OKLAHOMA
State Department
of Health

Delivery via email to: cristy.davis@legendseniorliving.com

October 17, 2023

License Number: AL0903

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

RE: Survey Event ID: 5HQL11

Dear Ms. Davis:

On **October 10, 2023**, agents from our office concluded a State Licensure survey with complaint investigation 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 October 10, 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 | Enforcement Analyst
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: **Arbor House Assisted Living of Mustang**
Address: **850 North Clearsprings Road**
City, State, Zip: **Mustang, OK, 73064**
Provider #: **AL0903**
Complaint #: **OK00061136**
Investigation Date(s): **October 9th and 10th, 2023**

ALLEGATION(S)

1. The facility failed to ensure food was served fully cooked, according to the menu, in adequate portions and according to preferred temperatures and failed to serve food in a sanitary manner.
2. The facility failed to ensure residents' right to refuse care.
3. The facility failed to ensure dependent residents received assistance with activities of daily living.
4. The facility failed to ensure medications were administered according to the standard of care.

An unannounced on-site investigation was initiated 10/09/2023 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 allegations.

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 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, at other various times throughout the survey, and across multiple shifts. The kitchen and dining services were observed. Food preparation was observed. Residents were observed receiving meals. Staff were observed passing medications and providing care to the residents.

Residents were interviewed related to food service, refusing care, receiving care, and medications.

Resident records were reviewed including assessments, care plans, physician orders, physician progress notes, nursing notes, medication/treatment records, and activities of daily living records. Facility policy and procedures were reviewed. Grievance records were reviewed. State reported incidents and investigations were reviewed. Multiple employee files were reviewed.

Staff members were interviewed regarding the facility policies related kitchen sanitation, food service, residents' rights, providing assistance, and administering medications.

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: 10/10/2023

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 10/10/2023

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 relicensure survey was conducted from 10/09/23 through 10/10/23. A complaint investigation (#OK00061136) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: CDM - Certified Dietary Manager DON- Director of Nursing	C 000		
C 391 SS=F	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, record review, and interview, the facility failed to ensure food items were labeled in the refrigerator and one refrigerator was maintained to promote a clean and sanitary kitchen. The DON identified 62 residents received nutrition from the kitchen. Findings: A "Leftovers and Prepared Foods" policy, dated 03/18/14, read in part, "...store all prepared foods in a container...and label the container with the type of food and the date..." An "Equipment Use and Safety" policy, dated 03/18/14, read in part, "...utensils, equipment, preparation surfaces, and the kitchen area must	C 391		

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 10/10/2023

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 391	Continued From page 1 be kept clean at all times..." On 10/09/23 at 7:18 a.m., the following observations were made of the reach-in refrigerator: a. ham wrapped in a plastic container, b. cooked sausage patties in a plastic bag, c. macaroni salad in a plastic bag, and d. egg salad sandwiches in a plastic bag. None of the items were dated or labeled. The bottom of the reach in-refrigerator was observed to have broken egg shells, dried yellow substance, spilled food debris, and a soiled paper towel. On 10/09/23 at 7:30 a.m., the CDM was shown the unlabeled/undated items in the reach-in refrigerator and the bottom of the refrigerator. The CDM stated the policies were not being followed and it needed to be cleaned. On 10/09/23 at 9:34 a.m., the Administrator was shown the unlabeled/undated items in the refrigerator and the bottom of the refrigerator. The Administrator stated they were aware of the observations because they saw the condition of the kitchen the week prior. The Administrator stated the items should of been addressed.	C 391		

OKLAHOMA
State Department
of Health

Delivery via email to: cristy.davis@legendseniorliving.com

November 8, 2023

License Number: AL0903

Ms. Cristy Davis, Area Director of Operations
Arbor House Assisted Living Of Mustang
850 North Clearsprings Road
Mustang, OK 73064

Survey Event ID: 5HQL11

Dear Ms. Davis:

On **October 10, 2023,** a Relicensure 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 **December 6, 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

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: 11/3/2023
	Facility Name: Arbor House Assisted Living/Mustang
	License Number: AL090
	Survey Event ID: 5HQL11
	Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C91 SS=F	Based on: Based on observation, record review, and interview, the facility failed to ensure food items were labeled in the refrigerator and one refrigerator was maintained to promote a clean and sanitary kitchen.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	Food, Storage, Preparation and Service shall be monitored closely by the Residence Director and Dietary Manager to promote a clean sanitary kitchen in compliance with 310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE and in accordance with Chapter 257 of this title. An inservice with dietary department on regulation and company Policy #06-01-0061P Equipment Use and Safety and Policy #06-01-0063P Leftovers and Prepared Foods.
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. Dietary manager shall check all kitchen logs for cleaning, temps and labeling and observe what has been checked off on making certain it has been completed.
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?	A special dietary inservice was completed on 10/12/2023 over the practices of a clean sanitary kitchen. Dietary logs will be discussed at our monthly quality improvement meeting to ensure they are being checked off on. Residence Director will do random thourough walkthroughs. An inservice with dietary department on cited regulation and company Policy #06-01-0061P Equipment Use and Safety and Policy #06-01-0063P Leftovers and Prepared Foods.
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;	Dietary logs shall be discussed at our monthly quality improvement meeting to ensure they are being checked off on. Residence Director shall do random thourough walkthroughs.

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.	
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/6/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Kristy Davis	**Date 11/3/2023**

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		**Submitted by**	

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Surveyor:

If Plan of Correction is unacceptable, the reasons are as follows:
Facility in Compliance by:

OKLAHOMA
State Department
of Health

Delivery via email to: cristy.davis@legendseniorliving.com

January 2, 2024

License Number: AL0903

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

RE: Survey Event 5HQL12

Dear Ms. Davis:

On **December 28, 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 **October 10, 2023,** have now been corrected effective **December 6, 2023.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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

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 12/28/2023

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 An offsite/paper revisit was conducted on 12/28/23. 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