
Delivery via email to: TWilkerson@canoebrookal.com

June 17, 2024

License Number: AL1003

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

RE: Survey Event ID: OGMG11

Dear Ms. Wilkerson:

On **May 21, 2024**, agents from our office concluded a State Licensure inspection with a complaint investigation at your facility. 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 (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required

evidence is not available; the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to: IDRCoordinator@health.ok.gov

Or mail 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.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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 05/21/2024
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
D 000	INITIAL COMMENTS A relicensure survey was conducted on 05/15/24 through 05/17/24 and 05/20/24 through 05/21/24. Complaint investigations (#OK00061579, OK00061591, OK00063104, OK00064258, OK00064334, and #OK00064681) were conducted in conjunction with the survey. No deficiencies were cited. Facility Census: 35	D 000		
C 000	INITIAL COMMENTS A relicensure survey was conducted on 05/15/24 through 05/17/24 and 05/20/24 through 05/21/24. Complaint investigations (#OK00061579, OK00061591, OK00063104, OK00064258, OK00064334, and #OK00064681) were conducted in conjunction with the survey. Facility Census: 35 Listed below are abbreviations that will be used throughout this document. CNA - certified nurse aide COPD - chronic obstructive pulmonary disease CPAP - continuous positive airway pressure DM - dietary manager ED - executive director ER - emergency room FSBS - finger stick blood sugar HTN - hypertension IJ - immediate jeopardy MAR - medication administration record OK - Oklahoma OSDH - Oklahoma State Department of Health Res - resident RN - registered nurse	C 000		

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

TITLE

(X6) DATE

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C 000	Continued From page 1 RCD - resident care director	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 observation and interview, the center failed to ensure the kitchen was maintained to promote food safety and sanitation. The "Assisted Living Resident Condition and Care Overview" form, dated 05/15/24, documented 35 residents resided in the center. Findings: On 05/15/24 at 11:10 a.m., a tour of the kitchen was conducted. The following observations were made. a. there was no sign or poster notifying the food employees to wash their hands at the hand wash sinks, b. there was brown and pink residue inside of the ice machine, c. the wall behind the ice machine was not finished. There was a hole and the wood and sheet rock were exposed, d. the ceiling lights in the dish wash area were not shielded and/or shatterproof,	C 391		

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C 391	Continued From page 2 e. the metal on the spray nozzle hose located on the three compartment sink was torn and the rubber was exposed, f. there was yellow and brown residue on the sides and bottom of the three compartment sink, g. there was water leaking from the neck of the faucet on the three compartment sink, h. there was a 32 ounce spray bottle of a blue liquid not labeled in the dish wash area, i. there was a buildup of grease on the handles of the fryer baskets, j. there was no lid on the trash can in the food employee restroom, k. there was an accumulation of lint on the ceiling around the heat/air and return vents, l. there was food splatter on the ceiling near the oven hood, m. the oven hood lights were not shielded and/or shatterproof, n. there was and accumulation of lint on the white floor fan next to the two compartment sink, o. the gaskets located on the three door reach in cooler were torn, p. there was a 15 pound box of raw bacon stored above containers of milk, juice and butter in the three door reach in cooler, and q. there were gaps and daylight was visible on	C 391		

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C 391	Continued From page 3 the top, side, and bottom of the back door. On 05/15/24 at 11:31 a.m., Cook #1 was shown the location of the box of raw bacon in the three door reach in cooler. They stated raw foods should be stored below ready to eat foods. On 05/16/24 at 10:34 a.m., a tour of the kitchen was conducted. The following observations were made. a. soiled cloths were stored on top of the food preparation table in the cook area and not in a sanitizer solution, b. ceramic plates were stored on a rack next to the steam table with the food contact surface upward, and c. the DM was washing and rinsing dishes in the two compartment sink and hand drying the dishes with a cloth. There was no sanitization step. On 05/16/24 at 10:43 a.m., the DM was asked what was the protocol for manual dish washing. They stated they used the two compartment sink to wash pans and other items. They stated they put a cap full of bleach in their dish water when they washed dishes. On 05/16/24 at 11:29 a.m., Cook #1 was asked how staff ensured the kitchen was kept clean and maintained in good repair. They stated they cleaned daily and reported maintenance concerns to the maintenance department. They were asked how dishes were to be stored. They stated they were to be inverted. They were asked how cleaning products were identified. They stated they were supposed to be labeled. Cook #1 was asked what informed the employees to	C 391		

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C 391	Continued From page 4 wash their hands. They stated there should be hand wash signs posted at the hand sinks. They were asked where in use cloths were to be stored. They stated they hung them over the sink. They were asked about trash receptacles. They stated they should have a cover. Cook #1 was made aware of the above observations.	C 391		
C 397 SS=D	310:663-3-8(d)(4) FOOD STORAGE, PREPARATION AND SERVICE (4) Only clean, whole eggs with shell intact, pasteurized liquid, frozen, dry eggs, egg products and commercially prepared and packaged hard boiled eggs may be used. All eggs shall be thoroughly cooked except pasteurized egg products or pasteurized in-shell eggs may be used in place of pooled eggs or raw or undercooked eggs. This Rule is not met as evidenced by: Based on observation and interview, the center failed to ensure whole eggs with their shell intact were pasteurized for eggs served not thoroughly cooked. The "Assisted Living Resident Condition and Care Overview" form, dated 05/15/24, documented 35 residents resided in the center. Findings: On 05/15/24 at 11:10 a.m., a tour of the kitchen was conducted. There were two large boxes of	C 397		

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C 397	Continued From page 5 unpasteurized raw shell eggs observed in the three door reach in cooler. There was no pasteurization designation on the egg or on the box. On 05/15/24 at 11:27 a.m., Cook #1 was asked what the raw shell eggs in the three door reach in cooler were used for. They stated they used the eggs for the residents and they could order eggs cooked any way they wanted. They were shown the eggs in the reach in cooler and asked if they were pasteurized. They stated they should have a pasteurization designation on the egg.	C 397			
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for one (#2) and failed to complete a comprehensive assessment within 14 days after admission for one (#10) of 10 sampled residents reviewed for comprehensive assessments. The "Assisted Living Resident Condition and	C 522			

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C 522	Continued From page 6 Care Overview" form, dated 05/15/24, documented 35 residents resided in the center. Findings: 1. Res #2 was admitted to the center on 06/27/21 with diagnoses which included COPD, major depressive disorder, hyperlipidemia, edema, HTN, hypothyroidism, Alzheimer's disease, and arthritis. There was no documentation a comprehensive assessment was completed in 2023. On 05/20/24 at 12:45 p.m., the ED was asked to provide a comprehensive assessment completed for the resident in 2023. On 05/20/24 at 2:49 p.m., the RCD stated the last comprehensive assessment completed for the resident was in 2022. 2. A "Resident Assessment Form", dated 02/04/24, documented a preadmission assessment was completed for Res #10. It was documented the resident was alert, confused at times, and had good judgment. It was documented the resident had diagnoses to include congestive heart failure, hypothyroidism, and mixed hyperlipidemia. A "Resident Service Agreement", dated 02/08/24, read in part, "...A monthly fee for Care Charges may be required for additional services to be provided by Canoe Brook Ardmore as determined by an assessment conducted by Canoe Brook Ardmore..." On 05/16/24 at 3:27 p.m., RCD reported they did the preadmission assessment for Res #10, but not the 14-day comprehensive assessment.	C 522		

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C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to coordinate an assessment with the signature of a RN or the resident's personal physician for one (#8) of 10 sampled residents reviewed for assessments. The "Assisted Living Resident Condition and Care Overview" form, dated 05/15/24, documented 35 residents resided in the center. Findings: Res #8's comprehensive assessment, dated 10/18/23, was not coordinated and signed by a RN or the resident's personal physician. On 05/16/24 at 4:17 p.m., the RCD was shown the resident's assessment. They stated the assessment had not been coordinated or signed by a RN or the resident's physician.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.	C 543		

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C 543	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the residents representative or the residents personal physician and the person completing the form for five (#1, 4, 5, 6, and #8) of 10 sampled residents reviewed for comprehensive assessments. The "Assisted Living Resident Condition and Care Overview" form, dated 05/15/24, documented 35 residents resided in the center. Findings: 1. A lease agreement, dated 11/28/23, for Res #1, read in part, "...Upon application, a complete assessment will be conducted by...licensed nurse in coordination with the Resident, Resident's personal representative (s), Resident's ADvantage case manager and the inter-disciplinary team of [Facility Name]..." On 05/16/24 at 3:20 p.m., clinical record reviews were conducted with the RCD. Res #1's comprehensive assessment, dated 05/07/24, was not signed by the resident and/or their representative. On 05/16/24 at 3:20 p.m., the RCD stated the assessment had not been signed to include a personal interview between the resident or the resident's representative and the person who	C 543		

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C 543	Continued From page 9 completed the form. 2. Res #4's comprehensive assessment, dated 08/11/23, was not signed by the resident and/or their representative. On 05/16/24 at 4:51 p.m., the RCD was shown the resident's assessment. They stated there should be a signature a personal interview was conducted. 3. Res #5's comprehensive assessment, dated 03/10/24, was not signed by the resident and/or their representative. On 05/17/24 at 9:14 a.m., the RCD was shown the resident's assessment. They stated there should be documentation of a personal interview. They stated there was no signature. 4. Res #6's comprehensive assessment, dated 03/28/24, was not signed by the resident and/or their representative. On 05/16/24 at 5:05 p.m., the RCD was shown the resident's assessment. They stated there was no documentation a personal interview was conducted. 5. Res #8's comprehensive assessment, dated 10/18/23, documented the resident's ability to communicate was good and they were interviewable. The assessment was not signed by the resident and/or their representative. On 05/15/24 at 2:37 p.m., the resident stated they were told staff assessments were being completed. They stated they did not see how staff could conduct an assessment and not discuss the assessment with them.	C 543		

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C 543	Continued From page 10 On 05/16/24 at 4:17 p.m., the RCD was shown the resident's assessment. They stated there should be a signature a personal interview was conducted and there was not one.	C 543		
C1505 SS=J	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 11 This REQUIREMENT is not met as evidenced by: On 05/17/24 a IJ situation was determined to exist related to the center's failure to provide Res #4 adequate supervision to prevent elopement. On 03/28/24 at 5:30 p.m., Res #4 was seen down the road from the center by Cook #2 who had been driving down the road. Cook #2 reported to the center. Staff members from the center went to get the resident and brought them back to the center. According to the center staff the resident was gone from the center for a duration of 10 minutes. On 07/11/22, the resident's care plan documented the resident was at risk for elopement, safety would be maintained, and to observe the resident's location in the community. On 02/08/24, the resident's care plan was updated with a new goal which documented they were not to leave the community unattended. There was no documentation a complete head to toe assessment was completed after the resident eloped. There was no documentation the resident's care plan was updated after a known elopement. There was no documentation the incident was reported to OSDH. On 05/17/24 at 12:09 p.m., OSDH was notified and verified the existence of the IJ situation. On 05/17/24 at 4:25 p.m., the ED was notified of the IJ situation. On 05/20/24 at 3:32 p.m., an acceptable plan of	C1505		

