OKLAHOMA
State Department
of Health

Delivery via email to: rray@chapterstulsa.com

July 16, 2026

License Number: AL7238

Ms. Rachel Ray, Administrator
Chapters Living Of Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

Survey Event ID: YM9011

Dear Ms. Ray:

On **July 9, 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: 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: **Chapters Living of Tulsa**
Address: **7807 South Mingo Road**
City, State, Zip: **Tulsa, OK 74133**
Provider #: **AL7238**
Complaint #: **91988**
Investigation Date(s): **07/08/26 and 07/09/26**

ALLEGATION(S)
The facility failed to ensure residents were free from abuse.
The facility failed to ensure residents were not secluded.

An unannounced on-site investigation was initiated 07/08/2026 at 9:45 a.m.

A sample of five 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 various times throughout the survey. Residents were observed for outward signs of abuse and neglect. Resident and staff interactions were observed for signs of fear or apprehension on the part of the residents. Residents were observed for signs of oversedation and being secluded.

Resident records were reviewed including physician orders, progress notes, mediation administration and treatment records, intake records, and assessments. Grievance records were reviewed. Incident reports were reviewed. Medication storage records were reviewed. Staffing records were reviewed. Staff employment and training records were reviewed. Policy and procedures were reviewed.

Residents with appropriate cognitive abilities were interviewed regarding abuse and seclusion.

Resident representatives were interviewed regarding the allegations of the complaint.

Staff members were interviewed regarding eh allegations of the complaint.

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: 07/10/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Chapters Living of Tulsa**
Address: **7807 South Mingo Road**
City, State, Zip: **Tulsa, OK 74133**
Provider #: **AL7238**
Complaint #: **84881**
Investigation Date(s): **07/08/26 and 07/09/26**

ALLEGATION(S)
The center failed to ensure comfort care was provided according to the physicians' orders and/or the standard of care.
The center failed to ensure incontinent care and turning and repositioning was provided for dependent residents.

An unannounced on-site investigation was initiated 07/08/2026 at 9:45 a.m.

A sample of four 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 various times throughout the survey. Residents were observed for outward signs of pain and neglect. Staff were observed providing various types of care to the residents. Staff were observed for the number on duty and license or certification.

Resident Records were reviewed including physician orders, assessments, hospice records, treatment records, medication administration records, medication count sheets and storage records, hospital records. Incident reports were reviewed. Grievance records were reviewed. Policy and procedures were reviewed. Staff employment and training records were reviewed. Daily staffing records were reviewed.

Residents with adequate cognitive abilities were interviewed regarding the allegations of the complaint.

Resident representatives were interviewed regarding the allegations of the complaint.

Staff members were interviewed regarding the allegations of the complaint.

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: 07/10/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Chapters Living of Tulsa**
Address: **7807 South Mingo Road**
City, State, Zip: **Tulsa, OK 74133**
Provider #: **AL7238**
Complaint #: **87781**
Investigation Date(s): **07/08/26 and 07/09/26**

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

An unannounced on-site investigation was initiated 07/08/2026 at 9:45 a.m.

A sample of 4 residents, including identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance to the facility and at various times throughout the survey. Residents were observed or outward signs of neglect or abuse. Staff were observed providing care for the residents and for outward signs of intoxication.

Resident records were reviewed including physician orders, treatment records, hospital records, medication administration records and narcotic count sheets. Staff employment records were reviewed. Staff training records were reviewed. Grievance records were reviewed.

Resident representatives were interviewed regarding the allegation of the complaint.

Staff members were interviewed regarding the allegation of the complaint.

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: 07/10/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Chapters Living of Tulsa**
Address: **7807 South Mingo Road**
City, State, Zip: **Tulsa, OK 74133**
Provider #: **AL7238**
Complaint #: **88038**
Investigation Date(s): **07/08/26 and 07/09/26**

ALLEGATION(S)
The center failed to assess, monitor and intervene in a timely manner for a change in condition.

An unannounced on-site investigation was initiated 07/08/2026 at 9:45 a.m.

A sample of four 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 to the facility and at various times throughout the survey. Residents were observed for outward signs of abuse and neglect. Residents' behaviors were observed while interacting with staff for signs of fear or apprehension on the part of the residents. Staff were observed providing varus types of care for the residents.

