
Delivery via email to: dreed@oxfordseniorliving.com

May 26, 2022

License Number: AL1003

Mr. Delbert Reed, Administrator
Canoe Brook Ardmore
2215 4th Avenue Nw
Ardmore, OK 73401

Survey Event ID: 1DBD11

Dear Mr. Reed:

On **May 5, 2022**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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. 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 will be completed for each violation; and

(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 Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Canoe Brook Ardmore
Address: 2215 4th Avenue NW
City, State, Zip: Ardmore, OK 73401, Carter
Provider #: AL1003
Complaint #: #OK00055774
Investigation Date(s): 05/03/22 through 05/05/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide medical services according to accepted standards.	S
2. The center failed to practice required infection control practice procedures.	US

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 05/03/2022 at 10:45 a.m.

A sample of three 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 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-0911 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to practicing required infection control procedures was conducted.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Infection control logs were reviewed. Upon entrance to the center, instructions were posted to check in, sanitize hands, wear a mask, and encouraged social distancing of 3-6 feet during visitation. A sign was posted at the front entrance to wear a mask at all times. A station was set up at the front entrance to monitor temperature, answer Covid-19 related questions, and masks were made available at the front entrance.

Staff members were observed wearing masks and performing hand washing between residents. The kitchen staff was observed with hair nets and wearing gloves. A sanitation dispenser was provided at the front entrance with instructions to sanitize your hands when entering the center. Sanitation was provided on the medication carts and was used by staff. Staff verbalized the procedure to sanitize hands between residents and to wash hands with soap and water after three residents

The acting Executive Director submitted the CLIA license in her name with an expiration date of 01/07/23. She submitted documentation for the infection preventionist training she received on 07/30/20. She reported the center had PPE to include face shields, foot coverings, gowns, KN-95 masks, and gloves. Residents interviewed verbalized no concerns or complaints related to infection control. Facility staff reported all residents except one had been vaccinated.

Determination Summary and Follow-Up Action:

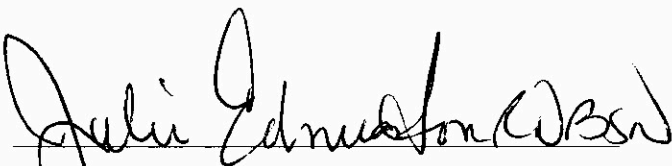
Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Julie Edmiaston RN, BSN

Date report completed: 05/10/2022

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Canoe Brook Ardmore
Address: 2215 4th Avenue NW
City, State, Zip: Ardmore, OK 73401, Carter
Provider #: AL1003
Complaint #: #OK00057310
Investigation Date(s): 05/03/22 through 05/05/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were provided adequate medical treatment, and failed to provide an environment where grievances could be voiced without fear of retaliation.	US

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 05/03/2022 at 10:45 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to adequate medical treatment and providing an environment where grievances could be voiced without fear of retaliation was conducted.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Two resident council meeting minutes were submitted for March 2022 and April 2022. The council minutes documented various grievances with solutions and some with ongoing solutions. Grievance logs and facility policies were reviewed.

Upon entrance to the center and throughout the survey, staff members were observed to interact with residents in a kind and respectful manner. Residents were observed during various activities including Bingo, nail polishing station, and puzzles were observed in the common area. Residents were observed to be treated with dignity and respect.

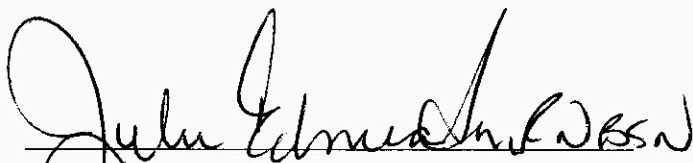
A family member, sampled residents, and numerous other residents voiced compliments related to the activity director and services provided. The center's former Administrator was no longer employed at the center and the center had an acting Executive Director in place. Residents reported no complaints or concerns related to receiving adequate medical treatment. Residents reported a knowledge of how to voice grievances, who to report to, and expressed no fear of retaliation.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read "Julie Edmiaston RN, BSN". The signature is fluid and cursive, with a large initial "J" and "E".

Julie Edmiaston RN, BSN

Date report completed: 05/10/2022

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Canoe Brook Ardmore
Address: 2215 4th Avenue NW
City, State, Zip: Ardmore, OK 73401, Carter
Provider #: AL1003
Complaint #: #OK00058731
Investigation Date(s): 05/03/22 through 05/05/22

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The facility has failed to provide a safe environment for residents.	S
2. The facility failed to provide housekeeping services to maintain an environment that does not have offensive odors.	US
3. The facility has failed to have an administrator for over a month.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 05/03/2022 at 10:45 a.m.