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(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
C1505	Continued From page 12 removal was submitted to OSDH. The plan of removal documented: "May 17, 2024 Plan of Removal Care-Plan has been updated to address elopement at 20:40 hours 5/17/2024. Complete head to toe assessment completed at 20:45 hours on 5/17/2024. 283 report faxed to state health department on 5/17/2024 at 19:50:49 hours. Resident will have one on one monitoring while a resident at the community. Staff will be in-serviced on elopement training either in person or via telephone on or before 05/17/2024 at 00:00 AM. Any staff member that cannot be reached by 00:00 will be in-serviced prior to starting work at the community. [Name withheld] Executive Director" The IJ was lifted, effective 05/17/24 at midnight, when all components of the plan of removal had been completed. The deficient practice remained as isolated with potential for harm for Res #4. Based on record review and interview, the center failed to: a. provide adequate supervision to prevent elopement resulting in an IJ situation for one (#4) of four sampled residents reviewed for incidents, and b. obtain and administer medications according to physician orders for one (#3) of two closed records reviewed for physician ordered medications. The "Assisted Living Resident Condition and Care Overview" form, dated 05/15/24,	C1505			

Oklahoma State Department of Health

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C1505	Continued From page 13 documented 35 residents resided in the facility. The RCD identified one resident at risk for elopement. Findings: An "Elopement/Missing Resident" policy, dated 02/22/22, read in part, "Policy...During normal conditions of operating the community...residents may wander away from the community...When the resident is located ...Assess resident for any harm...Complete an incident report...Complete assessments needed for a significant change in the resident..." 1. Res #4 had diagnoses which included dementia and major depressive disorder. A care plan, initiated 07/11/22, documented the resident was at risk for elopement, safety would be maintained, and to observe the resident's location in the community. An annual assessment, dated 08/11/23, documented the resident was oriented to person, place and time, confused at times, and their judgement was fair. It was documented the resident's mobility was good and they used a walker. It was documented the resident was not at risk for elopement. A care plan, updated 02/08/24, documented the resident's new goal was not to leave the community unattended. An "Incident-Occurrence Report", dated 03/28/24 at 5:30 p.m., documented Res #4 was seen down the road by Cook #2 who had been driving down the road. It was documented Cook #2 reported to the center and staff members from the facility	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 14 went to get the resident and brought them back to the center. It was documented the resident stated they were going to the main office to see their family member. It was documented the resident was gone from the center for a duration of 10 minutes and had no injury. It was documented vital signs were obtained and family members were notified of the incident. There was no documentation a complete head to toe assessment was completed after the resident eloped. There was no documentation the resident's care plan was updated after a known elopement. There was no documentation the incident was reported to OSDH. On 05/17/24 at 11:25 a.m., the RCD was asked about the incident where Res #4 eloped from the center. They stated Cook #2 had come to the center and stated they had seen the resident down the road. They stated staff went to get the resident and brought them back to the center. They stated the resident had made comments about leaving to go see a family member, but had never left the premises. They stated they were notified of the incident and came to the center. The RCD was asked if they assessed the resident for injury. They stated when they came to the center they obtained vitals and talked to the resident. They stated they did not complete a head to toe assessment. They were asked if the resident's care plan had been updated after a known elopement. They stated they thought it had been updated to check on the resident every two to three hours. The RCD was asked if the incident was reported to OSDH. They stated they did not consider the resident missing. They stated they did not know a missing resident was a reportable incident.	C1505		

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C1505	Continued From page 15 2. Res #3 had diagnoses which included type II diabetes mellitus, cerebrovascular accident, high blood pressure, depression, hyperlipidemia, cerebral infarction due to unspecified occlusion, constipation, and generalized anxiety. A "MAR", dated 03/01/24, documented the following medication dosages were not administered in accordance with the resident's physician orders. Atorvastatin (15 doses), famotidine (1 dose), farxiga (1 dose), glycoLax (2 doses), sertraline (14 doses), tamsulosin (17 doses), thiamine (14 doses), probiotic (28 doses), sennosides (2 doses). A number eleven code was documented on these medications to indicate the medications were not available. An assessment, dated 03/10/24, documented the resident was alert to person, place and time, had good judgment, and they did not require assistance with activities of daily living. A residency agreement, dated 03/11/24, read in part, "...Resident shall receive assistance with monitoring health care, ordering supplies/supplemental services, arranging medical care, assistance with medication ..." A "MAR", dated 04/01/24, documented the following medication dosages were not administered according to the resident's physician orders. Amitriptyline (6 doses), atorvastatin (6 doses), quetiapine (7 doses), sertraline (4 doses), tamsulosin (5 doses), thiamine (1 dose), Eliquis (5 doses). A number eleven code was documented on these medications to indicate the medications were not available. Res #3's "Physician Orders" dated 04/07/24, documented atrovastatin 40 mg at bedtime,	C1505		

