OKLAHOMA
State Department
of Health

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

May 5, 2025

License Number: AL0903

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

RE: Survey Event ID: P3DR11

Dear Ms. Davis:

On **April 23, 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 **April 23, 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:

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

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Arbor House Mustang
Address: 850 North Clearsprings Road
City, State, Zip: Mustang, OK 73064
Provider #: AL0903
Complaint #: OK00068888
Investigation Date(s): 04/22/25-04/23/25

ALLEGATION(S)
The facility failed to ensure care was provided for residents according to their plan of care
The facility failed to provide a clean, homelike environment
The facility failed to ensure staff provided assistance to meals to ensure proper hydration and nutrition
The facility failed to ensure informed consent was given by a resident's representative prior to administering a vaccination
The facility failed to ensure adequate and competent staff to provide care according to the plan of care

An unannounced on-site investigation was initiated 04/22/2025 at 10:20 a.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: An initial tour of the center showed the residents were well groomed, wearing clean clothing, and had no odors. The resident apartments including bathrooms were clean and a housekeeper was always on duty. Staff interacting with residents with dementia throughout the survey and cared for them appropriately and timely. Residents were observed being assisted with consuming food and fluids in an appropriate manner. Residents observed did not exhibit signs or symptoms of dehydration. Record reviews of resident service plans and health records showed the residents were being cared for according to plan and routine cleaning was in place. Interviews of staff, residents, and family confirmed consent prior to vaccines.

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

Date report completed: 04/23/2025

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 _____	C 04/23/2025

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 relicensure and complaint survey (#OK00068888) was conducted from 04/22/25 through 04/23/25. Deficiencies were cited as a result of the survey. Facility Census: 49 Listed below are abbreviations that will be used throughout this document. CNA- certified nurse aide	C 000		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure water temperatures for bathing did not exceed 115 degrees Fahrenheit (F) for 3 (#4, 6, and #7) of 3 resident showers sampled for hot water temperatures. The regional director of operations identified 49 residents resided in the center and all 49 residents utilized their apartment showers.	C 701		

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 04/23/2025

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 701	Continued From page 1 Findings: 1. On 04/23/25 at 8:40 a.m., the hot water in Resident #6's shower was 122 degrees F. On 04/23/25 at 10:00 a.m., the maintenance supervisor checked the water temperature inside of Resident #6's apartment and the thermometer read 123 degrees F. A policy titled "Physical Plant & Environment," dated 04/01/14, read in part, "Water temperature in the apartments should not exceed 120 degrees." An "Annual Comprehensive Assessment," dated 07/25/24, showed Resident #6 was admitted to the center on 07/12/16 with diagnosis of Alzheimer's disease. A "Mini-Mental State Examination," dated 03/12/25, showed Resident #6's score was 6, which indicated severe cognitive impairment. 2. On 04/23/25 at 8:48 a.m., the hot water in Resident #4's shower was 119 degrees F. An "Annual Comprehensive Assessment," dated 05/15/24, showed Resident #4 was admitted to the center on 05/24/22 with diagnoses which included Parkinson's disease, dementia, and right sided hemiplegia. A "Mini-Mental State Examination," dated 01/16/25, showed Resident #4's score was 0, which indicated severe cognitive impairment. 3. On 04/23/25 at 8:52 a.m., the hot water in Resident #7's shower was 119 degrees F.	C 701		

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 04/23/2025

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 701	Continued From page 2 A "Significant Change Assessment," dated 06/06/24, showed Resident #7 was admitted to the center on 01/28/21 with diagnoses which included mood disorder due to known psychological condition and depression. A "Mini-Mental State Examination," dated 02/25/25, showed Resident #7's score of 9, which indicated severe cognitive impairment. A document titled "Water Temp Log," dated 04/04/25, showed water temperatures were recorded in only one memory care apartment. A review of the documents on 10/18/24, 11/22/24, 12/16/24, 01/15/25, 02/12/25, and 03/12/25 showed the same memory care apartment was the only resident apartment checked for water temperatures. On 04/23/25 at 9:59 a.m., the maintenance supervisor was asked how often they checked water temperatures throughout the center. They stated, "Once a month." They were asked where in the center they checked water temperatures. The maintenance supervisor stated, "I check the same spot every time by the water heaters." On 04/23/25 at 10:02 a.m., the administrator was asked what the policy was for bathing water temperatures. They stated, "It cannot exceed 120 degrees F." They were asked what the state regulation was for bathing water temperatures. They stated, "I'm assuming 120 degrees F."	C 701		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made	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 04/23/2025

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
C1911	Continued From page 3 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. This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to submit an incident report to the Department within 1 business day of the incident's discovery for 1 (#2) of 8 residents sampled for incident reports. The regional director of operations identified 49 residents resided in the center.	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 04/23/2025

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
C1911	Continued From page 4 Findings: On 04/22/25 at 11:13 a.m., Resident #2 was observed to have a hospital bracelet on their left wrist and a scab to their forehead. An "Annual Comprehensive Assessment," dated 03/04/25, showed Resident #2 admitted to the center on 03/02/21 with diagnosis of Alzheimer's disease. An "Incident-Occurrence Report," dated 04/19/25, showed Resident #2 had an unwitnessed fall in the center at 9:25 p.m. and was sent to the hospital due to head injury. A "Discharge Instruction Packet," dated 04/19/25, showed Resident #2 was discharged from the hospital with a diagnosis of closed head injury. There was no documentation to show an incident report was submitted to the Department. On 04/22/25 at 11:13 a.m., CNA #1 was asked why Resident #2 was wearing a hospital bracelet. CNA #1 stated, "I think [Resident #2] fell on Saturday or Sunday." On 04/22/25 at 2:17 p.m., the corporate consult nurse was asked why Resident #2 was wearing a hospital bracelet. They stated, "[Resident #2] fell. We should have had the reportable in yesterday. I will have it in by the end of today."	C1911		