



Oklahoma State Department of Health
Creating a State of Health

February 18, 2020

License Number: AL1405

Ms. Christi Dobbs, Administrator
Arbor House Assisted Living Center
4501 West Main Street
Norman, OK 73072

RE: Survey Event ID: THCU11

Dear Ms. Dobbs:

Enclosed is a report of the inspection conducted at your Assisted Living Center on **February 13, 2020**. No deficiencies were cited. Oklahoma Statutes 63-1-1910 require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1405	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/13/2020
NAME OF PROVIDER OR SUPPLIER ARBOR HOUSE ASSISTED LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4501 WEST MAIN STREET NORMAN, OK 73072		
(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 on 02/11/2020 through 02/13/2020. Current census was 49. No deficient practice was cited.	C 000			

Oklahoma State Department of Health

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

TITLE

(X6) DATE

STATE WORKLOAD REPORT

 Provider/Supplier Number
 AL1405

 Provider/Supplier Name
 ARBOR HOUSE ASSISTED LIVING CENTER

Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. <i>pe</i> 35195	02/11/2020	02/13/2020	0.75	0.00	21.25	0.00	6.25	0.75
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

 FEB 19 2020 *fm*