



Oklahoma State Department of Health
Creating a State of Health

October 4, 2019

License Number: AL0908

Ms. Angela Crawford, Administrator
Carriage House Homes
11012 Coachman's Road
Yukon, OK 73099

RE: Survey Event ID: WF3T11

Dear Ms. Crawford:

On **September 16, 2019**, 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 September 16, 2019.

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;

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- (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) 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

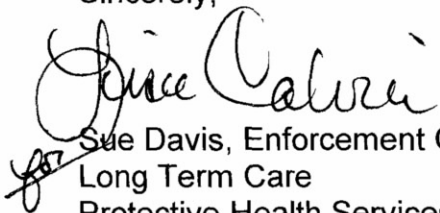
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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,

A handwritten signature in black ink, appearing to read "Sue Davis", is written over the typed name and title.

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL0908	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CARRIAGE HOUSE HOMES

**11012 COACHMAN'S ROAD
YUKON, OK 73099**

(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
N 000	Initial Comments A re-licensure survey was conducted on 09/16/19. Current census was 4. The following deficient practice was cited.	N 000		
N1105 SS=F	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure two hours of in-service training that was supervised by a registered nurse was provided monthly for 5 (#1 through #5) of 5 employees who provided direct resident care. This failed practice had the widespread potential for more than minimal harm for all 4 residents. Findings: On 09/16/19 at 1:46 p.m., in-service records were reviewed and the following months only one hour	N1105		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL0908	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 09/16/2019
NAME OF PROVIDER OR SUPPLIER CARRIAGE HOUSE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11012 COACHMAN'S ROAD YUKON, OK 73099		
(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 2 Establishment Regulations in regards to: a) Gloves not worn; and b) Dishes not sanitized. This failed practice resulted in the widespread potential for more than minimal harm for all four of the residents who received their nutrition from the kitchen. Findings: 310:257-5-34. Gloves, use limitation (a) ...single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 310:257-7-77. Warewashing equipment, determining chemical sanitizer concentration Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. On 09/16/19 at 11:48 a.m., long term care aide/employee #1 prepared peanut butter and jelly sandwiches for resident #1 and #3 without wearing gloves, and also placed potato chips on their plates with her bare hands. At 3:37 p.m., the administrator/registered nurse stated the dishwasher sanitation was checked every month with a test kit. She stated she had maintained a log of the dishwasher sanitation test strips. No documentation of dishwasher sanitation test strips was provided.	C 391		
C 954 SS=F	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be	C 954		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL0908	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2019
NAME OF PROVIDER OR SUPPLIER CARRIAGE HOUSE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 11012 COACHMAN'S ROAD YUKON, OK 73099		
(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 954	Continued From page 3 trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure first aid training had been provided to 4 (#1 through #4) of 5 direct care employees. This failed practice resulted in the widespread potential for more than minimal harm for all 4 residents. Findings: On 09/16/19 at 1:17 p.m., a review of the employees' records revealed the following direct care employees had not been provided first aid training: Long term care aide (LTCA)/employee #1 - hired 02/20/17; LTCA/employee #2 - hired 08/09/19; LTCA/employee #3 - hired 03/31/17; and LTCA/employee #4 - hired 08/13/19. At 1:34 p.m., the administrator/registered nurse stated employees #1 through #4 had not been provided any first aid training.	C 954		

STATE WORKLOAD REPORT

Provider/Supplier Number AL0908	Provider/Supplier Name CARRIAGE HOUSE HOMES
------------------------------------	--

Type of Survey (select all that apply)

☒ 2 ☐ ☐ ☐ ☐

- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | 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. <i>de</i> 35195	09/16/2019	09/16/2019	0.50	0.00	7.75	0.00	2.25	3.00
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

OCT 07 2019 *dm*



Oklahoma State Department of Health
Creating a State of Health

October 16, 2019

License Number: AL0908

Ms. Angela Crawford, Administrator
Carriage House Homes
11012 Coachman's Road
Yukon, OK 73099

RE: Survey Event WF3T11

Dear Ms. Crawford:

On September 16, 2019, 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 **November 4, 2019**.

