Oklahoma State Department of Health
Creating a State of Health

March 17, 2020

License Number: AL0903

Ms. Cristy Davis, Administrator
Arbor House Assisted Living Of Mustang
850 North Clearsprings Road
Mustang, OK 73064

RE: Survey Event ID: VO3V11

Dear Ms. Davis:

On **March 6, 2020**, 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 March 6, 2020.

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 (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 Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. 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;

Board of Health

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(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) 271-6868 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 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). 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 or conducted in a face-to-face 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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.

Sincerely,

Kaie Stagner

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0903	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING OF MUSTAI	850 NORTH CLEARSPRINGS ROAD MUSTANG, OK 73064

(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 re-licensure survey was conducted on 03/03/20 and 03/06/20. Current census was 65. The following deficiency was cited.	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure medications were dated after opening to ensure manufacturer instructions were followed	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0903	A. BUILDING _____ B WING _____	03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1505	Continued From page 1 for administration of: a) Eye drops for 3 (#11, 12, and #13) of 3 sampled residents who received employee administered eye drops and; b) Insulin for 1 (#14) of 1 sampled resident who received physician ordered insulin. These failed practices had the potential for more than minimal harm at a pattern. Findings: EYE DROPS On 03/03/20 at 3:26 p.m., resident # 11 was administered artificial tears (used to treat dry eyes) by certified medication aide (CMA)/employee #4, who stated the bottle was not dated when it was opened. Resident #12 was administered Refresh Optive eye drops (used to treat dry eyes) by CMA/employee #4, who stated the Refresh eye drops were supposed to be dated when they were opened, but were not. A manufacturer's instruction sheet documented to discard refresh eye drops 90 days after opening. At 3:56 p.m., medication administration technician (MAT)/employee #3 administered resident #13 Rhopressa (an eye drop used to treat elevated eye pressure) one drop in the right eye. The bottle was not dated when it was opened. MAT/employee #3 stated it was opened the previous week sometime. The box documented to discard the medication 6 weeks after opening. The employees did not date the eye drops when they were opened to ensure they were discarded	C1505		

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	AL0903	A. BUILDING: _____ B. WING _____	03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1505	Continued From page 2 in the recommended time frame. On 03/06/20 at 4:20 p.m., CMA/employee # 1 stated the Rhopressa was good for 6 weeks after it was opened. INSULIN On 03/06/20 at 4:00 p.m., resident #14 had one bottle of Lantus (long acting insulin use to treat high blood sugar) that was not dated when it was opened. CMA/employee #1 stated the box top which contained the date was torn off. The top was not with the insulin to determine when the insulin had been opened. A manufacturer's instruction sheet for Lantus documented to discard 28 days after opening. At 4:24 p.m., licensed practical nurse (LPN) #1 stated the eye drops and insulin should have been labeled with their open dates.	C1505		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL0903	ARBOR HOUSE ASSISTED LIVING OF MUSTANG

Type of Survey (select all that apply)

2				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 36191	03/03/2020	03/06/2020	0.75	0.00	16.25	0.00	4.75	4.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

MAR 18 2020

OKLAHOMA
State Department
of Health

September 3, 2020

License Number: AL0903

Ms. Cristy Davis, Administrator
Arbor House Assisted Living of Mustang
850 North Clearsprings Road
Mustang, OK 73064

RE: Survey Event VO3V11

Dear Ms. Davis:

On **March 6, 2020**, 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 **March 27, 2020**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State Department of Health, ou=Long Term Care, email=katies@health.ok.gov, c=US
Date: 2020.09.03 11:48:51 -05'00'

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/18/2020** **Facility Name:** Arbor House Assisted Living of Mustang **License Number:** AL0903 **Survey Event ID:** V03V011 **Date Survey Completed: 3/6/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505 SS=E	Based on: Based on observation, interview, and recordreview, it was determined the center failed to ensure medications were dated after opening to ensure manufacturer instructions were followed for administration of:a) Eye drops for 3 (#11, 12, and #13) of 3 sampled residents who received employee administered eye drops; and b) Insulin for 1 (#14) of 1 sampled resident who received physician ordered insulin. These failed practices had the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of the POC is not an admission of guilt, but rather we are fulfilling the requirements by the State Health Department.

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?	Dates were added to the three eye drop boxes and the insulin box.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	During the weekly medication cart audits, the medication aide shall ensure all eye drops and insulin boxes are dated.
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?	During the weekly medication cart audits, the medication aide shall ensure all eye drops and insulin boxes are dated. These audits are reviewed during the monthly CQI meetings and any discrepancies shall be noted. The Executive Director shall add a check off for eye drops and insulin box on the CQI agenda. An in-service shall also occur with the staff regarding dating of bottles/boxes opened. The Home Health and Hospice companies shall also be alerted regarding this requirement.
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.	During the weekly medication cart audits, the medication aide shall ensure all eye drops and insulin boxes are dated. If all eye drops and insulin boxes are labeled, this system will be effective. These audits are reviewed during the monthly CQI meetings and any discrepancies shall be noted. The Executive Director shall add a check off for eye drops and insulin box on the CQI agenda. An in-service shall also occur with the staff regarding dating of bottles/boxes opened. The Home Health and Hospice companies shall also be alerted regarding this requirement.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		3/27/2020	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administration signature required.	**Date** Enter a date of signature.	2/18/2020
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department
of Health

Delivery via email to: Cristy@arborhouseliving.com

April 23, 2021

License Number: AL0903

Cristy Davis, Administrator
Arbor House Assisted Living Of Mustang
850 North Clearsprings Road
Mustang, OK 73064

RE: Survey Event VO3V12

Dear Ms. Davis:

On **November 6, 2020,** an offsite/paper revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 6, 2020,** have now been corrected effective **May 6, 2020.**

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

Sincerely,

Users, Lisa D Calvin
Digitally signed by Users, Lisa D Calvin
Date: 2021.04.23 15:27:26 -05'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

LC/

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
	AL0903	A. BUILDING: _____ B. WING _____	R 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING OF MUSTANG	850 NORTH CLEARSPRINGS ROAD MUSTANG, OK 73064

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{C 000}	INITIAL COMMENTS An Offsite/Paper Revisit was completed on 11/06/20. Credible evidence of correction was submitted for all deficiencies.	{C 000}		

Oklahoma State Department of Health

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