OKLAHOMA
State Department
of Health

Delivery via email to: laura.leehan@jasmineestatesokc.com

July 30, 2026

License Number: AL5543

Ms. Laura Leehan, Administrator
Jasmine Estates Of Oklahoma City
2232 Southwest 104th Street
Oklahoma City, OK 73159

Survey Event ID: FVIK11

Dear. Ms.Leehan:

On **June 29, 2026, 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.**

The deficiencies cited resulted in ***(Level A)** deficiencies representing the potential for no more than minimal harm. *******(Level B)** 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. ******(only use on level B)** 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:

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,

Malinda Perry

Malinda Perry, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Jasmine Estates of OKC**
Address: **2232 SW 104th St**
City, State, Zip: **OKC, OK 73159**
Provider #: **AL5543**
Complaint #: **OK00090394**
Investigation Date(s): 06/22/26 – 06/24/26, 06/26/26, and 06/29/26

ALLEGATION(S)
The facility failed to ensure staff were awake while on duty to provide adequate supervision.

An unannounced on-site investigation was initiated 06/22/2026 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 incident reports, staffing, facility camera footage, resident records, and policy 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: 07/14/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Jasmine Estates of OKC**
Address: **2232 SW 104th St**
City, State, Zip: **OKC, OK 73159**
Provider #: **AL5543**
Complaint #: **OK00091735**
Investigation Date(s): 06/22/26 – 06/24/26, 06/26/26, and 06/29/26

ALLEGATION(S)
The facility failed to ensure residents were free from abuse.

An unannounced on-site investigation was initiated 06/22/2026 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 incident reports, staffing, facility camera footage, resident records, and policy 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: 07/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 Complaint investigations (#OK00090394 and #OK00091735) were conducted on 06/22/26 through 06/24/26, 06/26/26, and 06/29/26. Facility Census: 40 Listed below are abbreviations that will be used throughout this document. CNA - certified nurse aide CPAP - continuous positive airway pressure DON - director of nursing	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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)(5) (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	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 1 of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide awake and alert staff to monitor residents to prevent falls for 1 (#1) of 3 sampled residents reviewed for falls. The administrator identified 40 residents resided in the facility. Findings: On 06/26/26 at 1:21 p.m., the following observations were made from video footage: a. on 03/23/26 at 3:10 a.m., Resident #1 was observed to walk with an unsteady gait into the common area where CNA #1 was observed to be seated with no movement. Resident #4 was observed to rest in their positioning wheelchair; b. on 03/23/26 at 3:11 a.m., Resident #1 was observed to fall into the positioning wheelchair of Resident #4 causing it to move forward and CNA #1 was observed to lift their head and their body moved suddenly. CNA #1 was observed to remain seated with no other movement; c. on 03/23/26 at 3:12 a.m., CNA #6 was observed to stand at the entrance of the common area. Resident #1 was observed on the ground between CNA #6 and CNA #1. CNA #1 was observed to stand, wave arms, and to walk around and past, Resident #1. CNA #1 and CNA #6 were observed to walk out of the frame, leaving Resident #1 on the floor, near the	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 2 positioning wheelchair of Resident #4; d. Resident #1 who was observed on the floor, began to move around, and repositioned themselves; e. on 03/23/26 at 3:16 a.m., Resident #1 was observed to roll themselves onto their right side, to a kneeling position, and into a crawl position, moving closer to the positioning wheelchair of Resident #4, raised knee, pressed hand on knee and got them self up off the floor; f. on 03/23/26 at 3:17 a.m., Resident #1 was observed to walk slowly, unsteadily, and staggered towards a chair, placed back against the wall next to chair; g. on 03/23/26 at 3:19 a.m., Resident #1 was observed to walk slowly and unsteady, across the room towards the recliners against the wall. Resident #1 was observed to back themselves toward a recliner and fell backward on to the floor; h. the video showed Resident #1 had been left alone for seven minutes; i. on 03/23/26 at 3:19:58 a.m., CNA #6 and CNA #8 were observed at the entryway of common area. No blood pressure cuff was observed for vital signs; j. on 03/23/26 at 3:21 a.m., CNA #8 was observed sitting on the edge or arm of chair; and k. on 03/23/26 at 3:23 a.m., CNA #6 was observed to return to area with blood pressure cuff, 11 minutes from the time of the first fall.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 3 A final incident report with report to the Nurse Aide Registry and statement, dated 03/23/26 and 3/24/26, showed CNA #1 was terminated on 03/25/26. A significant change assessment for Resident #1, dated 11/04/25, showed the resident was admitted to the facility with diagnoses of major neuro-cognitive disorder, behavioral disturbances, and dementia with Lewy bodies on 08/24/23. The assessment showed the resident was alert and oriented x 3 (person, place, time) with forgetfulness and delusions, with good mobility, strength, gait, weight bearing, and ambulatory without assistance. A "Night Shift Expectations In-Service," dated 06/25/26, read in part, "Providing safe, quality care during the night shift"..."Staff are expected to remain awake, alert"..."Sleeping while on duty is strictly prohibited." An undated "Post-Fall Checklist," read in part, "Immediate Response: resident checked for injury"..."an Aide should remain with the resident"..."vital signs obtained and documented (Medication Aide)." On 06/29/26 at 10:59 a.m., the administrator stated staff should have responded more promptly. On 06/29/26 at 1:59 p.m., the administrator stated there was no effort to comfort the resident.	C1505		
C1512 SS=E	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 4 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 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	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 5 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 observation, record review, and interview, the facility failed to provide direct care for a resident for 1 (#4) of 3 sampled residents reviewed for neglect. The administrator identified 40 residents resided in the facility. Findings: On 06/26/26 at 1:21 p.m., observations were made from the video footage recorded starting on 03/24/26. The video footage reviewed was from 03/24/26 at 5:55 p.m. to 03/25/26 at 5:00 a.m. The following observations were made: a. on 03/24/26 at 5:55 p.m., Resident #4 was observed to be placed in the common area in their positioning wheelchair. CNA #1 was observed seated in a chair; b. on 03/24/26 at 9:37 p.m., Resident #4 was observed moving around in their positioning wheelchair. CNA #1 got up from the chair, looked over at Resident #4, and walked out of the common area;	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 6 c. on 03/24/26 at 9:44 p.m., CNA #1 was observed to walk back into the common area and sat down in the chair. CNA #2 and CNA #9 were observed waiting for their shift to end. Resident #4 was observed sitting in their positioning wheelchair, awake, rocking body, leaned over their positioning wheelchair and picked up their blanket; d. on 03/24/26 at 10:17 p.m., Resident #4 was observed wiggling around in their positioning wheelchair and removed their pants; e. on 03/24/26 at 11:21 p.m., Resident #4 had not been checked for incontinent care or repositioned by CNA #6; f. on 03/24/26 at 11:52 p.m., CNA #6 was observed to cover Resident #4 with their blanket; g. on 03/24/26 at 11:59 p.m., CNA #6 was observed to pick up Resident #4's pants and brief from the floor where Resident #4 had tossed them. Resident #4 was observed kicking their legs. CNA #6 was observed to pick up the blanket from the floor and covered Resident #4 with it; h. on 03/25/26 at 1:00 a.m., Resident #4 was observed moving around in their positioning wheelchair and kicked their blanket off; i. on 03/25/26 at 2:30 a.m., CNA #1 got up and left the common area; and j. on 03/25/26 at 5:00 a.m., Resident #4 was observed in their positioning wheelchair. No observation was made of any direct care, repositioning, or incontinent care for Resident #4 provided by facility staff for the 12 hours when the video footage cut out.	C1512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 7 An undated policy titled "Abuse, Neglect, or Exploitation," read in part, "Our facility staff prides itself in providing exceptional service to our residents and will not tolerate"..."involuntary seclusion"..."All staff are mandatory reporters"..."Neglect: A pattern of conduct or inaction by a person with duty of care that fails to provide the goods and services that maintain physical and mental health." A care plan for Resident #4, dated 04/14/26, showed the resident needed maximum assistance with dressing, toileting incontinence assistance, and staff assistance with ambulation due to their positioning wheelchair. On 06/26/26 at 1:20 p.m., the administrator stated the staff seemed oblivious of the resident's needs. 06/26/26 at 1:44 p.m., the administrator stated the video footage kept the employees accountable. They stated they had observed Resident #4 was not moved, changed, or repositioned for a 12 hour period.	C1512		
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)	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 8 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 facility staff failed to report an allegation of sexual abuse when staff became aware for 1 (#2) of 3 sampled residents reviewed for abuse. The administrator identified 40 residents resided in the facility. Findings: An undated policy titled "Abuse, Neglect, or Exploitation," read in part, "Reporting"..."The staff member should also report it immediately to someone within management so that immediate interventions can take place." A "Final Incident Report Form," dated 06/12/26 and 06/13/26, showed Resident #2 claimed they had sex with a care aide of the opposite sex on 06/12/16. Resident #2 made a claim they were raped on 06/13/26. An "Incident Investigation/Witness Statement," dated 06/14/26, showed CNA #4 was told by Resident #2 on 06/13/26 they had sex with an employee. On 06/29/26 at 1:21 p.m., CNA #4 stated Resident #2 reported they had sex with certified medication aide #1 on Friday, 06/12/26. CNA #4 stated on 06/14/26 (Sunday night), Resident #2 stated they were raped on Saturday, 06/13/26.	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 9 CNA #4 stated Resident #2 told them they knew who it was, but they were not going to tell them. CNA #4 stated they reported the incidents to the administrator on Sunday, 06/14/26. On 06/29/26 at 1:38 p.m., the administrator stated the first allegation was made on 06/12/26, but they were not notified by facility staff until 06/14/26.	C1911		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an accurate assessment and care plan for 1 (#2) of 3 sampled residents reviewed for accurate clinical records. The administrator identified 40 residents resided in the facility. Findings: An admission (comprehensive) assessment for Resident #2, dated 03/30/26, showed the resident had missing information related to past medical history such as hypertension, CPAP was listed under medications, and the resident was described as non-ambulatory.	C1951		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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
C1951	Continued From page 10 A care plan for Resident #2, dated 05/15/26, did not show the use of a CPAP. On 06/29/26 at 4:39 p.m., the DON stated the admission (comprehensive) assessment was not complete or accurate for Resident #2. On 06/29/26 at 4:45 p.m., the DON stated the admission (comprehensive) assessment was missing required components, the minimum amount of information required. The DON stated Resident #2 was described as non-ambulatory, but that was not accurate because Resident #2 could move freely throughout the facility using their feet to self-propel their wheelchair. On 06/29/26 at 4:47 p.m., the DON stated the admission (comprehensive) assessment was missing diagnoses related to medical history for Resident #2. On 06/29/26 at 4:50 p.m., the DON stated the care plan was not complete and accurate for Resident #2. The DON stated the CPAP had not been care planned. The DON stated there would be frequent checks to ensure the use of a CPAP by the resident. The DON stated an assisted living resident should be able to manage their CPAP, put it on, and take it off. The DON stated a CPAP would not be allowed in memory care. The DON stated a CPAP should have also included a non-risk disclosure form in the event of illness, throw up, vomit, and aspiration by Resident #2.	C1951		

OKLAHOMA
State Department of Health

Delivery via email to: laura.leehan@jasmineestatesokc.com

August 28, 2026

License Number: AL5543

Ms. Laura Leehan, Administrator
Jasmine Estates Of Oklahoma City
2232 Southwest 104th Street
Oklahoma City, OK 73159

RE: Survey Event FVIK11

Dear Ms. Leehan:

On **June 29, 2026**, a Licensure inspection 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 **August 5, 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,

Malinda Perry

Malinda Perry, Enforcement Analyst
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: 8/10/2026** **Facility Name:** Jasmine Estates OKC **License Number:** AL5543 **Survey Event ID:** FVIK11 **Date Survey Completed: 6/29/2026**
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Based on observation, record review, and interview, the facility failed to provide awake and alert staff to monitor residents to prevent falls for1 (#1) of 3 sampled residents reviewed for falls.
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?	CNA #1 and terminated from employment on 3/25/26 and reported to the Nurse Aide Registry. A Form 283 was also completed and submitted to OSDH. Reports were filed with APS and the OKCPD. Relevant video surveillance footage was preserved and subsequently provided to the Oklahoma Attorney General's Office for further investigation. .
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No other residents were identified as having been harmed by the deficient practice; The Executive Director, Laura Leehan, will video surveillance footage weekly for 90-days across all shifts, with particular emphasis on the night shift, to ensure staff remain alert and awake and are fulfilling assigned duties and responsibilities in accordance with their job descriptions, resident care needs, and facility policies and procedures.
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?	A policy was created, and an all staff in-service was conducted on 'Recognizing & Reporting Abuse, Neglect & Suspicion' dated 3/26/26 and 'Night Shift Expectations' policy and in-service was created for night shift staff 3/26/26, with emphasis on staying awake & alert. Both will be required for the on-boarding process of all new hires.
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.	Corrective measures will be sustained through the ongoing interventions, staff education, monitoring, and Quality Assurance/Performance Improvement activities outlined below. a. ED, Laura Leehan, will conduct weekly audits of video footage for 90 days, particularily on night shift, evening shift, and weekends when there is less or no management on site.

	b. The deficient practice was incorporated in the facility's QAIP meeting held on 4/30/2026. The incident and interventions were discussed and documented in detail. Abuse and Neglect prevention & reporting was incorporated in QAIP meeting held on 7/23/2026 based on 6/29/2026 survey exit. c. A log will be maintained of surveillance findings. Corrective action (if applicable) will be kept in emloyee file's. Any findings that are state reportable will be submitted immediately. In-service and QAIP records will be maintained and kept in the ED/Laura Leehan's office
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/10/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Laura L. Leehan, ED	**Date 8/10/2026**

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.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/10/2026** **Facility Name:** jasmine Estates OKC **License Number:** AL5543 **Survey Event ID:** FVIK11 **Date Survey Completed: 6/29/2026**
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1512	Based on: Based on observation, record review, and interview, the facility failed to provide direct carefor a resident for 1 (#4) of 3 sampled residents reviewed for neglect.
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?	CNA #1 & CNA #6 were terminated immediately upon discovery on the incident. Both were reported to NAR and a 283 form was submitted to OSDH. Reports were filed with APS and the OKCPD. Relevant video surveillance footage was preserved and subsequently provided to the Oklahoma Attorney General's Office for further investigation.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No other residents were identified as having been harmed by the deficient practice. The Executive Director, Laura Leehan, will review video surveillance footage weekly across all shifts for 90-days, with particular emphasis on the night shift, to ensure staff are fulfilling assigned duties and responsibilities in accordance with their job descriptions, resident care needs, and facility policies and procedures.
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?	A policy was created, and an all staff in-service was conducted on 'Recognizing & Reporting Abuse, Neglect & Suspicion' dated 3/26/26 and 'Night Shift Expectations' policy and in-service was created for night shift staff 3/26/26, Both will be required for the on-boarding process of all new hires.
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.	Corrective measures will be sustained through the ongoing interventions, staff education, monitoring, and Quality Assurance/Performance Improvement activities outlined below. a. The correction will be evaluated for effectiveness through weekly audits of video surveillance footage for 90-days by ED, Laura Leehan to verify that staff are completing resident care tasks and fulfilling assigned responsibilities in accordance with facility policies and procedures. In addition to

	staff education, leadership (WD-Robert Stephens & ED- Laura Leehan) will maintain ongoing communication with care staff regarding clinical operations, staffing concerns, and barriers that may impact their ability to effectively perform assigned duties. Any identified concerns will be addressed promptly through additional education, coaching, or corrective action as appropriate. b. The deficient practice was incorporated in the facility's QAIP meeting held on 4/30/2026. The incident and interventions were discussed and documented in detail. Abuse and Neglect prevention & reporting was incorporated in QAIP meeting held on 7/23/2026 based on 6/29/2026 survey exit. c. A log will be maintained of surveillance findings. Corrective action (if applicable) will be kept in emloyee file's. Any findings that are state reportable will be submitted immediately. In-service and QAIP records will be maintained and kept in the ED/Laura Leehan's office
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/10/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Laura Leehan, ED	**Date 8/10/2026**