Resident with appropriate cognitive abilities were interviewed regarding their treatment by the staff.

Resident representatives were interviewed regarding the allegation of the complaint.

Staff members were interviewed regarding the allegation of the complaint.

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: 07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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 (#OK00091988, OK00088038, OK00087781, and #OK00084881) conducted from 07/08/26 through 07/09/26 resulted in a finding of noncompliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Facility Census: 38 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nurse aided mg - milligrams ml - milliliters	C 000		
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident was not administered a medication that had not been prescribed for them for 1 (#1) of 4 sampled residents reviewed for medication administration. The administrator identified 38 residents who were administered medications. Findings: A policy titled "Medication Assistance /	C1921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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
C1921	Continued From page 1	C1921		

Administration," dated 09/2021, read in part, "Medications shall be administered only on a physician's order."

A "Physician Order Review" for Resident #1, dated 06/03/26, showed the resident had an order for alprazolam (an antianxiety medication with the brand name Xanax) 0.25 mg tablets, to be given orally, every six hours as needed. The document did not show an order for topical alprazolam (a form of the medication rubbed onto a person's skin).

A medication administration record for Resident #1, dated 07/01/26 through 07/31/26, did not show the resident had an order for topical alprazolam.

On 07/08/26 at 12:43 p.m., CNA #1 stated on 07/07/26, they observed CMA #3 rub an ointment onto the wrist of Resident #1.

On 07/09/26 at 10:07 a.m., the administrator stated they had just been made aware Resident #1 had been administered topical alprazolam on 07/07/26 instead of the tablet form of the medicine. The administrator stated they had instructed CMA #3 to administer Resident #1's alprazolam but did not know the resident did not have an order for the topical form. The administrator stated they did not recall instructing CMA #3 to administer topical alprazolam. The administrator stated Resident #1 should not have been administered the topical alprazolam since there was no physician order for it.

On 07/09/26 at 10:23 a.m., CMA #3 stated on 07/07/26, they had administered a medicated ointment that contained alprazolam onto the arm of Resident #1. CMA #3 stated Resident #1 did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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
C1921	Continued From page 2 not have the ointment ordered so they used another residents. CMA #3 stated they used the unprescribed alprazolam ointment after a failed attempt to give Resident #1 their prescribed tablet of alprazolam. CMA #3 stated the administrator had instructed them to get the ointment form of the medication. CMA #3 stated they knew they were not allowed to administer medication to residents without a physician's order.	C1921		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure documentation of medication administration was accurate for 2 (#1 and #6) of 4 sampled residents reviewed for medication administration.	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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
C1923	Continued From page 3 The administrator identified 38 residents who were administered medications. Findings: A policy titled "Medication Assistance /Administration," dated 09/2021, read in part, "An accurate written record of medications administered shall be maintained." A MAR for Resident #1, dated 07/01/26 through 07/31/26, did not show the resident had an order for topical alprazolam (an antiaxiety medication). The MAR did not show Resident #1 had been administered topical alprazolam 1 mg on 07/07/26. An undated "Individual Patient's Narcotic Record," showed one dose of Resident #6's topical alprazolam 25mg /ml was documented as administered to Resident #6 on 07/07/26. On 07/09/26 at 10:07 a.m., the administrator stated Resident #1's MAR and Resident #6's narcotic count sheet for topical alprazolam were not accurate. They stated the documents should have indicated Resident #1 received the topical alprazolam 25mg /ml and not Resident #6. On 07/09/26 at 10:23 a.m., CMA #3 stated they had administered a topical form of alprazolam prescribed for Resident #6 to Resident #1 on 07/07/26. CMA #3 stated they had not signed out the topical alprazolam on Resident #6's narcotic record on 07/07/26 although they had administered the medication. They stated CMA #2 had signed the alprazolam out and documented the medication as having been administered to Resident #6. CMA #3 stated Resident #6 did not receive the medication.	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	C 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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
C1923	Continued From page 4 On 07/09/26 at 11:47 a.m., CMA #2 stated they had signed out a dose of Resident #6's topical alprazolam 25mg /ml on 07/07/26 on the narcotic record. They stated they had not administered the medication but signed it out to help CMA #3. CMA #2 stated the narcotic record indicated Resident #6 had been administered the medication although it had been administered to Resident #1.	C1923		

