OKLAHOMA
State Department
of Health

Delivery via email to: TWilkerson@canoebrookal.com

April 12, 2023

License Number: AL1003

Ms. Terry Wilkerson, Administrator
Canoe Brook Ardmore
2215 4th Avenue NW
Ardmore, OK 73401

RE: Survey Event ID: U3M311

Dear Ms. Wilkerson:

On **April 6, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **April 6, 2023**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;

(2) Address how other residents with the potential to be affected will be identified;

(3) Address measures or systemic changes to ensure the deficiency will not recur;

(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;

(5) Include dates when corrective action and monitoring will be completed for each violation;

(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may

be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1003	A. BUILDING: _____ B. WING _____	04/06/2023

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 000	INITIAL COMMENTS A re-licensure survey was conducted from 04/04/23 through 04/06/23.	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the center failed to maintain the kitchen in accordance with Chapter 257 Food Service Establishment Regulations to: a) ensure cleaning and sanitation of the kitchen to prevent contamination of the kitchen; b) ensure the handwashing station was stocked with a functional soap dispenser; c) ensure utensils/scoops were not stored with the handles touching the contents in the sugar bin; d) ensure the food was cooked to the desired time/temperature control; and, e) ensure receptacles and waste handling units for refuse be kept covered; The Administrator reported 36 residents resided in the center and who receive nutrition from the kitchen. Findings:	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 391	Continued From page 1 1.) "...310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (a)...Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris..." On 04/04/23 at 2:50 p.m., a tour of the kitchen was initiated with cook #1. They were asked about the particles stuck on the side of refrigerator. They stated they saw the particles, and started to scrub it with a dish cloth and Dawn soap and it started to come off. They were asked about the sugar container. They stated the lid and the outside of the container was dirty. On 04/04/23 at 2:50 p.m., cook #2 was asked to submit cleaning logs. They reported they did not have any cleaning logs. On 04/04/23 at 3:00 p.m., the Administrator was asked to tour kitchen. They stated everything needed to be cleaned once a month and that would be required. 2.) "...310:257-3-13. Where to wash...Food employees shall clean their hands in a handwashing lavatory or approved automatic handwashing facility and may not clean their hands in a sink used for food preparation or ware washing, or in a service sink or a curbed cleaning facility used for the disposal of mop water and similar liquid waste..." On 04/04/23 at 2:50 p.m., the handwashing station located inside of the kitchen was observed	C 391		

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C 391	Continued From page 2	C 391		

to be broken on the outside. Cook #2 was asked about the soap dispenser in the handwashing station. They stated it was broken and they had to hold it up while you push the button to release the soap.

3.) "...310:257-5-31. In-use utensils, between-use storage
During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: (1) Except as specified under (2) of this Section, in the food with their handles above the top of the food and the container; (2) In food that is not Time/Temperature Control for Safety Food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon..."

On 04/04/23 at 2:50 p.m., cook #1 was asked if they should leave scoops inside of the sugar container. They stated, no, the scoop should not be left in the container.

4) "...310:257-5-9. Temperature
(d) Time/Temperature Control for Safety Food that is cooked to a temperature and for a time specified under OAC 310:257-5-46 through 310:257-5-48 and received hot shall be at a temperature of 57°C (135°F) or above..."

"...310:257-7-56. Food temperature measuring devices...(a) Food temperature measuring devices shall be provided and readily accessible for use in
ensuring attainment and maintenance of food temperatures as specified under Subchapter 5.
(b) A temperature measuring device with a suitable small-diameter probe that is designed to measure the temperature of thin masses shall be provided and readily accessible to accurately

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C 391	Continued From page 3 measure the temperature in thin foods such as meat patties and fish filets..." On 04/04/23 at 2:50 p.m., cook #1 was asked to submit food temperatures recorded from breakfast that morning. They stated they had not recorded any food temperatures this year and did not know anything about doing them. They did have a thermometer, but had not been shown anything about checking food temperatures. 5) 310:257-9-67. Covering receptacles. Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (1) Inside the food establishment if the receptacles and units: (A) Contain food residue and are not in continuous use; or (B) After they are filled; and (2) With tight-fitting lids or doors if kept outside the food establishment..." On 04/04/23 at 2:50 p.m., during the kitchen tour a trash can was observed without a lid next to the prep table. Cook #1 was asked about the lid for the trash can. They stated they had never had a lid for the trash can.	C 391		
C1304 SS=D	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.	C1304		

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C1304	Continued From page 4	C1304		

This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and interview, the center failed to inform one (#9) of one sampled pet owner at the center to obtain vaccinations for the dog as required in the center's contract. Findings:

Findings:

The Administrator identified two other residents with animals who resided in the center.

A "Certificate of Vaccination" for resident #9's dog, dated 01/19/22, documented in part..."...rabies 1 year..."

On 04/06/23 at 10:40 a.m., the Administrator was asked if resident #9's contract contained the statement, "...Residents must provide current immunization records for all pets at the time of admission and annually thereafter..." The Administrator reported he had read that in the contract and they had taken the dog to be vaccinated (on the day of survey).

Oklahoma State Department of Health

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D 000	INITIAL COMMENTS A re-licensure survey was conducted from 04/04/23 through 04/06/23.	D 000		
D 501 SS=E	317:30-5-763(D)(i)(I) PHYSICAL ENVIRONMENT (I) The ALC must provide lockable doors on the entry door of each unit and a lockable compartment within each member unit for valuables. Member residents must have exclusive rights to their units with lockable doors at the entrance of their individual and/or shared unit except in the case of documented contraindication. Units may be shared only if a request to do so is initiated by the member resident. This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to provide a lockable compartment, within each members unit for valuables, for four (#2, 5, 6, and #11) of five sampled residents required to have a lockable compartment to store valuables. Findings: A "Resident Roster," submitted on 04/04/23, documented 12 advantage waiver residents who resided in the center. On 04/05/23 at 10:00 a.m., resident #6 reported they did not have a lockable compartment and they had bought their own lockable box for valuables. On 04/05/23 at 10:00 a.m., resident #5 reported they did not have a lockable compartment and if they had valuables, they would put them in the	D 501		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 501	Continued From page 1 drawer and cover them up. On 04/06/23 at 8:12 a.m., resident #2 reported they did not have a lock box. They were asked if they would like to have one. They stated they did not have anything valuable. On 04/06/23 at 10:30 a.m., the Administrator was asked if each of the resident contracts contained the statement, "will be provided with one lockable compartment and personal key for valuables locked in their rental unit." The Administrator stated, yes, but they were not aware the units did not have a lockable compartment. On 04/06/23 at 11:55 a.m., resident #11 reported they did not have a lock box, did not have any valuables, but if they did they would give them to their daughter.	D 501		
D 582 SS=D	317:30-5-763(D)(v)(II) STAFF TRAINING AND QUALIFICATIONS (II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by the Oklahoma Department of Health; This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to obtain food service training program for one (#1) of one sampled cook who prepared and provided meals to 36 residents who received food from the kitchen. Findings: A "Resident Roster," submitted on 04/04/23, documented 36 residents who resided in the	D 582		

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 _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 582	Continued From page 2 center and received food from the kitchen. On 04/04/23 at 2:50 p.m., cook #1 was asked to submit food temperatures recorded from breakfast that morning. They stated they had not recorded any food temperatures this year and did not know anything about doing them. They were asked if they received food service training and stated they had not. They did have a thermometer, but had not been shown anything about checking food temperatures. On 04/04/23 at 3:00 p.m., the Administrator was asked if cook #1 had food service training. The Administrator reported they had asked them to go on-line and they were supposed to have signed up for the training.	D 582		

OKLAHOMA
State Department
of Health

Delivery via email to: TWilkerson@canoebrookal.com

April 27, 2023

License Number: AL1003

Mr. Terry Wilkerson, Executive Director
Canoe Brook Ardmore
2215 4th Avenue NW
Ardmore, OK 73401

RE: Survey Event U3M311

Dear Mr. Wilkerson:

On **April 6, 2023**, 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 **May 26, 2023**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2023.04.27 10:49:38 -05'00'

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department 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: 4/21/2023** **Facility Name:** Canoe Brook Ardmore AL **License Number:** 1003 **Survey Event ID:** U3M311 **Date Survey Completed: 4/6/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: record review and observationand center failed to maintain kitchen in accordance with Chapter257 Food service establishmentRegulationsto:

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herin. To remain in compliance with all federal and state regulations, the community has taken , or is planning to take , the actions set forth in the following plan of correction constitutes the center's allegation of compliance.

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?	The community will ensure that all appropriate cleaning and sanitizing protocols will be followed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents will be identified by the community census.
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?	The community has replaced the soap dispenser. The community will in- service all dietary staff on cleaning and sanitizing procedures for all surfaces . The Dietary Director will complete a daily check of Bins to ensure scoops are not left in the bins and stored appropriately when not in use. All dietary staff will be in-serviced on appropriate use of the scoops. Staff will utilize the food measuring thermometers provided to insure time/tempertures are correct for all the food. All dietary staff will be in-serviced on proper use of the thermometers. A new waste receptacle has been purchased with a lid. Dietary staff will be in-serviced proper use of waste receptacle.
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.	Temperature logs will be utilized by all dietary staff to insure food is cooked to appropriate tempertures. The Dietary Director will monitor the logs on a daily basis for thirty days and then on a random basis monthly.The dietary staff will utilize cleaning logs to insure cleaning and sanitizing are done. The Dietary Manager will monitor the cleaning logs daily for thirty days and the monthly on a random basis.

	The results of the reviews will be discussed in quarterly QA meeting The results of the review will be noted in the quartley QA notes
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/26/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	**Date 4/21/2023**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	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: 4/21/2023** **Facility Name:** Canoe Bok Ardmore AL **License Number:** 1003 **Survey Event ID:** U3M311 **Date Survey Completed: 4/6/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1304	Based on: Based on record review, observation,and interview,the center failed to inform one (#9) of one sampled pet owner at the centerto obtainvaccinations for the dogas required in the centers contract.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herin. To remain in compliance with all federal and state regulations, the community has taken , or is planning to take , the actions set forth in the following plan of correction constitutes the center's allegation of compliance.

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?	The residents dog was vaccinated as is required in the resident contract
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A review of all residents apartments indicated that two other residents have pets.
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?	The Business Office Manger and Executive Director have been in-serviced on the communities contract regarding pets allowed to live in the community. All residents pet records will be reviewed at the time of move in and on an annual basis as determined by the vaccination record submitted.
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.	A log of the residents with pets will created by the Business manger with the dates of the vaccinations. The log will be reviewed monthly by the Executive Director. The results of the reviews will be evaulted for effectiveness in the quarterly QA meeting. The results will be discussed in the quarterly QA meeting The reviews will be noted in the quarterly QA notes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/26/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 4/21/2023**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	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: 4/21/2023** **Facility Name:** Canoe Brook Ardmore AL **License Number:** 1003 **Survey Event ID:** U3M311 **Date Survey Completed: 4/6/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: D501	Based on: Based on record review , observation and interview, the center failed to provide a lockable compartment, within each members unit for valuables, for four (#2,5,6 and 11)of five sampled resdidents requiredto have a lockablecompartment to store vauluables.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herin. To remain in compliance with all federal and state regulations, the community has taken , or is planning to take , the actions set forth in the following plan of correction constitutes the center's allegation of compliance.

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?	The identified residents will have locks placed on a cabinet drawer in the apartment they reside in.
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 apartments with residents who are required to have locks will be identified by the community, through a walk through of each apartment.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All residents that are required to have locks will be identified by the Business Office Manager. The Business Office Manager will notify the Maintenance Director of the required installation of a lock. The BOM and DOM will be in-serviced on completing this action.
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.	A monthly review of the POC will be monitored by the Executive Director The results of the reviews will be evauluated for effectiveness in the quarterly QA meeting. The results will be discussed in the quarterly QA meeting The reviews will be noted in the quarterly QA meetings.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/26/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	**Date 4/21/2023**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	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.			

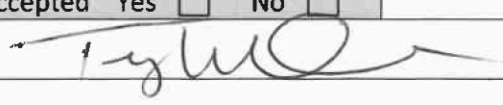
Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/21/2023** **Facility Name:** Canoe Brook Ardmore AL **License Number:** 1003 **Survey Event ID:** U3M311 **Date Survey Completed: 4/6/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: D582	Based on: Based on record review; observation and interview, the center failed to obtain food service training program for one (#1) of the sampled cook who who prepared and provided mealsto 36 residents who received food from the kitchen.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herin. To remain in compliance with all federal and state regulations, the community has taken , or is planning to take , the actions set forth in the following plan of correction constitutes the center's allegation of compliance.

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 cooks will be sent to training for the food training program. All cooks will be trained on the proper use of thermometers. All cooks will receive in-service training on how to use a thermometer appropriately.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents will be identified by the community census roster.
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?	The Dietary Service Manager will monitor food training certification by staff on a monthly basis to ensure training certifications are current. The Dietary Service manager and cooks will be in-serviced on the importance of maintaining the certification. The dietary manager will conduct monthly training reviews of staff for proper thermometer usage. The Dietary Manger will in-service all cooks on use of thermometer.
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.	A monthly review of the certications and of the proper usage of thermometers will be completed by the Dietary Manager. The results of the reviews will be evaluated for effectiveness in the quarterly QA meeting The results will bediscussed in the quarterly QA meeting. The reviews will be noted in the quarterly QA meeting.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/26/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature  OAC 310:663-25-4(F)	**Date** Enter a date of signature.

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

Delivery via email to: TWilkerson@canoebrookal.com

June 14, 2023

License Number: AL1003

Mr. Terry Wilkerson, Administrator
Canoe Brook Ardmore
2215 4th Avenue Nw
Ardmore, OK 73401

RE: Survey Event U3M312

Dear Mr. Wilkerson:

On **June 7, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 6, 2023,** have now been corrected effective **May 26, 2023.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1003	A. BUILDING: _____ B. WING _____	R 06/07/2023

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
{D 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 06/07/23. The facility was in substantial compliance.	{D 000}		
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 06/07/23. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE