OKLAHOMA
State Department
of Health

Delivery via email to: ewhitecloud@oxfordseniorliving.com

September 24, 2026

License Number: AL7239

Elizabeth Whitecloud, Administrator
Oxford Glen At Owasso
11113 East 103rd Street North
Owasso, OK 74055

RE: Survey Event ID: 9MGU11

Dear Ms. Whitecloud:

On **August 28, 2026**, agents from our office concluded a State Licensure survey with complaints at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **August 28, 2026**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). 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 and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

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: **Oxford Glen at Owasso**
Address: **11113 E 103rd St N**
City, State, Zip: **Owasso, OK 74055**
Provider #: **AL7239**
Complaint #: **OK00085572**
Investigation Dates: **08/25/26 - 08/28/26**

ALLEGATIONS
The center failed to ensure interventions were implemented to prevent falls.
The center failed to assist resident with ADL care in a timely manner.
The center failed to ensure activities were provided to the residents.
The center failed to ensure staffing to meet the needs of the residents.
The center failed to ensure residents were not chemically or physically restrained.

An unannounced on-site investigation was initiated 08/25/2026 at 9:05 a.m.

A sample of nine clients, including any identified clients, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with clients, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Throughout the survey observations were conducted for accident hazards for falls, activities of daily living being provided timely, activities provided to residents, staffing levels, and signs and symptoms of chemical restraints. Interviews were conducted with staff and residents regarding falls, activities of daily living, activities for residents, staffing, and chemical restraints. Record reviews included resident records, state reports with investigations, grievances, resident council meeting minutes, and policies.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Oxford Glen at Owasso**
Address: **11113 E 103rd St N**
City, State, Zip: **Owasso, OK 74055**
Provider #: **AL7239**
Complaint #: **OK00091117**
Investigation Date(s): **08/25/26**

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

An unannounced on-site investigation was initiated 08/25/2026 at 9:05 a.m.

A sample of 9 clients, including any identified clients, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with clients, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Oxford Glen at Owasso**
Address: **11113 E 103rd St N**
City, State, Zip: **Owasso, OK 74055**
Provider #: **AL7239**
Complaint #: **OK00086995**
Investigation Dates: **08/25/26 to 08/28/26**

ALLEGATIONS
The facility failed to ensure care was provided for dependent residents.
The facility failed to ensure staff followed their policy and procedure for safe medication administration.

An unannounced on-site investigation was initiated 08/25/2026 at 9:05 a.m.

A sample of nine clients, including any identified clients, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with clients, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Throughout the survey observations were conducted for assistance with activities of daily living for dependent residents and safe medication administration. Interviews were conducted with staff and residents for assistance with activities of daily living being provided and the administration of medications. Record reviews consisted of resident records, grievance logs, resident council meeting minutes, policies, and facility documentation of medication administration.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: OXFORD GLEN AT OWASSO
Address: 11113 EAST 103RD STREET NORTH
City, State, Zip: OWASSO, OK, 74055, TULSA
Provider #: AL7239
Complaint #: OK00090966
Investigation Date(s): 08/25/26-08/28/26

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

An unannounced on-site investigation was initiated 08/25/2026 at 9:05 a.m.

A sample of 9 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:

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Oxford Glen at Owasso**
Address: **11113 E 103rd St N**
City, State, Zip: **Owasso, OK 74055**
Provider #: **AL7239**
Complaint #: **OK00091117**
Investigation Date(s): **08/25/26**

ALLEGATION(S)
The facility failed to ensure the resident's money was reimbursed according to the contract.

An unannounced on-site investigation was initiated 08/25/2026 at 9:05 a.m.

A sample of 9 clients, including any identified clients, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with clients, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: OXFORD GLEN AT OWASSO
Address: 11113 EAST 103RD STREET NORTH
City, State, Zip: OWASSO, OK 74055
Provider #: AL7239
Complaint #: OK00091603
Investigation Date(s): 08/25/26-08/28/26

ALLEGATION(S)
The facility failed to ensure adequate supervision to prevent an elopement.

An unannounced on-site investigation was initiated 08/25/2026 at 9:05 a.m.

A sample of 9 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:

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2026

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: OXFORD GLEN AT OWASSO
Address: 11113 EAST 103RD STREET NORTH
City, State, Zip: OWASSO, OK, 74055, TULSA
Provider #: AL7239
Complaint #: OK00092073
Investigation Date(s): 08/25/26-08/28/26

ALLEGATION(S)
The facility failed to assess, monitor and intervene for a change in condition.
The facility failed to ensure medications were available for administration.
The facility failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 08/25/2026 at 9:05 a.m.

A sample of 9 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:

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7239	A. BUILDING: _____ B. WING _____	C 08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GLEN AT OWASSO	11113 EAST 103RD STREET NORTH OWASSO, OK 74055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey with complaints (#OK00085572, OK00086745, OK00086995, OK00090966, OK00091117, OK00091603, and #OK00092073) was conducted from 08/25/26 through 08/28/26. Deficiencies were cited. Facility Census: 47 Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide ED - executive director EMR - electronic medical record mg - milligrams POA - power of attorney RDO - regional director of operations	C 000		
C 521 SS=E	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the center failed to complete an admission assessment within 30 days before or at the time of admission for 4 (#7, 8, 3, and #6) of 9 sampled residents reviewed for admission assessments. The administrator identified 47 residents resided in the center. Findings: A facility policy titled "Assessment and Service	C 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7239	A. BUILDING: _____ B. WING _____	C 08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GLEN AT OWASSO	11113 EAST 103RD STREET NORTH OWASSO, OK 74055

(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 521	Continued From page 1 Plan," dated 10/21/23, read in part, "(a) The assisted living center shall complete the admission assessment within (30) days before, or at the time of admission. 1. An annual assessment for Resident #7, dated 06/12/25, showed the resident was admitted on 09/23/24 with diagnoses which included Alzheimer's disease. There was no documentation in the health record to show an admission assessment had been completed within 30 days before or at the time of admission. 2. A 14-day assessment for Resident #8, dated 03/20/26, showed the resident was admitted on 02/18/26 with diagnoses which included unspecified dementia. There was no documentation in the health record to show an admission assessment had been completed within 30 days before or at the time of admission. 3. A 14-day assessment for Resident #3, dated 06/01/26, showed the resident was admitted on 04/25/26 with diagnoses which included generalized anxiety disorder. There was no documentation in the health record to show an admission assessment had been completed within 30 days before or at the time of admission. 4. A 14-day assessment for Resident #6, dated 07/15/26, showed the resident was admitted on 07/15/26 with diagnoses which included major depressive disorder and Parkinson's disease.	C 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7239	A. BUILDING: _____ B. WING _____	C 08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GLEN AT OWASSO	11113 EAST 103RD STREET NORTH OWASSO, OK 74055

(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 521	Continued From page 2 There was no documentation in the health record to show an admission assessment had been completed within 30 days before or at the time of admission. On 08/28/26 at 10:41 a.m., the administrator stated admission assessments should have been completed when the residents first arrived. On 08/28/26 at 10:46 a.m., the RDO stated admission assessments should have been completed 30 days before or at the time of admission.	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed within 14 days after admission for 5 (#7, 8, 3, 5, and #6) of 9 sampled residents reviewed for comprehensive assessments. The administrator identified 47 residents resided in the center. Findings:	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7239	A. BUILDING: _____ B. WING _____	C 08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GLEN AT OWASSO	11113 EAST 103RD STREET NORTH OWASSO, OK 74055

(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 522	Continued From page 3 A facility policy titled "Assessment and Service Plan," dated 10/21/23, read in part, "(b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen days after admission of the resident; (2) once every (12) months thereafter; and (3) promptly after a significant change in the residents condition." 1. An annual assessment for Resident #7, dated 06/12/25, showed the resident was admitted on 09/23/2024 with diagnoses which included Alzheimer's disease. There was no documentation in the health record to show an comprehensive assessment had been completed within 14 days after admission on 09/23/2024. 2. A 14-day assessment for Resident #8, dated 03/20/26, showed the resident was admitted on 02/18/2026 with diagnoses which included unspecified dementia. There was no documentation in the health record to show an comprehensive assessment had been completed within 14 days after admission on 02/18/26. 3. A 14-day assessment for Resident #3, dated 06/01/26, showed the resident was admitted on 04/25/26 with diagnoses which included generalized anxiety disorder. There was no documentation in the health record to show an comprehensive assessment had been completed within 14 days after admission on 04/25/26.	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7239	A. BUILDING: _____ B. WING _____	C 08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GLEN AT OWASSO	11113 EAST 103RD STREET NORTH OWASSO, OK 74055