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C1505	Continued From page 16 amitriptyline 100 mg daily at bedtime, quetiapine 100 mg at bedtime, famotidine 20 mg daily, farxiga 10 mg daily, glycoLax 17 grams daily, sertraline 50 mg daily, tamsulosin 0.4 mg daily, thiamine 100 mg daily, eliquis 5 mg twice daily, probiotic 250 mg twice daily, sennosides 8.6 mg two times daily. On 05/20/24 at 3:15 p.m., the ED reviewed the MARs and agreed the medications had not been administered. On 05/20/24 at 3:23 p.m., the RCD agreed numerous dosages of the physician ordered medications were not administered in March and April 2024. The RCD reported they did not have an emergency box of medications. They reported the progress notes documented they were waiting for the resident's family member to pick up the resident's medications from the pharmacy. They reported the center could pick up medications, but the resident would be responsible for paying for them.	C1505		
C1914 SS=E	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form.	C1914		

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C1914	Continued From page 17 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure incidents requiring reporting were reported to OSDH for two (#4 and #8) of four sampled residents reviewed for incidents. The "Assisted Living Resident Condition and Care Overview" form, dated 05/15/24, documented 35 residents resided in the center. Findings: An "Elopement/Missing Resident" policy, dated 02/22/22, read in part, "Policy...During normal conditions of operating the community...residents may wander away from the community...When the resident is locate...Complete an incident report..." 1. An "Incident-Occurrence Report", dated 03/28/24 at 5:30 p.m., documented Res #4 was seen down the road by Cook #2 who had been driving down the road. It was documented Cook #2 reported to the center. Staff members from the facility went to get the resident and brought them back to the facility. It was documented the resident was gone from the center for a duration of 10 minutes. There was no documentation the incident was reported to OSDH. On 05/17/24 at 11:25 a.m., the RCD was asked if the incident was reported to OSDH. They stated they did not consider the resident missing. They stated they did not know a missing resident was a reportable incident. 2. An "Incident-Occurrence Report", dated 03/29/24 at 1:45 p.m., documented Res #8 had a	C1914		

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C1914	Continued From page 18 fall in the beauty shop and had an injury to the back of their head. It was documented the resident was sent to the ER. A hospital after visit summary, dated 03/29/24, documented the resident was seen for a fall. It was documented the resident had a diagnosis of a closed head injury, initial encounter. There was no documentation the incident was reported to OSDH. On 05/17/24 at 2:21 p.m., the RCD was asked if the resident's fall on 03/29/24 was reported to OSDH. They stated they did not know a diagnosis of a closed head injury was to be reported.	C1914		
C1951 SS=D	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure an organized accurate clinical record to include all services for two (#1 and #9) of five sampled residents with home health services. The RCD identified 5 residents received home health services.	C1951		

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C1951	Continued From page 19 Findings: 1. Res #1 had diagnoses which included COPD, type II diabetes mellitus, and essential HTN. On 05/15/24 at 11:20 a.m., Res #1's FSBS reading was obtained from the Dexcom located on their arm. On 05/16/24 at 3:00 p.m., the RCD reported the center's physician orders did not include a physician order for home health services and/or a Dexcom monitoring device for blood glucose levels. 2. Res #9 had diagnoses which included chronic atrial fibrillation, type II diabetes mellitus, and obstructive sleep apnea. On 05/17/24 at 8:15 a.m., Res #9 reported they used their CPAP machine anytime they would sleep. On 05/20/24 at 9:45 a.m., the ED reported the center did not have a policy and/or procedure for documentation of a clinical record. On 05/20/24 at 3:55 p.m., the RCD reported Res #9 received home health services. They stated they did not have physician orders for home health services or the resident's CPAP machine being used for obstructive sleep apnea.	C1951		
C1972 SS=D	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident	C1972		

Oklahoma State Department of Health

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C1972	Continued From page 20 property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an employee received abuse and neglect training within 90 days of employment for one (CNA #2) of five sampled employee records reviewed. The "Assisted Living Resident Condition and Care Overview" form, dated 05/15/24, documented 35 residents resided in the center. Findings: An "Abuse, Neglect, or Exploitation", dated 11/2016, read in part, "...The assisted living center shall provide team members, within (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same..." Employee records documented CNA #2 was hired on 08/08/23. There was no documentation they received abuse and neglect training. On 05/16/24 at 1:58 p.m., the ED was asked about abuse training within 90 days of hire for CNA #2. They stated they had the training, but not within 90 days.	C1972		

Oklahoma State Department of Health

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C6000	Continued From page 21	C6000			
C6000 SS=E	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or	C6000			

Oklahoma State Department of Health

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C6000	Continued From page 22 denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services. This Rule is not met as evidenced by: Based on record review and interview, the center failed to obtain fingerprint based background checks within 60 days of hire for one (CNA #2) of five employees files reviewed.	C6000		

Oklahoma State Department of Health

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C6000	Continued From page 23 The "Assisted Living Resident Condition and Care Overview" form, dated 05/15/24, documented 35 residents resided in the center. Findings: A "Background Check, Licensure/Certification and Employment Verification", dated 11/2016, read in part, "...All of the assisted living center's team members shall be subject to the requirements for criminal arrest checks applicable to nurses aides..." On 05/16/24 at 1:58 p.m., employee files were reviewed and no evidence was provided to determine eligibility for employment for CNA #2 hired on 08/08/23. On 05/16/24 at 1:58 p.m., the ED reported they obtained the criminal background check today from OK Screen and had overlooked it.	C6000			

Delivery via email to: TWilkerson@canoebrookal.com

July 5, 2024

License Number: AL1003

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

Survey Event ID: OGMG11

Dear Mr. Wilkerson:

On **May 21, 2024**, a Relicensure survey with a complaint investigation was conducted at your Assisted Living Center. 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 **July 28, 2024**.

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

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enc

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 6/27/2024	
	Facility Name: Canoe Brook Ardmore	
	License Number: AL1003	
	Survey Event ID: OGMG11	
Date Survey Completed: 5/21/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 391	Based on: observation and interview, the center failed to ensure the kitchen was maintained to promote food safety and sanitation.	
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 herein. 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 center will conduct in-services for the dietary and maintenance staff to ensure food safety and sanitation are properly maintained.
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?		A. Hand wash signs have been placed at the hand wash sinks. B. The Ice machine has been cleaned. C. The wall behind the ice machine has been repaired. D. New Light fixtures with appropriate shields will be installed on or before July 28, 2024. E. Spray nozzle will be replaced on or before July 28, 2024. F. The underneath and sides of the three compartment sink will be cleaned on or before July 28, 2024. G. The water leak on the neck of the faucet on the three sink compartment has been repaired. H. The 32 oz spray bottle has been labeled properly. I. The fryer handles were degreased on the fryer baskets. J. A new trash can, with lid, has been placed in the kitchen employee restroom. K. The lint on the ceiling around the heat/air vents have been cleaned. L. The food splatter on the ceiling has been cleaned. M. The oven hood lights will be with appropriate shielding on or before July 28, 2024. N. The lint on the floor fan has been cleaned. O. New gaskets for the three door refrigerator will be ordered and replaced on or before July 28, 2024. P. All meats will be stored in the bottom of the refrigerator, below the other food items.

		Q. The seals around the top, side, and bottom of the back door will be replaced on or before July 28, 2024. a. Soiled cloths are now and will continue to be kept in a sanitizer solution, while using. b. Ceramic plates are now stored in an inverted position. c. The dietary staff will no longer wash dishes in the two compartment sink. All dishes will be washed, rinsed and sanitized in the three compartment sink or the dishwashing machine.	
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 monitor log will be created. The DM will audit the monitor logs weekly X4. The ED will do monthly reviews. The audits and monitors will be reviewed in the QA meetings. The audits and monitors will be maintained in the QA records.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/28/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Administrator signature required.</i> OAC 310:663-25-4(F)		Date 6/28/2024	
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: 6/28/2024		
	Facility Name: Canoe Brook Ardmore		
	License Number: AL 1003		
	Survey Event ID: OGMG11		
Date Survey Completed: 5/21/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 397	Based on: The rule is not meet as evidenced by: Based on obswrvation and interview , the center failed to ensure whole eggs with their shell intact were pasturized for eggs served not fully cooked.		
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?		Only pasturized eggs will be purchased for use in the food preparation.	
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 DM will not purchase any non pasturized eggs for the community.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		The DM will monitor the food deliveries to insure compliance.	
a. How the correction will be evaluated for effectiveness;		A log of the inspection of the eggs will be completed on each delivery for the next four deliveries and then random checks thereafter for sixty days by the ED.	
b. How the correction will be incorporated into the center's quality assurance system; and		The monitors will be maintained in a log book and reviewed in the quarterly QA meetings for the remainder of the calendar year.	
c. How monitoring records will be kept to evidence the correction.		Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/28/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Administrator signature required</i>		Date 6/28/2024	
OAC 310:663-25-4(F)			
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: 6/27/2024

Facility Name: Canoe Brook Assisted Living

License Number: 1003

Survey Event ID: OGMG11

Date Survey Completed: 5/21/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522

Based on: record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for one (#2) and failed to complete a comprehensive assessment within 14 days after admission for one (#10) of 10 sampled residents reviewed for comprehensive assessments.

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 herein. 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

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All comprehensive assessments will be completed timely on all residents of the community.

Other residents will be identified by the community census.

Community will ensure that all future annual comprehensive assessments will be completed once every 12 months.
Community will ensure that all future admissions to the community will have a comprehensive assessment completed w/in 14 days of admission to the community.

ED to perform audits to ensure that annual assessments are being completed on residents monthly x1 month.

ED to perform audit on next 3(three) new admissions to community to ensure comprehensive assessments were completed within 14 days.

Community will QA audits to ensure compliance with timely assessments.

The monitors will be maintained in a log book and reviewed in the quarterly QA meetings for the remainder of the year.

7/28/2024

Administrator's Signature Terry Wilkerson, LNHA-ED

Date 6/28/2024

OAC 310:663-25-4(F)

10012013

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.
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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: 6/27/2024	
	Facility Name: Canoe Brook Assisted Living	
	License Number: 1003	
	Survey Event ID: OGMG11	
Date Survey Completed: 5/21/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 542	Based on: record review and interview, the center failed to coordinate an assessment with the signature of a RN or the resident's personal physician for one (#8) of 10 sampled residents reviewed for assessments.	
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 herein. 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 comprehensive assessments will be coordinated and signed with the community RN consultant or resident's personal physician.
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?		Community will ensure that all future annual comprehensive assessments will be coordinated with the community's RN consultant or resident's personal physician and signed by the RN consultant or residents personal physician.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		ED and/or RCD will perform random audits to ensure annual comprehensive assessments have been coordinated with RN or resident's personal physician and assessment has all required signatures x60 days.
a. How the correction will be evaluated for effectiveness;		ED and/or RCD will perform random audits to ensure annual comprehensive assessments have been coordinated with RN or resident's personal physician and assessment has all required signatures.
b. How the correction will be incorporated into the center's quality assurance system; and		Community will QA audits to ensure compliance with annual comprehensive assessments being coordinated with RN or resident's personal physician and required signatures are in place.
c. How monitoring records will be kept to evidence the correction.		The monitors will be maintained in a log book and reviewed in the quarterly QA meetings for the remainder of the year.
OSDH Response: Element accepted Yes ☐ No ☐		

