OKLAHOMA
State Department
of Health

Delivery via email to: jessica.bolen@legendseniorliving.com

August 13, 2026

License Number: AL7267

Ms. Jessica Bolen, Administrator
The Stonehaven Assisted Living And Memory Care
10802 East 81st Street
Tulsa, OK 74133

RE: Survey Event ID: 33NC11

Dear Ms. Bolen:

On **July 30, 2026**, agents from our office concluded a State Licensure survey 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 **July 30, 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
IDRCoordinator@health.ok.gov
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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7267	A. BUILDING: _____ B. WING _____	07/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STONEHAVEN ASSISTED LIVING AND ME	10802 EAST 81ST STREET 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 A relicensure survey was conducted from 07/28/26 through 07/30/26. Deficiencies were cited. Facility Census: 113 Listed below are abbreviations that will be used throughout this document. ACMA - advanced certified medication aide	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure expired foods in the kitchen were disposed of for 1 of 3 kitchen observations. The administrator identified 113 residents received nutrition from the kitchen. Findings: On 07/29/26 at 9:41 a.m., the following items were observed expired in the dry storage area of the kitchen: a. a 12-ounce package of wonton wrappers had a use by date of 12/09/25, b. a 12-ounce package of wonton wrappers had a use by date of 07/19/26, c. three 46-fluid ounces of thickened tea had a	C 391		

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C 393 SS=E	310:663-3-8(c) FOOD STORAGE, PREPARTION AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours. This Rule is not met as evidenced by: Based on observation and interview, the center failed to ensure cooked food items were disposed of within 24 hours for 1 of 2 refrigerators sampled for cooked food items stored.	C 393		

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C 711 SS=F	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an annual fire inspection was completed. The administrator identified 113 residents resided in the center. Findings: A document titled "[Name withheld] Fire Department, Inspection Report," dated 09/12/24, showed the fire department conducted a fire inspection on 09/12/24. There was no documentation a fire inspection had been	C 711		

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C 711	Continued From page 3 completed since 2024. On 07/30/26 at 4:00 p.m., the administrator stated the center did not have a policy regarding annual fire inspections to be completed. The administrator stated the fire marshal inspection was out of compliance.	C 711		
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 (#13) of 10 sampled residents observed for medication administration. The administrator stated 103 residents were administered medications from the center. Findings: On 07/28/26 at 12:09 p.m., CMA #3 was observed administering medications to Resident #13. CMA #3 handed Resident#13 a medication cup containing the resident's medications and left the room. CMA #3 did not observe Resident #13 swallowing the medications administered.	C1922		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jessica Bolen Residence Director 8/26/26

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			refrigerators and dispose of per regulation and facility policy. 5. Chef/designee will inspect refrigerators weekly to ensure leftover foods are properly labeled or disposed of.	

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	A document titled "Resident with Self Administer Medications," dated 07/28/26, did not show Resident #13 was assessed to self-administer medications. On 07/28/26 at 12:15 p.m., CMA #3 stated they should have observed Resident #13 swallow the medications.		-Remain with the resident during administration; -Observe the resident swallow oral medications; and -Properly document medication administration 5. Medication Administration audits will be conducted routinely for a minimum of 4 weeks then periodically thereafter to ensure sustained compliance. 6. Any staff member found not following medication administration requirements will receive immediate corrective education and, when appropriate, additional disciplinary action consistent with facility policy. 7. Residents were educated regarding the medication administration requirements and the reason staff must remain present during medication administration. Residents were asked to cooperate with staff so medications can be administered safely and in compliance with stated regulations. 8. The community will reinforce that these requirements are intended to protect residents, promote medication safety, and ensure compliance with state regulations. Monitoring: The Administrator/designee will review medication administration audit results and address any identified concerns immediately. Audit findings will be reviewed through the facility's quarterly assurance process to ensure continued compliance.	

OKLAHOMA
State Department
of Health

Delivery via email to: jessica.bolen@legendseniorliving.com

August 28, 2026

License Number: AL7267

Ms. Jessica Bolen, Administrator
The Stonehaven Assisted Living And Memory Care
10802 East 81st Street
Tulsa, OK 74133

RE: Survey Event 33NC11

Dear Ms. Bolen:

On **July 30, 2026**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 13, 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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure