OKLAHOMA
State Department
of Health

Delivery via email to: Bryan.Smith@TheCommonsOK.com; susan.easterling@bridgesok.com; Ellen.Kremeier@bridgesok.com

November 26, 2025

License Number: NH2407AL

Mr. Bryan Smith, Administrator
The Commons
301 South Oakwood Road
Enid, OK 73706

RE: Survey Event ID: 3MFX11

Dear Mr. Smith:

On **November 20, 2025**, 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 **November 20, 2025**.

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: 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
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
	NH2407AL	A. BUILDING: _____ B. WING _____	C 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COMMONS	301 SOUTH OAKWOOD ROAD ENID, OK 73706

(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 complaint (#OK00084910) was conducted from 11/18/25 through 11/20/25. Deficiencies were cited as a result of the survey. Facility Census:23 Listed below are abbreviations that will be used throughout this document. APAP-acetaminophen MAR - medication administration record mg - milligrams	C 000		
C 522 SS=D	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 annual resident assessments were completed for 2 (#4 and #6) of 8 sampled residents reviewed for comprehensive assessment completion. The administrator identified 23 residents resided	C 522		

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C 522	Continued From page 1 in the center. Findings: 1. Resident #4's preadmission 14 day assessment, dated 08/01/24, showed Resident #4 had diagnoses of sick sinus syndrome and coronary artery disease. There was no documentation an annual assessment had been completed for 08/2025. 2. Resident#6 had a 14 day assessment, dated 09/26/24, showed Resident #6 had diagnoses of chronic obstructive pulmonary disease and dementia. There was no documentation an annual assessment had been completed for 09/2025. On 11/20/25 at 3:46 p.m., the care coordinator stated the resident assessments were to be completed on pre admission, 14 day, and annually. They stated the annual was to be done every year. On 11/20/25 at 3:48 p.m., the care coordinator stated there should have been an annual assessment completed for Resident #4 by 08/01/25. On 11/20/25 at 3:56 p.m., the care coordinator stated they had an assessment to do on Resident #6 now. They stated it was due in September 2025. The care coordinator stated the annual assessment had not been completed timely.	C 522		
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION	C1921		

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C1921	Continued From page 3	C1921		

following dates/times:
a. 06/09/25 at 2:00 p.m., held with no reason documented,
b. 06/10/25 at 2:00 p.m., held with no reason documented,
c. 06/11/25 at 8:00 a.m., held for behaviors, and
d. 06/11/25 at 2:00 p.m., held with no reason documented.

The June 2025 MAR showed the administration of Hydrocodone/APAP was on 06/21/25.

A "24 hour report sheet on watch," dated 06/11/25, showed Resident #1 was on watch for fall. The report showed in the comments that the resident was "still a lil [sic] off held." The report showed reports of difficulty/pain. The report showed the concern was the resident was being pushed on a walker to the bathroom.

On 11/19/25 at 9:26 a.m., Resident #1 stated they had no concerns with their pain medication.

On 11/20/25 at 3:42 p.m., the care coordinator stated the diagnosis for Lyrica was pain. They stated the 24 hour report showed someone reported difficulty with pain, but did not say anything else. They stated the only reasons to hold pain medication was if the physician put in an order to hold it or the patient refused it. The care coordinator stated the circles around the initials on the medication administration form meant not given. They stated there was no reason given for holding the medication on 06/09/25 at 2:00 p.m., or on 06/10/25 at 2:00 p.m. They stated on 06/11/25 at 8:00 a.m., it was held for behaviors, and on 06/11/25 at 2:00 p.m., there was no reason given for holding the medication.

On 11/20/25 at 3:45 p.m., the care coordinator

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C1921	Continued From page 4 stated the Lyrica should not have been held with a diagnosis of pain. They stated the record did not show the resident received any other form of pain medication when the Lyrica was not given.	C1921		

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of Health

INVESTIGATIVE REPORT

Facility: **The Commons**
Address: **301 South Oakwood Road**
City, State, Zip: **Enid, OK, 73706**
Provider #: **NH2407AL**
Complaint #: **OK00084910**
Investigation Date(s): **11/18/25 through 11/20/25**

ALLEGATION(S)
The center failed to ensure the physician's orders were followed for medications and treatments
The center failed to ensure medications were stored in a safe location.

An unannounced on-site investigation was initiated 11/18/2025 at 2:25 p.m.

