OKLAHOMA
State Department
of Health

Delivery via email to: Jennifer@gladeavenueassistedliving.com

September 3, 2026

License Number: AL5512

Ms. Jennifer Beagle, Administrator
Glade Avenue Assisted Living South
2480 North Glade Avenue
Bethany, OK 73008

Survey Event ID: 8P2O11

Dear Ms. Beagle:

On **August 25, 2026,** representatives from the Oklahoma State Department of Health (OSDH) concluded a relicensure survey with a complaint investigation at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the 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 a 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: **Glade Avenue South**
Address: **2480 North Glade Avenue**
City, State, Zip: **Bethany, OK 73008**
Provider #: **AL5512**
Complaint #: **OK00092747**
Investigation Date(s): **08/25/2026**

ALLEGATION(S)
The center failed to ensure residents were free from elopement.
The center failed to ensure incidents of elopement were reported to the Oklahoma State Department of Health (OSDH) according to State Regulations.

An unannounced on-site investigation was initiated 08/24/2026 at 2:30p.m.

A sample of 2 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 upon entrance and at other various times throughout the survey. Observations of staff to resident ratio, staff to resident interactions, medication pass, appearance of residents, functionality of door alarms, and staff response to door alarms were made. Records of incident reports, resident health charts, service plans, assessments, physician orders, resident medications, and center policies were reviewed. Interviews with residents, the ombudsman, and family members regarding care of residents were conducted. Interviews with staff regarding care of residents and center policies were conducted.

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: 08/25/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5512	A. BUILDING: _____ B. WING _____	C 08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING SOUTH	2480 NORTH GLADE AVENUE BETHANY, OK 73008

(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 complaint (#OK00092747) was conducted from 08/24/26 through 08/25/26. Deficiencies were cited. Facility Census: 29 Listed below are abbreviations that will be used throughout this document. ACMA - advanced certified medication aide DON - director of nursing OSDH - Oklahoma State Department of Health	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 ensure an elopement incident was reported to the OSDH with one business day for 1 (#1) of 1 sampled resident reviewed for elopement incidents.	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1911	Continued From page 1 The executive director identified 29 residents resided in the center. Findings: An incident report for Resident #1, dated 08/17/26 at 8:45 p.m., showed the resident had eloped. The report showed the OSDH was notified on 08/19/26 at 9:32 p.m. A document titled "Glade Avenue South Elopement Policy & Procedure Update," dated 11/01/25, read in part, "Administration will complete a formal investigation and submit required reports to the state regulatory agency." A policy titled "Emergency Care for Residents Accident/Incident Reporting," dated 07/26/22, read in part, "All reports to the Department shall be made by fax within twenty four (24) hours of the reportable incident." A policy titled "Missing Resident," dated 07/26/22, read in part, "Complete an incident report form, The Director/Director of Nursing will notify the certifying agency as appropriate." On 08/25/26 at 11:10 a.m., the executive director stated there was a breakdown in communication with respect to reporting the incident. The executive director stated ACMA #1 was the person who should have reported the incident to the DON and executive director, but ACMA #1 was on break during the incident. They stated staff present at the time Resident #1 eloped, all assumed someone else had reported the incident. On 08/25/26 at 4:50 p.m., the DON stated incidents like abuse/neglect, head injuries,	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1911	Continued From page 2 misappropriation of resident property, and missing residents should have been reported within 24 hours or the next business day. On 08/25/26 at 4:53 p.m., the executive director stated incidents including abuse/neglect, certain injuries, and missing residents should have been reported to the OSDH within 24 hours or the next business day.	C1911		

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State Department of Health

Delivery via email to: Jennifer@gladeavenueassistedliving.com

September 21, 2026

License Number: AL5512

Ms. Jennifer Beagle, Executive Director
Glade Avenue Assisted Living South
2480 North Glade Avenue
Bethany, OK 73008

Survey Event ID: 8P2O11

Dear Ms. Beagle:

On **August 25, 2026,** a Relicensure survey with 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 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 will be corrected and you will be in substantial compliance by **October 19, 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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/17/2026** **Facility Name:** Glade Avenue Assisted Living South **License Number:** AL-5512 **Survey Event ID:** 8P2O11 **Date Survey Completed: 8/25/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1911	Based on: record review and interview, the center failed to ensure an elopement incident was reported to the OSDH within one business day for 1 of 1 sampled resident reviewed for elopement incidents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction is submitted as the facility's credible allegation of compliance. Preparation and submission of this Plan of Correction does not constitute agreement with the deficiency cited and is submitted solely to comply with regulatory requirements.

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?	Upon administration becoming aware of the elopement, the resident was assessed and confirmed to have returned to the community without injury. The resident's responsible party and physician were notified, and the incident was investigated by administration. The required report was subsequently submitted to OSDH. Staff involved in the incident were re-educated regarding the facility's elopement policy, including immediate notification of the Administrator or designee following an elopement or suspected elopement.
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 residing in the community have the potential to be affected by a failure to timely report a reportable incident. Administration will review incident documentation to identify any additional elopement incidents or other reportable events for which notification to OSDH is/was required . Any identified concerns will be addressed and reported as required.
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?	The facility's Elopement Policy was reviewed and revised to clarify staff and administrative responsibilities following an elopement. All staff will be educated that any elopement or suspected elopement must be immediately reported to the Administrator or DON, in addition to following established resident safety and notification procedures. The revised policy designates a designee to facilitate the investigation and required reporting when the Administrator is unavailable. The Administrator or designee will ensure a formal investigation is completed and all required reports are submitted to the appropriate state regulatory agency within applicable regulatory timeframes. Staff education will emphasize immediate notification to administration and reinforce that the

	facility's reporting responsibilities are not complete until all required regulatory reports have been submitted.
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.	The Administrator or designee will review incident reports and reportable events weekly for 4 weeks, then monthly for 3 months, to verify that administration was notified timely and that required regulatory reports were submitted within applicable timeframes. Monitoring will verify 100% compliance with timely notification to administration and timely submission of required reports to the appropriate regulatory agency. Any identified failure will result in immediate corrective action and additional staff education as indicated. Results of monitoring will be reviewed through the facility's Quality Assurance process. Trends, identified deficiencies, corrective actions, and the effectiveness of the revised process will be reviewed and documented by the Quality Assurance committee. The facility will maintain completed monitoring/audit records, documentation of staff education, revised policy documentation, and applicable Quality Assurance review records as evidence that corrective actions were implemented and sustained.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/19/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Jennifer Beagle, Executive Director OAC 310:663-25-4(F)	**Date 9/17/2026**

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