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,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/ks

Board of Health

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Commissioner of Health

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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/10/2019

Facility Name: Carriage House Homes

License Number: AL0908

Survey Event ID: WF3T11

Date Survey Completed: 9/16/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: Observation and interview, it was determined the center failed to ensure the compliance with Chapter 257 Food Service Establishment Regulations in regards to Gloves not worn and Dishes not sanitized.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All staff that handles food will complete Learn to Serve food handler training course in month of October 2019 and will be updated annually. Administrator will perform random audit of meal prep to make sure employees are following policy and procedure. This will be done quarterly and results will be tracked in QA. Sanitizing strips will be done monthly in the dishwasher and results will be logged in the kitchen log book. All staff will be inserviced on strips and how to record.

All residents identified. We are only a 5 bed facility

Training will be completed by end of October 2019. All staff will be monitored for compliance on a quarterly basis to ensure proper handling and preparation of foods. Will monitor kitchen log book for documentation of sanitizing strips for testing dishwasher. All data will be monitored for compliance and results will be documented quarterly in QA.

Administrator will monitor staff for training certificates and completeness. Administrator will also audit staff during meal prep on quarterly basis to make sure policy and procedures are being followed.

Facility should have 100% compliance as evidenced by results in QA of proper food handling and sanitizing.

Will review employee charts to make sure training is done upon hire and upon expiration dates of certification. Staff will also have refresher courses yearly. Kitchen log book will be updated on a monthly basis.

All chart audits and kitchen log audits will be completed quarterly by Administrator.

OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/25/2019
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Angie Crawford OAC 310:663-25-4(F)	Date 10/10/2019
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
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/10/2019

Facility Name: Carriage House Homes

License Number: AL0908

Survey Event ID: WF3T11

Date Survey Completed: 9/16/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954

Based on: Interview and record review it was determined the center failed to ensure first aid training had been provided for 5 direct care employees

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- 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?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Angie Crawford RN

OAC 310:663-25-4(F)

Date 10/10/2019

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 Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 10/10/2019	
	Facility Name: Carriage House Homes	
	License Number: AL0908	
	Survey Event ID: WF3T11	
Date Survey Completed: 9/16/2019		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: N1105	Based on: Interview and record review, it was determined the center failed to ensure 2 hours of in-service training supervised by an RN	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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?	All monthly in-services will be 2 hours in length and not one hour. All in-services will be monthly and performed by Angie Crawford RN. All staff will sign in and the In-service will include topic and length of in-service.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	No other residents affected. Facility is only a 4 person facility and all residents have been identified.	
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?	All in-services scheduled going forward will be 2 hours in length and will need approval from the Administrator. All in-services will be monitored quarterly for compliance and all findings will be placed in QA data compilation. Administrator will review inservice calendar quarterly.	
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.	Inservice Calendar will be reviewed quarterly by administrator to make sure proper policy and procedure are being followed. Chart audits will be performed quarterly for employee staff training compliance. Results will be followed up in QA data. In-service calendar will be audited on quarterly basis for compliance by the administrator. Results will be kept in QA minutes. In-service topics will be reviewed for compliance such as topic, time and monthly scheduling.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	10/16/2019	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Angie Crawford OAC 310:663-25-4(F)	Date 10/10/2019	
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
Creating a State of Health

December 12, 2019

License Number: AL0908

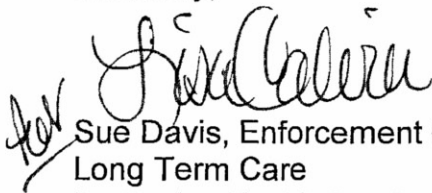
Ms. Angela Crawford, Administrator
Carriage House Homes
11012 Coachman's Road
Yukon, OK 73099

RE: Survey Event WF3T12

Dear Ms. Crawford:

On **November 4, 2019**, a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **September 16, 2019**, have now been corrected effective **November 4, 2019**. If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,



Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Board of Health

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Commissioner of Health

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Edward A Legako, MD (*Vice-President*)
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Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. AL0908	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/04/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CARRIAGE HOUSE HOMES

**11012 COACHMAN'S ROAD
YUKON, OK 73099**

(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
{N 000}	Initial Comments A follow-up survey was conducted on 11/04/19. Current census was 4. The deficient practice was cleared.	{N 000}		
{C 000}	INITIAL COMMENTS A follow-up survey was conducted on 11/04/19. Current census was 4. All deficient practices were cleared.	{C 000}		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE WORKLOAD REPORT

Provider/Supplier Number
AL0908

Provider/Supplier Name
CARRIAGE HOUSE HOMES

Type of Survey (select all that apply)

2	D			
---	---	--	--	--

- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | 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.  35195	11/04/2019	11/04/2019	0.50	0.00	0.75	0.00	1.75	0.75
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