A sample of three 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 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-1304 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to housekeeping services and odor free environment was investigated.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Housekeeping schedules were reviewed and documented specific apartments to be cleaned each day. Written instructions were provided at the entrance to the center to sanitize hands and a sanitizer dispenser was observed at the front entrance.

Upon entrance to the center a tour was conducted. The housekeeping staff was observed cleaning apartments. Apartment #28 was under remodel and no strong offensive odor was detected in the apartment. The apartment's original carpeting was still in the apartment and no urine odor was detected. There were no odors detected in hallways or common areas of the center. Resident apartments were clean and free of odors.

Residents voiced no complaints or concerns related to housekeeping. The housekeeper reported she had no apartments which required daily housekeeping but did follow a cleaning schedule.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-0930 for details.

Determination Summary and Follow-Up Action:

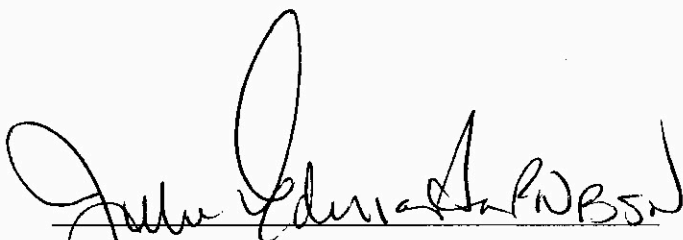
Deficient practice was substantiated for allegation #1 and #3. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Julie Edmiaston RN, BSN

Date report completed: 05/10/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER CANOE BROOK ARDMORE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS Complaint investigations (#OK00058731, OK00057310, and #OK00055774) were conducted on 05/03/22 through 05/05/22. Listed below are abbreviations that will be used throughout this document. CNA/MAT - Certified Nurse Aide/Medication Administration Technician DM II - Diabetes Mellitus ED - Executive Director ER - Extended Release FSBS - Finger Stick Blood Sugar G - Good IJ - Immediate Jeopardy MAR - Medication Administration Record MG - Milligrams OSDH - Oklahoma State Department of Health Res - Resident SE - Southeast Tab - Tablet X - Times	C 000		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions;	C 911		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
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C 911	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide qualified staff to administer FSBS for one (#7) of three sampled residents for blood glucose monitoring. Findings: The acting Executive Director (ED) identified four residents with blood glucose monitoring who resided at the center. An "Annual Assessment," dated 02/14/22, read in parts, "...Alert x 3, Judgment: G, ...Diagnosis: Parkinson's..." The assessment did not mention FSBS's. The special treatment portion of the assessment was left blank and no mention of a diagnosis for diabetes. A "Physician's Order," dated 03/31/22, read in parts, "...Check FSBS daily before breakfast at 6 AM... Glipizide ER [anti-diabetic medication] Tab 5 mg take one tablet by mouth daily..." The physician orders contained no order to self-administer the FSBS and were signed by the physician on 04/08/22. On 05/03/22 at 1:00 p.m., the acting ED was asked who performed the blood glucose monitoring at the center. She stated they had four residents who required FSBS's and they administered their own FSBS's and/or insulin. On 05/05/22 at 9:50 a.m., CNA/MAT #11 was	C 911		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
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C 911	Continued From page 2 asked about Res #7's FSBS. She stated night shift did it. She reported the resident did not perform his own FSBS. On 05/05/22 at 9:55 a.m., Res #7 was asked who performed their FSBS. The resident stated, "The aides do it. I shake too much, I can't do it." On 05/05/22 at 10:00 a.m., the acting ED was asked who performed Res #7's FSBS. She reported the resident did their own FSBS. The ED was informed Res #7 had reported the aides performed the FSBS. The ED stated, "I know [Res #7] shakes real bad, but they just help." She was asked if the staff who had initialed Res #7's FSBS on the MAR for May 2022 were qualified to perform blood glucose monitoring and she stated, "no." She stated Res #7 had a diagnosis of diabetes but she did not see it in the physician orders or in the assessment.	C 911		
C 930 SS=E	310:663-9-3(1-3) STAFF QUALIFICATIONS Each assisted living center shall designate an administrator responsible for the operation of the assisted living center. The administrator shall hold at least one (1) of the following credentials: (1) a license issued by the State Board of Examiners for Nursing Home Administrators; or (2) a residential care home administrator's certificate of training from an institution of higher learning whose program has been reviewed by the Department; or (3) a nationally recognized assisted living certificate of training and competency for assisted living administrators that has been reviewed and approved by the Department.	C 930		

Oklahoma State Department of Health

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C 930	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the center failed to have the known licensed Administrator/Executive Director on file at the Oklahoma State Department of Health (OSDH). Findings: The acting Executive Director (ED) identified 36 residents resided at the center. A "Designation of Administrative Responsibility and Manager on Duty" policy, dated 11/2016, read in parts, "...The Company shall employ an Executive Director who has completed the training requirements pursuant to state law...A current and valid copy of applicable licenses and certifications of the Executive Director shall be inserted into this manual immediately following this policy..." On 05/03/22 at 10:45 a.m., the acting ED was asked who was the Executive Director and/or Administrator on file for the center. She reported ED #1 should be the ED on file. She was asked how long ED #1 had been at the center, and reported since March 2022. The acting ED stated she was attending class to be the ED and would graduate in June 2022. On 05/04/22 at 6:35 p.m., the Chief Operating Officer was asked if ED #1 was on file with the OSDH. She stated he said he had notified the	C 930		

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: AL1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
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C1304	Continued From page 5 phone and entered the center again to ask for a ride. The unauthorized person gained access to the center after normal business hours. On 05/04/22 at 4:27 p.m., the acting Executive Director and Chief Operating Officer submitted a plan of removal. The plan of removal was not accepted. On 05/04/22 at 6:06 p.m., the acting Executive Director and Chief Operating Officer submitted a second plan of removal. On 05/04/22 at 7:00 p.m., the second plan of removal was accepted. The plan of removal documented the following: "Ardmore Assisted Living Plan of Removal 5.4.22 * Door handle with lock on front door was replaced 05.03.22 at 6:00 p.m. * Executive Director [acting] began in servicing all direct care staff members the lock on the front door has been replaced, and on the policy and procedure of locking doors at dusk and unlocking at dawn. The east medication aide is responsible to ensure the doors are locked nightly. The in service included the southeast exit door locking by removing the pin/screw, and informing when the screw/pin is inserted the door is unlocked. A sign-off sheet will be used to log this task. In servicing began 05.04.22 at 9:29 a.m., and will be complete by 05.04.22 at 11:00 p.m. * Executive Director [acting] to monitor the sign-off sheet to ensure the doors are locked timely." Based on record review, observation, and interview, the center failed to lock the front door entrance at dusk, as outlined per the center's	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
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C1304	Continued From page 6 contract, and failed to instruct staff when and how to secure the entrances to the center to ensure the safety of all residents who resided at the center. Findings: The acting Executive Director identified 36 residents who resided at the center. A "Door locking procedure," dated 05/04/22, read in parts, " ...The front door locks by turning the lock from the inside to the right/horizontal. It will unlock when someone exits and will need to be relocked [sic]. The southeast door is locked when the push bar is out. This occurs when the screw/pin is removed from the top of the bar. It is unlocked when the push bar is pushed in and the screw/pin is inserted, which keeps the bar inserted and unlocked." The Center's resident contract, not dated, read in parts, " ...Your safety and security are a primary consideration in the design of this Community. From dusk until 6:00 a.m., all public entrances are locked; therefore, entry will be monitored via Canoe Brook Assisted Living Staff ..." An "Introduction" form, not dated, read in parts, "...This Handbook has been prepared to assist and familiarize Residents with the various services and activities available at Canoe Brook Assisted Living. The handbook is also intended to provide direction and information regarding the various policies and procedures and are part of your Resident Service Agreement. The policies and procedures contained in this manual are subject to change from time to time. Residents will be notified when changes are required..."	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER CANOE BROOK ARDMORE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1304	Continued From page 7 On 05/03/22 at 11:22 a.m., during a confidential resident interview, concerns were voiced about the key lock at the front entrance which was broken and the center was not being locked at night. On 05/03/22 at 11:35 a.m., the acting Executive Director and the Administrator from a sister company was asked to submit policy/procedure and/or documentation related to the center's doors being locked at night. She stated she would look for it. On 05/03/22 at 12:10 p.m., the acting Executive Director was asked if the center's doors were locked every night. She stated, "They lock the doors at 11:00 p.m." She stated they locked the front door entrance and the side door [SE entrance door]. She was asked about an incident that occurred on April 30, 2022. She reported they had someone in the parking lot walking around and was acting "high," so they called the police and they came and got him. She was asked if the man had entered the center. She reported no, because the center was locked. She was asked if she submitted an incident report to the Oklahoma State Department of Health and she stated, "no." On 05/03/22 at 12:10 p.m., the acting Executive Director was asked about the center's SE door. She stated there was a screw in the SE door so the door would not lock and the residents could enter and exit freely to take their dogs out. She was asked if the door was locked at night and she stated, "yes." On 05/03/22 at 12:20 p.m., the acting Executive Director was asked to demonstrate how the lock on the front door entrance worked. The push	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
NAME OF PROVIDER OR SUPPLIER CANOE BROOK ARDMORE		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1304	Continued From page 8 button portion [inside key lock] on the inside of the door lock was observed to be missing. She stated, the "inside key lock is missing." She reported you would need to put your finger inside the hole to lock it or unlock it, or push the handle down from inside and it released. She stated maintenance was in the process of repairing it when he was terminated on 04/20/22. On 05/03/22 at 12:52 p.m., CMA #12 was asked about the screw that was placed in the push bar on the SE door. She reported she didn't know anything about it. On 05/03/22 at 1:00 p.m., CNA/MAT #7, a night shift employee, was notified via telephone and asked if the center was secure and locked at night. She reported if the front door was locked it was secure. She was asked if she locked the center's front door at night. She stated, "I don't think the front door locks." She stated, "I don't think the lock works." She was asked when she received her training, did it include to lock and secure the center's entrances. She stated, "no, but there's no lock that works on the front entrance door." She was asked if she had reported the front door entrance lock was not functioning. She stated she did not recall when she had reported it to the acting Executive Director. She was asked about an incident when someone entered the center after hours. She stated a man came in and asked to use the phone and came back in to ask for a ride. She stated she could tell he was incapacitated, so she called the police. She stated the police came and told him to go away. She stated the police asked if she wanted to file trespassing charges and she said no. She was asked if the center's front entrance door was locked that night and she reported it was not. She was asked if center was	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
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C1304	Continued From page 9 supposed to be locked. She stated, "I think it should be locked, but how could you lock it if we do not have one." She stated the center did not have a maintenance man right now to fix the lock. She was asked if she had completed an incident report or been asked to complete an incident report and she reported she had not. She was asked if she notified the acting Administrator an unauthorized person had entered the building. She stated, "Yes I did." She was asked who she had notified and she reported she told the acting Executive Director. On 05/03/22 at 1:10 p.m., the acting Executive Director stated she did not remember the staff telling her someone came in the building and she stated all she knew was someone was in the parking lot and was "high" [under the influence]. On 05/03/22 at 2:22 p.m., CMA #3 was asked what time she had been instructed to lock the center at night. She stated, "eight o'clock." She was asked about the lock on the front door. She stated it had been broken for about two weeks, ever since the maintenance man left. CMA #2 was asked when she locked the front entrance door at night, and she reported between 8:00 p.m. or 9:00 p.m. She stated the front entrance door had not been getting locked because it was broken. On 05/03/22 at 2:25 p.m., CNA/MAT #1 was asked about the actual key for the front entrance door. She checked both sets of the medication cart keys and stated, "It is not on ours." On 05/03/22 at 4:43 p.m., the Administrator from a sister company located the above documentation from the contract related to when the center should lock the doors at night. She	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
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C1304	Continued From page 10 stated the contract and the handbook were both provided to the resident at the time of admission. She reported the lock would be fixed immediately. On 05/05/22 at 9:30 a.m., CNA/MAT #11 and CMA # 13 were asked if they had been in-serviced related to the policy for locking the SE door entrance at night. They both replied, "yes." They reported they had been in-serviced related to the repair made to the front entrance door lock and when to lock it. . On 05/05/22 at 9:33 a.m., CMA #12 and a new employee #18 were asked if they had been in-serviced related to the policy for locking the SE door entrance at night. They both replied, "yes," and reported they had been in-serviced related to the repair made to the front entrance door lock.	C1304		

Delivery via email to: 'dreed@oxfordseniorliving.com'

May 31, 2022

License Number: AL1003
Survey Event ID: 1DBD11

Mr. Delbert Reed, Administrator
Canoe Brook Ardmore
2215 4th Avenue Nw
Ardmore, OK 73401

Dear Mr. Reed:

On **May 5, 2022**, agents from our office concluded an investigation at your facility. You were advised of the findings of that investigation in our notice of **May 26, 2022**.

The original 2567-STATE FORM report was revised during administrative review of this case on **May 31, 2022**. A copy of the corrected/AMENDED 2567-STATE FORM report is included. Deficiencies identified during the investigation are not affected by these corrections but a plan of correction is required for this Amended FORM. The corrected investigation 2567- STATE FORM report is being provided for your records. Please complete a plan of correction response to this Amended statement of deficiencies (2567-STATE FORM).

If we can be of any further assistance, please contact us at 405-426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Canoe Brook Ardmore
Address: 2215 4th Avenue NW
City, State, Zip: Ardmore, OK 73401, Carter
Provider #: AL1003
Complaint #: #OK00055774
Investigation Date(s): 05/03/22 through 05/05/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide medical services according to accepted standards.	S
2. The center failed to practice required infection control practice procedures.	US

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 05/03/2022 at 10:45 a.m.

A sample of three 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 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-0911 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to practicing required infection control procedures was conducted.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Infection control logs were reviewed. Upon entrance to the center, instructions were posted to check in, sanitize hands, wear a mask, and encouraged social distancing of 3-6 feet during visitation. A sign was posted at the front entrance to wear a mask at all times. A station was set up at the front entrance to monitor temperature, answer Covid-19 related questions, and masks were made available at the front entrance.

Staff members were observed wearing masks and performing hand washing between residents. The kitchen staff was observed with hair nets and wearing gloves. A sanitation dispenser was provided at the front entrance with instructions to sanitize your hands when entering the center. Sanitation was provided on the medication carts and was used by staff. Staff verbalized the procedure to sanitize hands between residents and to wash hands with soap and water after three residents

The acting Executive Director submitted the CLIA license in her name with an expiration date of 01/07/23. She submitted documentation for the infection preventionist training she received on 07/30/20. She reported the center had PPE to include face shields, foot coverings, gowns, KN-95 masks, and gloves. Residents interviewed verbalized no concerns or complaints related to infection control. Facility staff reported all residents except one had been vaccinated.

Determination Summary and Follow-Up Action:

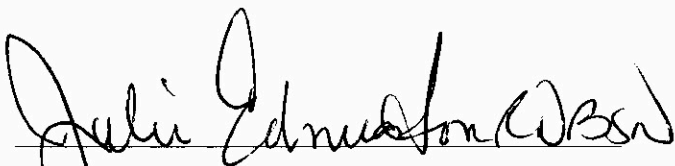
Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Julie Edmiaston RN, BSN

Date report completed: 05/10/2022

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Canoe Brook Ardmore
Address: 2215 4th Avenue NW
City, State, Zip: Ardmore, OK 73401, Carter
Provider #: AL1003
Complaint #: #OK00057310
Investigation Date(s): 05/03/22 through 05/05/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were provided adequate medical treatment, and failed to provide an environment where grievances could be voiced without fear of retaliation.	US

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 05/03/2022 at 10:45 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to adequate medical treatment and providing an environment where grievances could be voiced without fear of retaliation was conducted.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Two resident council meeting minutes were submitted for March 2022 and April 2022. The council minutes documented various grievances with solutions and some with ongoing solutions. Grievance logs and facility policies were reviewed.

Upon entrance to the center and throughout the survey, staff members were observed to interact with residents in a kind and respectful manner. Residents were observed during various activities including Bingo, nail polishing station, and puzzles were observed in the common area. Residents were observed to be treated with dignity and respect.

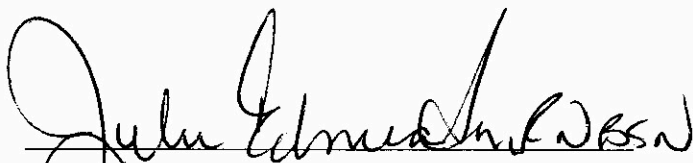
A family member, sampled residents, and numerous other residents voiced compliments related to the activity director and services provided. The center's former Administrator was no longer employed at the center and the center had an acting Executive Director in place. Residents reported no complaints or concerns related to receiving adequate medical treatment. Residents reported a knowledge of how to voice grievances, who to report to, and expressed no fear of retaliation.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read "Julie Edmiaston RN, BSN". The signature is fluid and cursive, with a large initial "J" and "E".

Julie Edmiaston RN, BSN

Date report completed: 05/10/2022

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Canoe Brook Ardmore
Address: 2215 4th Avenue NW
City, State, Zip: Ardmore, OK 73401, Carter
Provider #: AL1003
Complaint #: #OK00058731
Investigation Date(s): 05/03/22 through 05/05/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility has failed to provide a safe environment for residents.	S
2. The facility failed to provide housekeeping services to maintain an environment that does not have offensive odors.	US
3. The facility has failed to have an administrator for over a month.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 05/03/2022 at 10:45 a.m.

A sample of three 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 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-1304 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to housekeeping services and odor free environment was investigated.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Housekeeping schedules were reviewed and documented specific apartments to be cleaned each day. Written instructions were provided at the entrance to the center to sanitize hands and a sanitizer dispenser was observed at the front entrance.

Upon entrance to the center a tour was conducted. The housekeeping staff was observed cleaning apartments. Apartment #28 was under remodel and no strong offensive odor was detected in the apartment. The apartment's original carpeting was still in the apartment and no urine odor was detected. There were no odors detected in hallways or common areas of the center. Resident apartments were clean and free of odors.

Residents voiced no complaints or concerns related to housekeeping. The housekeeper reported she had no apartments which required daily housekeeping but did follow a cleaning schedule.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-0930 for details.

Determination Summary and Follow-Up Action:

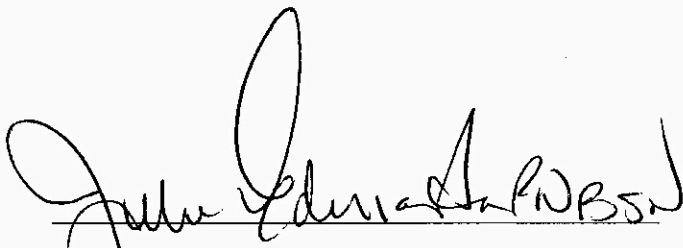
Deficient practice was substantiated for allegation #1 and #3. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Julie Edmiaston RN, BSN

Date report completed: 05/10/2022

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS Complaint investigations (#OK00058731, OK00057310, and #OK00055774) were conducted on 05/03/22 through 05/05/22. Listed below are abbreviations that will be used throughout this document. CNA/MAT - Certified Nurse Aide/Medication Administration Technician DM II - Diabetes Mellitus ED - Executive Director ER - Extended Release FSBS - Finger Stick Blood Sugar G - Good IJ - Immediate Jeopardy MAR - Medication Administration Record MG - Milligrams OSDH - Oklahoma State Department of Health Res - Resident SE - Southeast Tab - Tablet X - Times An administrative review was conducted on 5/31/2022, and the 2567 was amended at this time to include the plan of removal date.	C 000		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled	C 911		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
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C 911	Continued From page 1 nursing interventions; This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide qualified staff to administer FSBS for one (#7) of three sampled residents for blood glucose monitoring. Findings: The acting Executive Director (ED) identified four residents with blood glucose monitoring who resided at the center. An "Annual Assessment," dated 02/14/22, read in parts, "...Alert x 3, Judgment: G, ...Diagnosis: Parkinson's..." The assessment did not mention FSBS's. The special treatment portion of the assessment was left blank and no mention of a diagnosis for diabetes. A "Physician's Order," dated 03/31/22, read in parts, "...Check FSBS daily before breakfast at 6 AM... Glipizide ER [anti-diabetic medication] Tab 5 mg take one tablet by mouth daily..." The physician orders contained no order to self-administer the FSBS and were signed by the physician on 04/08/22. On 05/03/22 at 1:00 p.m., the acting ED was asked who performed the blood glucose monitoring at the center. She stated they had	C 911		

Oklahoma State Department of Health

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C 911	Continued From page 2 four residents who required FSBS's and they administered their own FSBS's and/or insulin. On 05/05/22 at 9:50 a.m., CNA/MAT #11 was asked about Res #7's FSBS. She stated night shift did it. She reported the resident did not perform his own FSBS. On 05/05/22 at 9:55 a.m., Res #7 was asked who performed their FSBS. The resident stated, "The aides do it. I shake too much, I can't do it." On 05/05/22 at 10:00 a.m., the acting ED was asked who performed Res #7's FSBS. She reported the resident did their own FSBS. The ED was informed Res #7 had reported the aides performed the FSBS. The ED stated, "I know [Res #7] shakes real bad, but they just help." She was asked if the staff who had initialed Res #7's FSBS on the MAR for May 2022 were qualified to perform blood glucose monitoring and she stated, "no." She stated Res #7 had a diagnosis of diabetes but she did not see it in the physician orders or in the assessment.	C 911		
C 930 SS=E	310:663-9-3(1-3) STAFF QUALIFICATIONS Each assisted living center shall designate an administrator responsible for the operation of the assisted living center. The administrator shall hold at least one (1) of the following credentials: (1) a license issued by the State Board of Examiners for Nursing Home Administrators; or (2) a residential care home administrator's certificate of training from an institution of higher learning whose program has been reviewed by the Department; or (3) a nationally recognized assisted living certificate of training and competency for assisted	C 930		

Oklahoma State Department of Health

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C 930	Continued From page 3 living administrators that has been reviewed and approved by the Department. This Rule is not met as evidenced by: Based on record review and interview, the center failed to have the known licensed Administrator/Executive Director on file at the Oklahoma State Department of Health (OSDH). Findings: The acting Executive Director (ED) identified 36 residents resided at the center. A "Designation of Administrative Responsibility and Manager on Duty" policy, dated 11/2016, read in parts, "...The Company shall employ an Executive Director who has completed the training requirements pursuant to state law...A current and valid copy of applicable licenses and certifications of the Executive Director shall be inserted into this manual immediately following this policy..." On 05/03/22 at 10:45 a.m., the acting ED was asked who was the Executive Director and/or Administrator on file for the center. She reported ED #1 should be the ED on file. She was asked how long ED #1 had been at the center, and reported since March 2022. The acting ED stated she was attending class to be the ED and would graduate in June 2022.	C 930		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2022
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C 930	Continued From page 4 On 05/04/22 at 6:35 p.m., the Chief Operating Officer was asked if ED #1 was on file with the OSDH. She stated he said he had notified the State, but she had not verified that. OSDH records did not record ED #1 as the licensed Administrator/Executive Director.	C 930		
C1304 SS=L	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: On 05/04/22 at 3:43 p.m., an Immediate Jeopardy (IJ) situation was determined to exist when the center failed to lock the center after normal business hours, as outlined in the resident contract, and an unauthorized person was allowed to enter the center. At 3:58 p.m., the Oklahoma State Department of Health (OSDH) verified the existence of the IJ	C1304		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER CANOE BROOK ARDMORE		STREET ADDRESS, CITY, STATE, ZIP CODE 2215 4TH AVENUE NW ARDMORE, OK 73401		
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C1304	Continued From page 5 situation. The acting Executive Director and Chief Operating Officer was notified of the IJ situation when on April 30, 2022, an unauthorized person entered the center once to ask to use the phone and entered the center again to ask for a ride. The unauthorized person gained access to the center after normal business hours. On 05/04/22 at 4:27 p.m., the acting Executive Director and Chief Operating Officer submitted a plan of removal. The plan of removal was not accepted. On 05/04/22 at 6:06 p.m., the acting Executive Director and Chief Operating Officer submitted a second plan of removal. On 05/04/22 at 7:00 p.m., the second plan of removal was accepted. The plan of removal documented the following: "Ardmore Assisted Living Plan of Removal 5.4.22 * Door handle with lock on front door was replaced 05.03.22 at 6:00 p.m. * Executive Director [acting] began in servicing all direct care staff members the lock on the front door has been replaced, and on the policy and procedure of locking doors at dusk and unlocking at dawn. The east medication aide is responsible to ensure the doors are locked nightly. The in service included the southeast exit door locking by removing the pin/screw, and informing when the screw/pin is inserted the door is unlocked. A sign-off sheet will be used to log this task. In servicing began 05.04.22 at 9:29 a.m., and will be complete by 05.04.22 at 11:00 p.m. * Executive Director [acting] to monitor the sign-off sheet to ensure the doors are locked timely."	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 6 On 05/04/22 at 11:00 p.m., the IJ immediacy was removed, effective 05/04/22 at 11:00 p.m., when all components of the plan of removal had been completed. The deficiency remained at a level of widespread with the potential for more than minimal harm. Based on record review, observation, and interview, the center failed to lock the front door entrance at dusk, as outlined per the center's contract, and failed to instruct staff when and how to secure the entrances to the center to ensure the safety of all residents who resided at the center. Findings: The acting Executive Director identified 36 residents who resided at the center. A "Door locking procedure," dated 05/04/22, read in parts, " ...The front door locks by turning the lock from the inside to the right/horizontal. It will unlock when someone exits and will need to be relocked [sic]. The southeast door is locked when the push bar is out. This occurs when the screw/pin is removed from the top of the bar. It is unlocked when the push bar is pushed in and the screw/pin is inserted, which keeps the bar inserted and unlocked." The Center's resident contract, not dated, read in parts, " ...Your safety and security are a primary consideration in the design of this Community. From dusk until 6:00 a.m., all public entrances are locked; therefore, entry will be monitored via Canoe Brook Assisted Living Staff ..." An "Introduction" form, not dated, read in parts,	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 7 "...This Handbook has been prepared to assist and familiarize Residents with the various services and activities available at Canoe Brook Assisted Living. The handbook is also intended to provide direction and information regarding the various policies and procedures and are part of your Resident Service Agreement. The policies and procedures contained in this manual are subject to change from time to time. Residents will be notified when changes are required..." On 05/03/22 at 11:22 a.m., during a confidential resident interview, concerns were voiced about the key lock at the front entrance which was broken and the center was not being locked at night. On 05/03/22 at 11:35 a.m., the acting Executive Director and the Administrator from a sister company was asked to submit policy/procedure and/or documentation related to the center's doors being locked at night. She stated she would look for it. On 05/03/22 at 12:10 p.m., the acting Executive Director was asked if the center's doors were locked every night. She stated, "They lock the doors at 11:00 p.m." She stated they locked the front door entrance and the side door [SE entrance door]. She was asked about an incident that occurred on April 30, 2022. She reported they had someone in the parking lot walking around and was acting "high," so they called the police and they came and got him. She was asked if the man had entered the center. She reported no, because the center was locked. She was asked if she submitted an incident report to the Oklahoma State Department of Health and she stated, "no."	C1304		

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C1304	Continued From page 8 On 05/03/22 at 12:10 p.m., the acting Executive Director was asked about the center's SE door. She stated there was a screw in the SE door so the door would not lock and the residents could enter and exit freely to take their dogs out. She was asked if the door was locked at night and she stated, "yes." On 05/03/22 at 12:20 p.m., the acting Executive Director was asked to demonstrate how the lock on the front door entrance worked. The push button portion [inside key lock] on the inside of the door lock was observed to be missing. She stated, the "inside key lock is missing." She reported you would need to put your finger inside the hole to lock it or unlock it, or push the handle down from inside and it released. She stated maintenance was in the process of repairing it when he was terminated on 04/20/22. On 05/03/22 at 12:52 p.m., CMA #12 was asked about the screw that was placed in the push bar on the SE door. She reported she didn't know anything about it. On 05/03/22 at 1:00 p.m., CNA/MAT #7, a night shift employee, was notified via telephone and asked if the center was secure and locked at night. She reported if the front door was locked it was secure. She was asked if she locked the center's front door at night. She stated, "I don't think the front door locks." She stated, "I don't think the lock works." She was asked when she received her training, did it include to lock and secure the center's entrances. She stated, "no, but there's no lock that works on the front entrance door." She was asked if she had reported the front door entrance lock was not functioning. She stated she did not recall when she had reported it to the acting Executive	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 9 Director. She was asked about an incident when someone entered the center after hours. She stated a man came in and asked to use the phone and came back in to ask for a ride. She stated she could tell he was incapacitated, so she called the police. She stated the police came and told him to go away. She stated the police asked if she wanted to file trespassing charges and she said no. She was asked if the center's front entrance door was locked that night and she reported it was not. She was asked if center was supposed to be locked. She stated, "I think it should be locked, but how could you lock it if we do not have one." She stated the center did not have a maintenance man right now to fix the lock. She was asked if she had completed an incident report or been asked to complete an incident report and she reported she had not. She was asked if she notified the acting Administrator an unauthorized person had entered the building. She stated, "Yes I did." She was asked who she had notified and she reported she told the acting Executive Director. On 05/03/22 at 1:10 p.m., the acting Executive Director stated she did not remember the staff telling her someone came in the building and she stated all she knew was someone was in the parking lot and was "high" [under the influence]. On 05/03/22 at 2:22 p.m., CMA #3 was asked what time she had been instructed to lock the center at night. She stated, "eight o'clock." She was asked about the lock on the front door. She stated it had been broken for about two weeks, ever since the maintenance man left. CMA #2 was asked when she locked the front entrance door at night, and she reported between 8:00 p.m. or 9:00 p.m. She stated the front entrance door had not been getting locked because it was	C1304		

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C1304	Continued From page 10 broken. On 05/03/22 at 2:25 p.m., CNA/MAT #1 was asked about the actual key for the front entrance door. She checked both sets of the medication cart keys and stated, "It is not on ours." On 05/03/22 at 4:43 p.m., the Administrator from a sister company located the above documentation from the contract related to when the center should lock the doors at night. She stated the contract and the handbook were both provided to the resident at the time of admission. She reported the lock would be fixed immediately. On 05/05/22 at 9:30 a.m., CNA/MAT #11 and CMA # 13 were asked if they had been in-serviced related to the policy for locking the SE door entrance at night. They both replied, "yes." They reported they had been in-serviced related to the repair made to the front entrance door lock and when to lock it. . On 05/05/22 at 9:33 a.m., CMA #12 and a new employee #18 were asked if they had been in-serviced related to the policy for locking the SE door entrance at night. They both replied, "yes," and reported they had been in-serviced related to the repair made to the front entrance door lock.	C1304		