(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 522	Continued From page 4 4. A 14-day assessment for Resident #5, dated 07/07/26, showed the resident was admitted on 06/04/26 with diagnoses which included anxiety disorder and major depressive disorder. There was no documentation in the health record to show an comprehensive assessment had been completed within 14 days after admission on 06/04/26. 5. A 14-day assessment for Resident #6, dated 07/15/26, showed the resident was admitted on 07/15/26 with diagnoses which included major depressive disorder and Parkinson's disease. There was no documentation in the health record to show an comprehensive assessment had been completed within 14 days after admission on 07/15/26. On 08/28/26 at 10:41 a.m., the administrator stated admission assessments should have been completed within 14 days of the residents admission. On 08/28/26 at 10:46 a.m., the RDO stated comprehensive assessments should have been completed within 14 days after admission.	C 522		
C1304 SS=D	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by:	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7239	A. BUILDING: _____ B. WING _____	C 08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1304	Continued From page 5 Based on record review and interview, the center failed to provide services specified in the resident's service contract for 1 (#4) of 9 sampled residents whose service contracts were reviewed. The administrator identified 47 residents resided in the center. Findings: A "Residency Agreement" for Resident #4, signed and dated 12/30/21, read in part, "any refund after all final charges have been assessed shall be paid within 60 days of move out." A document titled "Refund Request," dated 12/22/25, showed the Resident #4's POA requested a refund in the amount of $1849.53. The document showed Resident #4's POA, the ED, and the RDO had signed and dated the document. An email from the RDO, dated 12/22/25 at 3:47 p.m., showed the "Refund Request" was emailed to the accounting representative requesting a refund. A document titled "Check Register," dated 05/13/26, showed a check was made payable to Resident #4's POA in the amount of $1849.53. A document titled "Check Register," dated 05/31/26, showed the check made payable to Resident #4's POA in the amount of $1849.53 had cleared the bank. On 08/25/26 at 2:25 p.m., Resident #4's POA stated the resident had passed away on 12/22/25. The POA stated they had signed the "Refund Request" on 12/22/25.	C1304		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7239	A. BUILDING: _____ B. WING _____	C 08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GLEN AT OWASSO	11113 EAST 103RD STREET NORTH OWASSO, OK 74055

(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
C1304	Continued From page 6 On 08/27/26 at 10:50 a.m., the ED stated the POA for Resident #4 should have recevied the refund within 60 days per the residency agreement. They stated the POA had not received the refund during that time period.	C1304		
C1922 SS=D	310:663-19-2(a)(2) MEDICATION ADMINISTRATION (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour prior to administration. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure safe medication administration for 1 (#9) of 9 sampled residents observed for medication administration. The administrator identified 47 residents were administered medications by the center. On 08/26/26 at 9:00 a.m., CMA #2 was observed preparing medications for Resident #9. CMA #2 logged into the EMR, selected lisinopril 10 mg, and checked off the entry on the EMR as administered but did not place the tablet in the medication cup. CMA #2 was observed to place atorvastatin calcium 10 mg in the medication cup to be administered to Resident #9. CMA #2 was asked to verify the contents of the medication placed in the medication cup against the actual physician orders on the EMR. CMA #2 confirmed	C1922		

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	AL7239	A. BUILDING: _____ B. WING _____	C 08/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
C1922	Continued From page 7 the medication placed in the medication cup did not match the medication checked off in the EMR. CMA #2 was observed to discard the incorrect medication per facility policy. A facility policy titled "Medication administration record," revised 10/25/23, read in part, "Practice the 'five rights' of medication administration: a. Right resident, b. Right drug, c. Right time, d. Right dose, e. Right route." A physician's order for Resident #9, dated 03/05/25, showed atorvastatin calcium 10 mg tablet (a medication to treat hyperlipidemia) by mouth at bedtime for the treatment of hyperlipidemia. A physician's order for Resident #9, dated 04/21/26, showed lisinopril 10 mg tablet (a medication to treat hypertension) by mouth daily for the treatment of hypertension. On 08/28/26 at 10:46 a.m., the RDO stated the "5 rights" of medication administration should have been followed. On 08/28/26 at 12:16 p.m., CMA #2 stated the "5 rights" of medication administration should have been followed.	C1922		

OKLAHOMA
State Department of Health

Delivery via email to: ewhitecloud@oxfordseniorliving.com

October 8, 2026

License Number: AL7239

Elizabeth Whitecloud, Administrator
Oxford Glen At Owasso
11113 East 103rd Street North
Owasso, OK 74055

RE: Survey Event 9MGU11

Dear Ms. Whitecloud:

On **August 28, 2026**, a Licensure inspection with complaints 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 **October 8, 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,

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: 10/6/2026** **Facility Name:** Oxford Glen at Owasso **License Number:** AL 7239-7239 **Survey Event ID:** 9MGU11 **Date Survey Completed: 8/28/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 521	Based on: record review and interview, the center failed to complete an admission assessment within 30 days before or at the time of admission for 4 (#7, 8, 3, and #6) of 9 sampled residents reviewed for admission assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance.

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?	Executive Director or designee will audit assessments to ensure admission assessment is completed on admission day.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have potential to be affected.
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?	Executive Director or designee will audit on admission to ensure completion of assessment. Audit to be completed for 30 days and monthly thereafter.
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.	New admission checklist to be completed to ensure assessments completed in a timely manner. New admission checklist to be completed to ensure assessments completed in a timely manner. Specific discussion during Quality Assurance meeting minutes. Executive Director or designee will audit on admission to ensure completion of assessment. Audit to be completed for 30 days and monthly thereafter. Continue to review in Quarterly Assurance meeting until substantial compliance is met and no evidence of errors recurring.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/6/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Elizabeth WhiteCloud, RCAL** OAC 310:663-25-4(F)	**Date 10/6/2026**

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: 10/6/2026** **Facility Name:** Oxford Glen at Owasso **License Number:** AL 7239-7239 **Survey Event ID:** 9MGU11 **Date Survey Completed: 8/28/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522	Based on: record review and interview, the center failed to ensure comprehensive assessments were completed within 14 days after admission for 5 (#7, 8, 3, 5, and #6) of 9 sampled residents reviewed for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance.

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?	Executive Director or designee will audit for 14th day assessment completion for 30 days and monthly thereafter. Recent admissions audited and 14 day assessments now completed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
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?	Executive Director or designee will audit for 14th day assessment to ensure completion of assessment. Audit to be completed for 30 days and then monthly thereafter.
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.	Executive Director or designee will audit for 14th day assessment to ensure completion of assessment. Audit to be completed for 30 days and then monthly thereafter. Executive Director or designee will audit for 14th day assessment to ensure completion of assessment. Audit to be completed for 30 days and then monthly thereafter. Specific discussion in Quality Assurance Meeting minutes. Executive Director or designee will audit for 14th day assessment to ensure completion of assessment. Audit to be completed for 30 days and monthly thereafter. Continue to review in Quarterly Assessment meetings until substantial compliance is met and no evidence of errors recurring.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/6/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Elizabeth WhiteCloud, RCAL**	**Date 10/6/2026**

OAC 310:663-25-4(F)

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.			
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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/7/2026** **Facility Name:** Oxford Glen at Owasso **License Number:** AL 7239-7239 **Survey Event ID:** 9MGU11 **Date Survey Completed: 8/28/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1304	Based on: record review and interview, the center failed to provide services specified in the resident's service contract for 1 (#4) of 9 sampled residents whose service contracts were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged defiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance.

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?	Resident #4 refund was paid 5.13.2026.
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 Executive Director/designee will audit all resident accounts with a discharge in the previous 150 days to identify any refund that was not requested or processed. Any identified account will be reconciled and a refund request to be submitted to accounting for processing.
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?	Upon discharge, the Business Office Manager/designee will reconcile the resident ledger and determine whether a refund is due. If a refund is due, the Executive Director/designee will review and approve the reconciliation and submit a refund request to their RDO within 7 calendar days of discharge. The community will maintain a refund tracking log showing the resident discharge date, amount due, and request date submitted to RDO. RDO will verify, approve, and submit to accounting for processing.
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.	Regional Director Operations will review AR Aging bi-monthly ensuring any discharged resident is not showing with a credit balance. If there are, a reconciliation and refund request will be completed and submitted to accounting. The AR Aging, resident account, will not zero out until accounting processes the refund. Refunds will be reviewed in quarterly quality assurance meetings to ensure all refunds have been submitted and processed, which removes the balances off the AR Aging.

	Refunds will be reviewed in quarterly quality assurance meetings to ensure all refunds have been submitted and processed, which removes the balances off the AR Aging. Refunds and refund tracking record will be in a binder and stored in the Executive Director office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/8/2026
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Elizabeth WhiteCloud, RCAL** OAC 310:663-25-4(F)	**Date 10/7/2026**

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.

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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: 10/6/2026** **Facility Name:** Oxford Glen at Owasso **License Number:** AL 7239-7239 **Survey Event ID:** 9MGU11 **Date Survey Completed: 8/28/2026**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1922	Based on: observation, record review, and interview, the center failed to ensure safe medication administration for 1 (#9) of 9 sampled residents observed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance.

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?	Executive Director observed medication pass and completed inservice on the rights of medication administration on 08/28/2026.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
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?	Inservice completed on 08/28/2026 for the rights of medication administration.
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.	Executive Director or designee to observe medication pass weekly for 30 days to ensure the rights of medication administration are being followed. Inservice sheet to be signed by Certified Medication Aides upon completion of observation. Executive Director or designee to observe medication pass weekly for 30 days to ensure the rights of medication administration are being followed. Inservice sheet to be signed by Certified Medication Aides upon completion of observation. Specific discussion to be documented under nursing section of Quality Assusrance Meeting minutes regarding the rights of medication administration. Executive Director or designee to observe medication pass weekly for 30 days to ensure the rights of medication administration are being followed. Inservice sheet to be signed by Certified Medication Aides upon completion of observation.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed? OSDH Response: Element accepted Yes ☐ No ☐	10/2/2026

Administrator's Signature **Elizabeth WhiteCloud, RCAL** OAC 310:663-25-4(F)	**Date 10/6/2026**

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