OKLAHOMA
State Department
of Health

Delivery via email to: Cristy@arborhouseliving.com

June 6, 2023

License Number: AL0903

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

RE: Survey Event ID: 7M8111

Dear Ms. Davis:

On **May 26, 2023**, agents from our office concluded a State Licensure survey with complaint investigations 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 May 26, 2023.

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;
(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 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
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.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Arbor House Assisted Living of Mustang**
Address: **850 North Clearsprings Road**
City, State, Zip: **Mustang, OK, 73064**
Provider #: **AL0903**
Complaint #: **OKOOO56259**
Investigation Date(s): **05/26/23**

ALLEGATION(S)

1. The center neglected to ensure residents received adequate and appropriate medical care.

An unannounced on-site investigation was initiated 05/26/2023 at 7:00 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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 care was observed.

Staff training records related to staffing were reviewed. Resident records including assessments, care plans, physician orders, nursing notes, treatment records, and incident reports were reviewed.

Residents were interviewed regarding whether or not they received adequate and appropriate medical care.

Staff members were interviewed regarding the facility's policy to ensure residents received adequate and appropriate medical care.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Rae Belt, RN

Rae Belt, RN

Date report completed: 05/30/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Arbor House Assisted Living of Mustang**
Address: **850 North Clearsprings Road**
City, State, Zip: **Mustang, OK, 73064**
Provider #: **AL0903**
Complaint #: **OK00057499**
Investigation Date(s): **05/26/23**

ALLEGATION(S)

1. The center failed to ensure residents received adequate and appropriate medical care and failed to provide care according to resident contracts.

An unannounced on-site investigation was initiated 05/26/2023 at 7:00 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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 care was observed.

Staff training records related to staffing were reviewed. Resident records including assessments, care plans, physician orders, nursing notes, treatment records, contracts, and incident reports were reviewed.

Residents were interviewed regarding whether or not they received adequate and appropriate medical care according to their contracts.

Staff members were interviewed regarding the facility's policy to ensure residents received adequate and appropriate medical care according to the residents' contracts.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Rae Belt, RN

Rae Belt, RN, CHFS

Date report completed: 05/30/2023

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 _____	C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING OF MUSTANG	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 05/26/23. Complaint investigations (OK00056259 and OK00057499) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: COPD - chronic obstructive pulmonary disease CT - computerized tomography DON - Director of Nursing ER - emergency room OSDH - Oklahoma State Department of Health	C 000		
C1911 SS=E	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		

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	AL0903	A. BUILDING: _____ B. WING _____	C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1911	Continued From page 1	C1911		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure reportable incidents were reported to OSDH within 24 hours for two (#11 and #13) of three sampled residents reviewed for incident reports.

The administrator identified 64 residents resided in the facility.

Findings:

An "Abuse" policy, updated 10/2019, contained no documentation regarding the facility reporting incidents to OSDH as required.

1. Resident #11 had diagnoses which included COPD.

A facility "Incident Report Form," dated 02/26/23 at 11:50 a.m., documented Resident #11 had fallen, complained of their arm hurting, and had a large skin tear to the right arm. It documented 911 was notified.

An OSDH "Reportable Incident Form," dated 02/26/23, documented Resident #11 had fallen and was sent to the ER. It documented the resident had bumped their head and had received a CT scan.

A facsimile transmission report, dated 02/28/23 at

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	AL0903	A. BUILDING: _____ B. WING _____	C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING OF MUSTANG	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
C1911	Continued From page 2 3:56 p.m., documented Resident #11's reportable incident had been reported to OSDH two days after the incident. 2. Resident #13 had diagnoses which included Alzheimer's disease. A facility "Incident Report," dated 01/28/23 at 7:10 p.m., documented Resident #13 was observed in their room on the floor. It documented Resident #13 complained of pelvic pain. An OSDH "Incident Report Form," dated 01/28/23, documented Resident #13 had fallen and complained of pelvic pain. It documented Resident #13 was sent to the ER and had x-rays performed. A facsimile transmission report, dated 01/31/23 at 11:17 a.m., documented Resident #13's reportable incident had been reported to OSDH three days after the incident. On 05/26/23 at 2:40 p.m., the DON was asked when they would report an incident to OSDH. They stated they reported within 24 hours. The DON was asked who was responsible for reporting to OSDH. They stated they or the regional nurse would be the one to send the reports. The DON was shown the incident reports, OSDH reportables, and the facsimile transmissions for Residents #11 and #13. They were asked when the reportable incidents had been reported to OSDH. The DON stated Resident #11"s incident had been reported two days later. The DON stated Resident #13's reportable incident had been reported two days later. They were shown the facsimile report document it had been	C1911		

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 _____	C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1911	Continued From page 3 reported three days later.	C1911		

OKLAHOMA
State Department
of Health

Delivery via email to: Cristy@arborhouseliving.com

June 15, 2023

License Number: AL0903

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

Survey Event ID: 7M8111

Dear Ms. Davis:

On **May 26, 2023,** a licensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and 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 **June 30, 2023**.

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) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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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: 6/8/2023** **Facility Name:** Arbor House Assisted Living of Mustang **License Number:** AL0903 **Survey Event ID:** 7M8111 **Date Survey Completed: 5/26/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1911 SS=E	Based on: Based on record review and interview, the facility failed to ensure reportable incidents were reported to OSDH within 24 hours for two (#11and #13) of three sampled residents reviewed for incident reports.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Arbor House is submitting a plan of correction as a state regulation and not an admission of guilt.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The incidents for the residents were reported to OSDH within 48 business hours of the incidents although the guideline is within 24 business hours .
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Incident reports shall be reported to management as soon as possible. If an incident occurs during non business hours, team members shall report to management as soon as possible. If the incident is a state reportable incident, management shall submit the incident to OSDH within 24 business hours.
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?	Incident reports shall be reported to management as soon as possible. If an incident occurs during non business hours, team members shall report to management as soon as possible. If the incident is a state reportable incident, management shall submit the incident to OSDH within 24 business hours. Incident reports shall be discussed during the monthly quality improvement meeting and ensure that the reports were submitted to OSDH on time. The Executive Director shall ensure this is completed.
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.	Incident reports shall be reported to management as soon as possible. If an incident occurs during non business hours, team members shall report to management as soon as possible. If the incident is a state reportable incident, management shall submit the incident to OSDH within 24 business hours. Incident reports shall be discussed during the monthly quality improvement meeting and ensure that the reports were submitted to OSDH on time. The Executive Director shall ensure this is completed. Incident reports shall be discussed during the monthly quality improvement meeting and ensure that the reports

	were submitted to OSDH on time. The Executive Director shall ensure this is completed. Incident reports shall be discussed during the monthly quality improvement meeting and ensure that the reports were submitted to OSDH on time. The Executive Director shall ensure this is completed. Incident reports shall be reported to management as soon as possible. If an incident occurs during non business hours, team members shall report to management as soon as possible. If the incident is a state reportable incident, management shall submit the incident to OSDH within 24 business hours. Incident reports shall be discussed during the monthly quality improvement meeting and ensure that the reports were submitted to OSDH on time. The Executive Director shall ensure this is completed.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 6/9/2023

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

August 8, 2023

License Number: AL0903

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

RE: Survey Event 7M8112

Dear Ms. Davis:

On **August 4, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 26, 2023,** have now been corrected effective **June 30, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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-C 08/04/2023

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 visit was conducted on 08/04/23. 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