A sample of 8 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 other various times throughout the survey. Resident halls, rooms and facility medication carts and medication room as well as dining rooms were observed for medication storage. Staff were observed administering medication and assisting residents with their needs. Medication administration was observed.

Resident records were reviewed including assessments, care plans, physician orders, notes, medication and treatment administration records. Facility policy and procedures were reviewed.

Residents were interviewed regarding their medication and medication storage in their rooms.

Staff were interviewed regarding the process of medication administration and storage.

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

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Delivery via email to: Bryan.Smith@TheCommonsOK.com; susan.easterling@bridgesok.com; Ellen.Kremeier@bridgesok.com

December 16, 2025

License Number: NH2407AL

Mr. Bryan Smith, Administrator
The Commons
301 South Oakwood Road
Enid, OK 73706

RE: Survey Event 3MFX12

Dear Mr. Smith

On **December 12, 2025,** a revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 20, 2025,** have now been corrected effective **December 9, 2025.**

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Delivery via email to: Bryan.Smith@TheCommonsOK.com; susan.easterling@bridgesok.com; Ellen.Kremeier@bridgesok.com

December 8, 2025

License Number: NH2407AL

Mr. Bryan Smith, Administrator
The Commons
301 South Oakwood Road
Enid, OK 73706

RE: Survey Event 3MFX11

Dear Mr. Smith:

On **November 20, 2025**, 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 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 **December 9, 2025**.

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

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C 522 SS=D	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 annual resident assessments were completed for 2 (#4 and #6) of 8 sampled residents reviewed for comprehensive assessment completion. The administrator identified 23 residents resided	C 522	How will the corrective action be accomplished for the residents cited? The annual assessments for the identified residents have been completed. How will the facility identify other residents having the potential to be affected by this problem? There were 23 residents identified residing in the facility. The licensed nurses were in-serviced regarding completion of annual assessments	

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C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION	C1921	How will the corrective action be accomplished for the residents cited?	

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C1921	Continued From page 2 (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 center failed to ensure medications were administered per physician orders for 1 (#1) of 8 sampled residents reviewed for receiving medications as prescribed. The administrator identified 23 residents resided in the center. Findings: A policy titled" Preparation for medication administration," dated 09/01/12, read in part, "Medications are administered as prescribed in accordance with good nursing principles and practices." A physician's order, dated 04/07/24 showed Hydrocodone/APAP pain medication) 5-325 mg one tablet every six hours as needed for pain. A physician's order, dated 06/05/25, showed Lyrica (neuropathic pain medication) 25 mg one pill by mouth three times a day. Resident #1's MARs from 06/2025 through 11/2025 were reviewed. The 06/2025 medication administration record showed a diagnosis of pain for the Lyrica ordered 06/05/25. There were circles around the initials for administration on the	C1921	All medication records for the affected resident(s) have been reviewed to ensure no other medications were held without proper documentation of the reason for holding. The nurse/medication staff responsible for the missed documentation have been re-educated on the requirement to document a specific reason whenever a medication is held, including notification of the licensed nurse or provider when appropriate. What measures will be put into place or what systematic changes will be made to ensure this will not happen again? Effective immediately, all medication staff will receive retraining on the facility' s Medication Administration Policy, including: requirements for documenting the reason a med is held and when to notify a nurse or provider. The Director of Nursing or designee will conduct daily MAR audits for 5 days to verify that all held medications contain proper documentation, then weekly for 8 weeks. Once compliance is maintained the Director of Nursing or designee will conduct monthly audits through 2 QA meetings to ensure continued adherence. How will the facility Quality Assurance Committee monitor the corrective action?	

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THE COMMONS	301 SOUTH OAKWOOD ROAD ENID, OK 73706

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 12/12/25. The facility was in substantial compliance.	{C 000}		

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

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2407AL	A. BUILDING: _____ B. WING _____	R-C 12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COMMONS	301 SOUTH OAKWOOD ROAD ENID, OK 73706

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

OKLAHOMA
State Department
of Health

Delivery via email to: Bryan.Smith@TheCommonsOK.com; susan.easterling@bridgesok.com; Ellen.Kremeier@bridgesok.com

December 16, 2025

License Number: NH2407AL

Mr. Bryan Smith, Administrator
The Commons
301 South Oakwood Road
Enid, OK 73706

RE: Survey Event 3MFX12

Dear Mr. Smith

On **December 12, 2025,** a revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 20, 2025,** have now been corrected effective **December 9, 2025.**

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure