OKLAHOMA
State Department
of Health

Delivery via email to: Carley@milestoneretirement.com

June 10, 2026

License Number: AL5591

Scott Stein, Administrator
The Mansion At Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

Survey Event ID: 6TRM11

Dear Mr. Stein:

On **May 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 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:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to OSDH.LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **The Mansion at Waterford**
Address: **6110 NORTH PENN AVENUE**
City, State, Zip: **Oklahoma City, OK, 73112**
Provider #: **AL5591**
Complaint #: **OK00089441**
Investigation Date(s): **05/21/26 and 05/26/26 through 05/29/26**

ALLEGATIONS
The facility failed to ensure residents received medications according to the physician orders
The facility failed to ensure residents were provided food selection.
The facility failed to ensure resident rooms were safe, clean, and homelike environment.
The facility failed to ensure residents were not retaliated against.
The facility failed to ensure care was provided according to the physician orders.
The facility failed to ensure medications were administered according to policy and procedure.
The facility failed to ensure ADL care was provided for dependent residents.
The facility failed to provide adequate supervision to prevent accidents.

An unannounced on-site investigation was initiated 05/21/2026 at 1:52 p.m.

A sample of three residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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 memory care unit was conducted upon entrance and throughout the survey. Residents were observed during meals, in their rooms, in common areas, and while participating in activities. Staff members were observed providing assistance with meals and housekeeping was observed to be cleaning rooms throughout the day.

Sampled clinical records, including any named residents, were reviewed for physician orders, service plans, progress notes, medication administration records and assessments. Facility policies and procedures were reviewed. Resident grievances and Resident Council minutes were reviewed.

Residents were interviewed regarding the cleanliness of the facility and the provisions of meals. Staff members were interviewed regarding policies for environmental services and the provision of meals, and medication administration.

OKLAHOMA
State Department
of Health

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 06/01/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **The Mansion at Waterford**
Address: **6110 NORTH PENN AVENUE**
City, State, Zip: **Oklahoma City, OK, 73112**
Provider #: **AL5591**
Complaint #: **OK00091278**
Investigation Date(s): **05/21/26 and 05/26/26 through 05/29/26**

ALLEGATIONS
The faicilty failed to provide adequate supervision to prevent resident elopements.

An unannounced on-site investigation was initiated 05/21/2026 at 1:52 p.m.

A sample of three residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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 memory care unit was conducted upon entrance and throughout the survey. Residents were observed during meals, in their rooms, in common areas, and while participating in activities. Staff members were observed interacting with residents, providing activities, and redirecting residents.

Sampled clinical records, including any named residents, were reviewed for physician orders, service plans, progress notes, medication administration records and assessments. Facility policies and procedures were reviewed. Resident grievances and Resident Council minutes were reviewed.

Staff members were interviewed regarding elopement.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

OKLAHOMA
State Department
of Health

Date report completed: 06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5591	A. BUILDING: _____ B. WING _____	C 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANSION AT WATERFORD	6110 NORTH PENN AVENUE OKLAHOMA CITY, OK 73112

(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 (#OK00089441 and OK00091278) were conducted from 05/19/26 through 05/20/26. Deficiencies were cited. Facility Census: 94 Listed below are abbreviations that will be used throughout this document. MAR - medication administration record mg - milligram	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 of such actions unless adjudged to be mentally incapacitated.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5591	A. BUILDING: _____ B. WING _____	C 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANSION AT WATERFORD	6110 NORTH PENN AVENUE OKLAHOMA CITY, OK 73112

(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 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure residents received their medication according to physician orders for 2 (#2 and #3) of 3 sampled residents reviewed for medications. The regional nurse identified 18 residents resided in the memory care unit. Findings: 1. A physician order for Resident #2, dated 02/10/26, showed to administer famotidine (histamine-2 blocker) 10 mg daily. A MAR, dated 03/2026, showed a diagnosis of gastroesophageal reflux disease. The MAR showed dashes for the famotidine on 03/12/26 through 03/16/26 instead of initials. 2. A physician order for Resident #3, dated 03/05/26, showed to administer hydrocodone/acetaminophen 5/325 mg (opioid pain reliever) one tablet every eight hours for pain. A MAR, dated 05/16/26 at 2:00 p.m., showed blanks with no initials to indicate if the hydrocodone/acetaminophen was provided. A MAR, dated 05/18/26 at 6:00 a.m., showed blanks with no initials to indicate if the hydrocodone/acetaminophen was provided. An undated narcotic control count sheet for Resident #3 did not show the	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5591	A. BUILDING: _____ B. WING _____	C 05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANSION AT WATERFORD	6110 NORTH PENN AVENUE OKLAHOMA CITY, OK 73112

(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 hydrocodone/acetaminophen was given to Resident #3 on 05/16/26 at 2:00 p.m. and 05/18/26 at 6:00 a.m. On 05/28/26 at 1:33 p.m., the regional nurse stated a dash on the MAR meant the medication was not given to Resident #2. They stated there was an error with the administration time and it was removed from the MAR. The regional nurse stated the medication with the correct time was never documented back on the MAR. On 05/28/26 at 1:54 p.m., the regional nurse stated the famotidine was not given to Resident #2 on 03/12/26 through 03/16/26. On 05/29/26 at 11:44 a.m., the regional nurse reviewed the MAR and the narcotic count sheet and stated the hydrocodone/acetaminophen was not given to Resident #3 on 05/16/26 at 2:00 p.m. and 05/18/26 at 6:00 a.m.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: Carley@milestoneretirement.com; jessica.bieger@mansionatwaterfordslc.com

July 1, 2026

License Number: AL5591

Scott Stein, Administrator
The Mansion At Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

Survey Event ID: 6TRM11

Dear Mr. Stein:

On **May 29, 2026,** 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 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 **June 24, 2026**.

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/10/2026** **Facility Name:** The Mansion at Waterford **License Number:** AL5591 **Survey Event ID:** 6TRM11 **Date Survey Completed: 5/29/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: record review and interview, the centerfailed to ensure residents received their medication according to physician orders for 2(#2 and #3) of 3 sampled residents reviewed for medications.

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?	The community will ensure residents receive their medications according physician orders by conducting audits and providing retriaing to Certified Medication Aids.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The Director of Health and Wellness (DHW) or designee will review the medication dashboard weekly and narcotic count sheets weekly to ensure medications are given per physician order.
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 DHW or designee will conduct ongoing monitoring of the medication dashboard. All Certified Medication Aids (CMAs) will undergo mandatory retraining on 6/17/26 regarding medication management specifically focusing on administration and documentation.
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 DHW or designee will conduct daily audits of the medication dashboard for all residents for 1 week, then twice weekly for 3 weeks to ensure medication is being given per physician order and accuracy in documentation. Findings will be reported to the Executive Director weekly and review during the quarterly QA meetings to ensure ongoing compliance. The QA will include resident rights, medication administration and physician order compliance. Executive Director will keep audits and minutes from QA in POC binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/24/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Jessica Bieger** OAC 310:663-25-4(F)	**Date 6/12/2026**

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

Delivery via email to: Carley@milestoneretirement.com;
jessica.bieger@mansionatwaterfordslc.com

July 7, 2026

License Number: AL5591

Ms. Jessica Bieger, Administrator
The Mansion At Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

RE: Survey Event 6TRM12

Dear Ms. Bieger:

On **July 7, 2026,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **May 29, 2026,** have now been corrected effective **June 24, 2026.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5591	A. BUILDING: _____ B. WING _____	R-C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANSION AT WATERFORD	6110 NORTH PENN AVENUE OKLAHOMA CITY, OK 73112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 07/07/26. All deficiencies from the 05/29/26 survey were cleared.	{C 000}		

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