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.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/10/2026** **Facility Name:** Jasmine Estates OKC **License Number:** AL5543 **Survey Event ID:** FVIK11 **Date Survey Completed: 6/29/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1911	Based on: Based on record review and interview, the facility staff failed to report an allegation of sexual abuse when staff became aware for 1 (#2) of 3 sampled residents reviewed for 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?	CNA #4 was given a written corrective action on 6/17/2026 for failure to report allegations of a sexual abuse on 6/12/26 by resident #2 upon discovery on 6/13/26. CNA reported to the ED, Laura Leehan on 6/14/26. ED immediately sent resident #2 to the Deaconess Medical Center ER for examination. A 283 for was submitted to OSDH. An APS & police report was filed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No other residents were harmed by the deficient plactice.
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?	A 'Sexual Assault Allegation Response' policy was created on 6/15/2026. All staff were in-serviced on the policy in addition to 'Abuse & Neglect Reporting' on 6/17/2026
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.	Corrective measures will be sustained through the ongoing interventions, staff education, monitoring, and Quality Assurance/Performance Improvement activities outlined below. a. The correction will be evaluated through periodic audits of incident reports and staff interviews by WD, Robert Stephens & ED, Laura Leehan to ensure all allegations or suspicions of abuse, neglect, or sexual assault are immediately reported to facility leadership in accordance with facility policy. Any identified non-compliance will result in immediate re-education and/or disciplinary action. b. The investigative findings and corrective interventions were reviewed during the facility's QAIP meeting on 7/23/2026. Ongoing monitoring will be incorporated into the QA process to ensure continued compliance with abuse and neglect reporting requirements.

	c. Monitoring records will be maintained through staff in-service records, incident documentation, and investigative reports. All monitoring records will be retained in ED Laura Leehan's office as evidence of ongoing compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Click here to enter a date when corrective action will be completed.
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Laura L. Leehan, ED OAC 310:663-25-4(F)	**Date 8/10/2026**

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.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/10/2026** **Facility Name:** Jasmine Estates OKC **License Number:** AL5543 **Survey Event ID:** FVIK11 **Date Survey Completed: 6/29/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1951	Based on: Based on record review and interview, the facility failed to maintain an accurate assessment and care plan for 1 (#2) of 3 sampled residents reviewed for accurate clinical records.

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?	Wellness Director, Robert Stephens – initiated a change of condition assessment on 6/15/2026 that was amended on 8/5/2026. Care Plan has been updated and is consistent with assessment. WD will contact Alis account manager to amend evaluation & careplan to ensure compliance and consistency with the OK State Assessment.
OSDH Response: Element accepted Yes ☒ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit is in process by WD, Robert Stephens of all resident's assesssment's and care plans to identify any descrapancies. If identified, corrections will be made upon discovery.
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 center's policy & procedure 'Assesment & Care Plan' has been updated to include procedure: "The resident's care plan must accurately match the current assessment, including all identified care needs, risks, assistance levels, and required interventions."
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.	A New Admission checklist has been created and will be utilized to ensure all regulatory and facility practices are observed including consistency between assement and care plan. a. The WD, Robert Stephens will conduct monthly audits of new admissions to verify completion of the New Admission Checklist and ensure consistency between the resident assessment and care plan. b. Any discrepancies identified will be corrected immediately and reviewed through the facility's Quality Assurance process to determine continued compliance. c. Completed New Admission Checklists will be maintained in the resident's chart. Audit findings

		that require correction will be documented in the QAIP process and maintained in the QA binder.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		9/11/2026	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. ED		**Date 8/10/2026**
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.			