OKLAHOMA
State Department
of Health

Delivery via email to: rray@chapterstulsa.com

August 5, 2026

License Number: AL7238

Ms. Rachel Ray, Administrator
Chapters Living Of Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

Survey Event ID: YM9011

Dear Ms. Ray:

On **July 9, 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 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 **September 11, 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
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/24/2013** **Facility Name:** Chapters Living of Tulsa **License Number:** AL 7238 **Survey Event ID:** YM9011 **Date Survey Completed: 7/9/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1921 SS=D	Based on: Based on record review and interview , the facility failed to ensure a resident was not administered a medication that had not been prescribed for them for # 1 of 4 sampled residents reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Based on record review and interview , the facility failed to ensure a resident was not administered a medication that had not been prescribed for them for # 1 of 4 sampled residents reviewed for medication administration.

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 Administrator , Nurse or designee will review narcotic count sheet along with reviewing the MARS for any Meds errors daily x7 days , then weekly x 4 weeks then monthly x 3 months. Inservice for medaides on Punch, initial give along with the 7 rights of medication administration completed on 7-9-2026 day survey concluded.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DON wll monitor and ensure that all residents are given the correct form of medication as the physician order states by auditing narcotic sheets and Mars to ensure counts are correct and match the mars
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?	ADMIN , DON or assigned designee, will inservice Medication Aides on giving the correct form of medication and the 7 rights of administration rights, DON Audit on Mars and Narcotic sheet. RN will check skilled check off list on monthly visits
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. ADMIN , DON or assigned designee, will inservice Medication Aides on giving the correct form of medication and the 7 rights of administration rights,there will be a medication skilled check off weekly x 7 then weekly x 4 then monthly x6 Will address and QA at next QA meeting. B. Will discuss at next QA meeting , will continue auditing, performing random cart audits along with randomly watching medication pass's to ensure that medaide is giving the correct form of medication to correct resident. C. The Administrator , Nurse or designee will review narcotic count sheet along with reviewing the MARS for any Meds

	errors daily x7 days , then weekly x 4 weeks then monthly x 3 months. Inservice for medaides on Punch, initial give along with the 7 rights of medication administration completed on 7-9-2026 day survey concluded.
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 Administrator signature required. OAC 310:663-25-4(F) Rachel Rayford	**Date** Enter a date of signature. 9/27/26.

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 7/24/2013
	Facility Name: Chapters Living of Tulsa
	License Number: AL 7238
	Survey Event ID: YM9011
	Date Survey Completed: 7/9/2026

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1923 SS=E	Based on: Based on record review and interview , the facility failed to ensure documentation ws accurate for #2 (#1 and #6) of 4 sampled residents reviewed for medication administration

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Based on record review and interview , the facility failed to ensure documentation was accurate for #2 (#1 and #6)of 4 sampled residents reviewed for medication administration

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 Administrator , Nurse or designee will review narcotic count sheet along with reviewing the MARS for any Meds errors daily x7 days , then weekly x 4 weeks then monthly x 3 months. Inservice for medaides on Punch, initial give along with the 7 rights of medication administration completed on 7-9-2026 day survey concluded.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DON wll monitor and ensure that all residents are given the correct form of medication as the physician order states by auditing narcotic sheets and Mars to ensure counts are correct and match the mars
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?	ADMIN , DON or assigned designee, will inservice Medication Aides on giving the correct form of medication and the 7 rights of administration rights, DON Audit on Mars and Narcotic sheet. RN will check skilled check off list on monthly visits
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. ADMIN , DON or assigned designee, will inservice Medication Aides on giving the correct form of medication and the 7 rights of administration rights,there will be a medication skilled check off weekly x 7 then weekly x 4 then monthly x6 Will address and QA at next QA meeting. B. Will discuss at next QA meeting , will continue auditing, performing random cart audits along with randomly watching medication pass's to ensure that medaide is giving the correct form of medication to correct resident. C. The Administrator , Nurse or designee will review narcotic count sheet along with reviewing the MARS for any Meds errors daily x7 days , then weekly x 4 weeks then monthly

	x 3 months. Inservice for medaides on Punch, initial give along with the 7 rights of medication administration completed on 7-9-2026 day survey concluded.
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 Administrator signature required. Rachel Reyes OAC 310:663-25-4(F)	**Date** Enter a date of signature. 7/27/26

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.