5. On what date will corrective action be completed?		7/28/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Terry Wilkerson</i> OAC 310:663-25-4(F)		Date 6/28/2024	
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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: 6/27/2024	
	Facility Name: Canoe Brook Assisted Living	
	License Number: 1003	
	Survey Event ID: OGMG11	
Date Survey Completed: 5/21/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 543	Based on: record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the residents representative or the residents personal physician and the person completing the form for five (#1, 4, 5, 6, and #8) of 10 sampled residents reviewed for comprehensive assessments.	
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 herein. 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 future comprehensive assessments will be coordinated with and signed off by the resident or the resident's representative or resident's personal physician.
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?		Community will ensure that all future comprehensive assessments will be coordinated with the resident or the resident's representative or resident's personal physician and signed off by the resident or resident's representative or residents personal physician.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		ED and/or RCD will audit comprehensive assessments to ensure it was coordinated with with the resident or the resident's representative or resident's personal physician and signed off by the resident or resident's representative or residents personal physician x60 days.
a. How the correction will be evaluated for effectiveness;		ED and/or RCD will perform random audits to ensure annual comprehensive assessments have been coordinated with with the resident or the resident's representative or resident's personal physician and signed off by the resident or resident's representative or residents personal physician.
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.		Community will QA audits to ensure compliance with annual comprehensive assessments being coordinated with the resident or the resident's representative or resident's personal physician and signed off by the

		resident or resident's representative or residents personal physician. The monitors will be maintained in a log book and reviewed in the quarterly QA meetings for the remainder of the year.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/28/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <u>Terry Wilkerson, LNHA-ED</u> OAC 310:663-25-4(F)		Date 6/28/2024	
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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: 6/27/2024	
	Facility Name: Canoe Brook Assisted Living	
	License Number: 1003	
	Survey Event ID: OGMG11	
		Date Survey Completed: 5/21/2024
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 1505	Based on: record review and interview, the center failed to: a.) provide adequate supervision to prevent elopement resulting in an IJ situation for one (#4) of four sampled residents reviewed for incidents, and b.) obtain and administer medications according to physician orders for one (#3) of two closed records reviewed for physician ordered medications.	
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 herein. 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?		Resident identified as #3 was already discharged from community. Resident identified as #4 was placed on one on one supervision until son moved resident to LTC facility on 5/24/24.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Risk assessments completed on all residents now and annually. New admissions to the community must have a copy of signed physician's orders for medication's, as well as, the ordered medications, in entirety, at the community on the day of resident's admission.
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?		ED/RCD will monitor resident assessments to ensure there are no further at risk residents in community. New admissions to community must have a copy of signed physician's orders for medication's, as well as, the ordered medications, in entirety, at the community on the day of resident's admission.
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		RCD will ensure signed physician's orders are at community, along with current ordered medications on resident move-in date. ED will perform a review of physicians orders and medications to ensure that orders have physician signature and medication's match current orders x3 admissions. RCD will audit risk assessments monthly x60 days then at random through end of 2024.

c. How monitoring records will be kept to evidence the correction.		The monitors will be maintained in a log book and reviewed in the quarterly QA meetings for the remainder of the year. Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/28/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Terry Wilkerson</i> LNMA-ED OAC 310:663-25-4(F)		Date 6/28/2024	
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