisfy the objective.

| 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? | The RN, Administrator, and Community Manager had QA meeting to check all current Residents fourteen day assessments. |
| 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 by this deficiency practice. |
| 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 current Residents fourteen day assessments have been checked and all are current at ths time. All new Residents will have a fourteen day assessment competed. The RN will complete the assessments the Administrator and Community Manager will ensure assessments have been completed on all new Residents. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | RN will complete all fourteen day assessments and report to Administrator or Community Manger when it has been completed.<br><br>Both the Administrator and Community Manager check for the completed fourteen day assessments after new Residents move in.<br><br>The RN, Administrator and Community Manager will quarterly review new move in fourteen day assessments.<br><br>The quarterly QA meetings will be documented and maintained. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 7/28/2026 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature** Administrator signature required.<br>OAC 310:663-25-4(F) | **Date 7/28/2026** |
|---|---|

| 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.<br>Facility in Compliance by: Click here to enter a date. | | | |

| Oklahoma State Department of Health<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 7/28/2026**<br>**Facility Name:** Woodland Gardens Assisted Living<br>**License Number:** AL3801<br>**Survey Event ID:** U8HS11<br>**Date Survey Completed: 7/7/2026** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 1505 | Based on: Based on record review and interview, the center failed to ensure CPR was performed on a resident that was a full code and found unresponsive for (#2) of 3 sampled residents reviewed for code status. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: This plan of correction is not to be constructed as an admission of, or agreement with, the findings and conclusions in the statement of deficiencies, or any related sanctions or fines. Rather it is submitted as a confremation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We remain committed to the delivery of quality health services and will continue to make changes and improvement to satisfy the objective.

| **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? | The RN reviewd 100% of current Residents' charts to verify and reconcile physician orders for CPR/Code Status (Full Code vs DNR. DNR or Full Code identifiers are clearly flagged in electronic health record for each Resident, inside Resident's doorways,and all direct care staff will wear their person card that contains all Residents red/green indicator that notifies staff who is Full Code(Green) and DNR(Red). Emergency Code Status Roster red folders are placed on both MED Carts and CNA Med Room. |
| 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 by this definciecy practice, |
| 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 current and new direct care CMA'S, CNA'S has complete the immediate emergency competency training assuring emergency CPR initiation |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | We completed Shift-Level Audits pop quizzes all 3 shifts (Day,Evening,Night) for 14 days and we will continue weekly pop quizzes for 3 months for Quality Assurance and Performance Improvements.<br><br>Random shift audit pop quizzes all shifts will be conducted by RN, Administrator, or Community Manager.<br><br>RN, Administrator, or Community Manager will keep documentation of the Shift-Level Audit pop quizzes.<br><br>RN, Administrator, and Community Manager (QAPI) will conduct monthly Quality Assurance Meetings for 6 |