Oklahoma State Department of Health
Creating a State of Health

August 15, 2019

License Number: AL1003

Ms.. Cheryl Blount, Administrator
Canoe Brook Ardmore
2215 4th Avenue Nw
Ardmore, OK 73401

RE: Survey Event ID: 3X5E11

Dear Ms.. Blount:

On **July 9, 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 **July 9, 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;
(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;

Board of Health

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Interim Commissioner of Health

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(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,

Sue Davis

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1003	A. BUILDING _____ B. WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANOE BROOK ARDMORE	2215 4TH AVENUE NW ARDMORE, OK 73401

(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 On 07/08/19 through 07/09/19 a re-licensure survey was conducted. Census was 30. The following deficient practice was cited.	N 000		
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure certified medication aide (CMA) skills performance/competencies had been validated annually for 2 (#5, and #6) and 1 (#4) skills were validated prior to medication administration of 4 sampled CMA's who provided assistance with medication. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: On 07/09/19 at 2:05 p.m., a review of current employee records was conducted. No documentation was provided to validate CMA #4 skills performance prior to medication administration (hired 09/02/18). No documentation was provided to validate CMA #5 and CMA #6 had an annual performance	N1442		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1003	A BUILDING: _____ B WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANOE BROOK ARDMORE	2215 4TH AVENUE NW ARDMORE, OK 73401

(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
N1442	Continued From page 1 competency. On 07/09/19 at 2:05 p.m., LPN (licensed practical nurse) #1 was asked if CMA #4 had demonstrated medication competency before passing medications to residents. She stated no, however she had a form to start validation for medication competency. LPN #1 was asked about CMA #5 and #6's annual performance competencies. She stated she did not know until recently they needed an annual competency.	N1442		
C 000	INITIAL COMMENTS On 07/08/19 through 07/09/19 a re-licensure survey was conducted. Census was 30. The following deficient practice was cited.	C 000		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to complete the comprehensive assessment once every twelve (12) months for 3 (#2, 5, and #6) of 8 sampled residents. Additionally, the center failed to complete the	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1003	A BUILDING _____ B WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANOE BROOK ARDMORE	2215 4TH AVENUE NW ARDMORE, OK 73401

(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 522	Continued From page 2 14-day comprehensive assessment after admission to the center for 1 (#3) of 8 sampled residents. These deficient practices resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #2 The comprehensive assessment, dated 03/26/18, documented resident #2 was admitted to the center on 03/13/16. The clinical record did not contain an updated annual assessment. RESIDENT #3 The clinical record contained a pre-admission comprehensive assessment, dated 02/21/19, for resident #3. The licensed practical nurse (LPN) #1 was asked if the assessment in resident #3's clinical record was her pre-admission assessment. She stated, yes. LPN #1 was asked when resident #3 was admitted to the center. She stated on 03/01/19. The clinical record did not contain a 14-day assessment. RESIDENT #5 The comprehensive assessment, dated 03/01/18, documented resident #3 was admitted to the center on 03/15/18. The clinical record did not contain an updated annual assessment. RESIDENT #6 There was no comprehensive assessment for resident #6 located in the clinical record. On 07/09/19 at 11:10 a.m., LPN #1 was asked if there were more recent comprehensive assessments for resident #2, #5, and #6. She	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1003	A BUILDING _____ B WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANOE BROOK ARDMORE	2215 4TH AVENUE NW ARDMORE, OK 73401

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C 522	Continued From page 3 stated no, but there should have been. LPN #1 was asked if resident #3 had a 14-day comprehensive assessment. She stated no she could not find one. Policy The center's policy for Assessment and Service Plan dated 11/2016, documented the assisted living shall complete the comprehensive assessment in accordance with the following: within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter.	C 522		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to conduct a personal interview between the resident and/or resident's representative and the person completing the form for 1 (#7) of 8 sampled residents. This deficient practice resulted in the isolated potential for more than minimal harm. Findings: RESIDENT #7	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1003	A. BUILDING _____ B. WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANOE BROOK ARDMORE	2215 4TH AVENUE NW ARDMORE, OK 73401

(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 543	Continued From page 4 The comprehensive assessment dated 12/18/18, for resident #7, documented high blood pressure, cerebrovascular accident, and Diabetes Mellitus. The comprehensive assessment was not signed by the resident and/or resident's representative. The licensed practical nurse (LPN) #1 was asked if resident #7's assessment had been signed by the resident. She stated, no. She was asked if resident #7 was her own POA (Power of Attorney). She stated, yes. Policy The center's policy for Assessment and Service Plan dated 11/2016, documented the assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form.	C 543		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL1003	CANOE BROOK ARDMORE

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)
Team Leader ID 1. 30875	07/08/2019	07/09/2019	1.00	0.00	11.50	0.00	5.00	3.50
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**

AUG 16 2019

Oklahoma State Department of Health
Creating a State of Health

September 5, 2019

License Number: AL1003

Ms. Cheryl Blount, Administrator
Canoe Brook Ardmore
2215 4th Avenue Nw
Ardmore, OK 73401

RE: Survey Event 3X5E11

Dear Ms. Blount:

On July 9, 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 **August 26, 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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Interim Commissioner 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: 8/22/2019** **Facility Name:** Canoe Brook-Ardmore Assisted Living **License Number:** AL1003 **Survey Event ID:** 3X5E11 **Date Survey Completed: 7/9/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: N1442	Based on: Based on interview and record review, it was determined the center failed to ensure certified medication aide (CMA) skills performace competencies had been validated annually for 2 (#5 and #6) and 1 (#4) sills were validated prior to medicaction administration of 4 sampled CMA's who provided assistance with medications. The deficient practice resulted in the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Canoe Brook-Ardmore Assisted Living will perform skills checklist with each new staff as part of their training/orientation program.

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?	Upon hire and during their training program the team members who are responsible for passing medications will receive a skills checklist completed by the LPN before being released on the med cart.
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 new staff will complete the orientation/training program before being released on the medication cart by the LPN.
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?	An orientation/training program has been implemented with all documentation included in the new hire packet that will be reviewed by the LPN and BOM, then placed in the employee certification binder.
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.	Implementation of the orientation/training program for all new hires presented by BOM under supervision of the ED and LPN. The LPN will monitor Certification, employee paperwork, all employment forms will be followed up during our QA meeting on a quarterly basis. An employee certification binder has been created with dates of certifications and all documents required by the state to ensure our Resident Rights are being met. This is maintained by the BOM under supervision of the ED. ED will review during QA meeting to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/21/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Shawn Brown OAC 310:663-25-4(F)			**Date 8/22/2019**
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: 8/22/2019** **Facility Name:** Canoe Brook-Ardmore Assisted Living **License Number:** AL1003 **Survey Event ID:** 3X5E11 **Date Survey Completed: 7/9/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: Based on interview and record review, it was determined the center failed to complete the comprehensive assessment once every twelve (12) months for 3 (#2, 5 and #6) of 8 sampled residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Canoe Brook-Ardmore Assisted Living will perform annual assessments, 14 day assessments on new move ins and on any other resident with a significant change according to our policies.

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 residents are assessed during the application process. Once the resident becomes a member of our community, we will follow up with the 14 day assessment, then annually unless there is a significant change following our policies and procedures.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The Director and LPN have created a "tickler" spreadsheet, placed the timeline on our calendars with reminders of due dates for all residents.
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 our monthly staff meeting we will discuss the residents that are scheduled for the annual assessments and Director will follow up before end of month to verify all have been 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.	Implementation of the "tickler" spreadsheet will ensure that all dates are met for assessments. LPN and ED will discuss in monthly meeting what assessments are due and ED will follow up for compliance LPN, ED and RN will verify all assessments are current, and in the residents chart at our quarterly QA meeting The "tickler" spreadsheet will be updated on completion of all assessment both annually and 14 assessments monitored by the LPN and ED to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/26/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required OAC 310:663-25-4(F)	**Date 8/27/2019**

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: 8/22/2019** **Facility Name:** Canoe Brook-Ardmore Assisted Living **License Number:** AL1003 **Survey Event ID:** 3X5E11 **Date Survey Completed: 7/9/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C543	Based on: Based on interview and record review, it was determined the center failed to conduct a personal interview between the resident and/or resident's representative and the person completing the form for 1 (#7) of 8 samples residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Canoe Brook-Ardmore Assisted Living will ensure all assessments are signed at the time performed by either the resident or resident representative.

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 assessments will be signed by the resident or resident representative at the time of the assessment along with the LPN signature.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The LPN and staff have checked every resident chart for both signatures to ensure the AL is following protocol.
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 our monthly staff meeting we will discuss the residents that are scheduled for the annual assessments, with all the necessary information to be completed during the assessment.
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.	Complete and correct documentation will be discussed in our monthly staff meeting and during our quarterly QA meetings. ED will review with LPN and RN during our monthly and quarterly QA review ED will review during the QA meeting to ensure compliance ED will document in the QA notes with LPN and RN acceptance
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/26/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date 8/26/2019**

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.

SEP - 6 20

Oklahoma State Department of Health
Creating a State of Health

December 12, 2019

License Number: AL1003

Ms.. Cheryl Blount, Administrator
Canoe Brook Ardmore
2215 4th Avenue Nw
Ardmore, OK 73401

RE: Survey Event 3X5E12

Dear Ms.. Blount:

On **October 10, 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 **July 9, 2019*,** have now been corrected effective **August 26, 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/ldc

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA *(President)*
Edward A Legako, MD *(Vice-President)*
Becky Payton *(Secretary)*
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1003	A. BUILDING: _____ B. WING _____	R 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANOE BROOK ARDMORE	2215 4TH AVENUE NW ARDMORE, OK 73401

(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 On 10/10/19 a follow-up survey was conducted. Census was 26. All deficient practice was cleared.	{N 000}		
{C 000}	INITIAL COMMENTS On 10/10/19 a follow-up survey was conducted. Census was 26. All deficient practice was 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	Provider/Supplier Name
AL1003	CANOE BROOK ARDMORE

Type of Survey (select all that apply)

2	D			

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)
Team Leader ID 1. 30875	10/10/2019	10/10/2019	0.50	0.00	1.00	0.00	4.00	1.00
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**