



Oklahoma State Department of Health
Creating a State of Health

October 4, 2019

License Number: AL1602

Ms. Tammy Kuhlman, Administrator
Ten Oaks Place
3610 Southeast Huntington Circle
Lawton, OK 73501

RE: Survey Event ID: SE2M11

Dear Ms. Kuhlman:

On **September 4, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on September 4, 2019.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;

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- (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) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

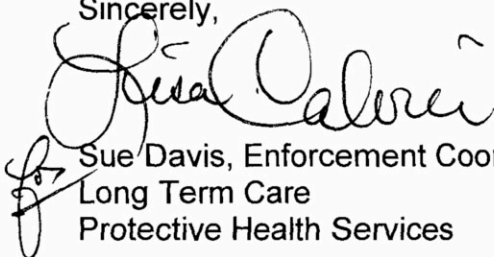
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sue Davis".

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1602	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 09/04/2019
NAME OF PROVIDER OR SUPPLIER TEN OAKS PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A relicensure survey was conducted on 09/04/19 to 09/05/19. Resident census was 76. Deficient practice was cited as follows.	N 000		
N1437 SS=E	310:677-13-7 (b) (8) Skills And Functions Limitations. A certified medication aide shall not: (8) Administer medications or nutrition via nasogastric or gastrostomy tubes, or administer oral metered dose inhalers or nebulizers, unless the CMA has completed a Department-approved advanced training program and has demonstrated competency for such services; or This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure nebulizer treatments and insulin were administered and FSBS (finger stick blood sugar testing) was performed by a CMA (certified medication aide) who had completed a Department approved advanced training program for 1 (#6) of 1 sampled resident who received physician ordered nebulizer treatments and 1 (#1) of 1 sampled resident who had physician ordered FSBS testing and insulin injections. This failed practice had the potential for more than minimal harm, at a pattern. Findings: Resident #1 Resident #1 had a physician's order for FSBS testing three times per day and Lantus (insulin) 35 units to be injected daily at 5:00 p.m. The resident's MAR (medication administration record) documented employee/CMA #5	N1437		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N1437	Continued From page 1 performed the resident's FSBS testing and administered Lantus on July 14, 2019, performed the resident's FSBS testing on August 18, 2019 and performed the resident's FSBS testing and administered Lantus on August 25, 2019. Resident 6 Resident #6 had a physician's order for albuterol sulfate inhalation to be administered to the resident four times daily for shortness of breath. The resident's MAR documented employee/CMA #5 administered the albuterol inhaler to resident #6 nine times in July, 2019, six times in August, 2019 and four times in September, 2019. On 09/03/19, the employee records were reviewed. CMA/employee #5 did not have any advanced training approved by the Department to administer inhaled medication or insulin or perform FSBS testing. On 09/04/19 at 1:50 p.m., registered nurse #2 was shown the resident's MAR. She looked at the MAR and stated employee/CMA #5 should not have administered the insulin or performed the FSBS testing as she was not qualified. At 2:30 p.m., employee/CMA #5 stated she did not have any advanced training, but she was scheduled to start training in a few weeks.	N1437		
C 000	INITIAL COMMENTS A relicensure survey was conducted on 09/04/19 to 09/05/19. Resident census was 76. Deficient practice was cited as follows.	C 000		

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C 391	Continued From page 2	C 391		
C 391 SS=F	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, interview and record review it was determined the center failed to comply with the requirements outlined in Chapter 257. This deficient practice had the widespread potential for more than minimal harm for all 76 residents who ate from the kitchen. Findings: 310:257-8-82 (c) Non-food contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 310-257-7-83 Equipment food-contact surfaces and utensils (e) Except when dry cleaning methods are used as specified under 310-257-7-8, surfaces of utensils and equipment contacting food that is not potentially hazardous shall be cleaned: (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (B) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold. On 09/03/19 at 2:20 p.m., On initial tour of the kitchen with Dietary Aide #8, a yellow substance was observed splattered on the stove vent hoods, and the emergency fire sprinkler system for the	C 391 C 391		

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C 391	Continued From page 3 stove. There were long thin hairlike objects, dust and debris stuck in the yellow thick substance on the sprinklers. Dietary Aide #3 stated it looked like built up grease, and lint stuck to the sprinkler. Dietary Aide #8 stated the vent hoods were cleaned about 3 months ago. On observation of the icemaker located in the kitchen there was a black substance on the edge of the ice dispenser located inside the ice maker. Dietary Aide #8 wiped the area with a paper towel, and there was a visible black substance on the towel. When asked what that was? The dietary aide #8 stated mold maybe? Record review of the monthly cleaning schedule documents the ice maker was cleaned on August 23, 2019. At 4:40 p.m., The chef was shown the yellow substance on the sprinklers and hoods, she said it looked like hair was stuck in the substance on the sprinklers. She reported that the hoods had been cleaned on August 15th.	C 391		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to use the results of the residents' assessment to develop individualized care plans with interventions and goals for 4 (#3, 6, 7 and #9) of 4 sampled residents. This failed practice had the potential for more than minimal harm, at a pattern.	C 552		

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C 552	Continued From page 4 Findings: Resident #3 The most recent assessment for resident #3, dated 05/30/19, documented diagnoses of lymphedema and obesity. The assessment documented he had wraps to both lower legs performed by home health, required stand by assistance from staff for activities of daily living and was ambulatory via wheel chair. Resident #6 Resident #6's most recent assessment, dated 07/11/19, documented the resident had diagnoses of diabetes mellitus type II, high blood pressure (for which she took medication) and congestive obstructive pulmonary disease (she had inhaled medication) and used oxygen. It documented she also had limited range of motion due to right foot drop and was ambulatory with the assistance of staff via scooter. Resident #7 Resident #7 was admitted to the center 2/14/19 with diagnoses of dementia, high blood pressure, anxiety disorder and recurrent urinary tract infections. The admission assessment documented the resident was agitated at times and was an elopement risk. Resident #9 Resident #9 was admitted to the center 09/07/18 with a diagnoses of dementia with behavioral disturbances and high blood pressure. The admission assessment documented the resident was confused, forgetful, agitated and only	C 552		

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C 552	Continued From page 5 oriented to herself. The resident also had a physician's order for Seroquel and Haldol (both antipsychotic medications). None of the resident records included a plan of care with individualized goals and interventions. On 09/04/19 at 1140 a.m., RN (registered nurse) #1 was asked for the care plans for the above residents. She pointed to a document and said that was the form the center used for resident care plans. The document did not include individual diagnoses, interventions or goals. It was a generic form that utilized a point system to that was used to calculate a level of care for billing purposes. RN #1 was asked about individualized interventions and goals for the residents. She stated the center did not do that kind of care plan.	C 552		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to use qualified staff to administer inhaled medication for 1(#6) of 1 sampled resident who had inhaled medication prescribed by a physician and administer insulin for 1 (#1) sampled resident who had insulin prescribed by a physician. This failed practice had the potential for more than minimal harm, at a pattern. Findings:	C 921		

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C 921	Continued From page 6 Resident #6 Resident #6 had a physician's order for albuterol sulfate inhalation to be administered to the resident four times daily for shortness of breath. Resident #6's MAR (medication administration record) for July and August, 2019 documented the resident was administered her inhaler twice by employee/MAT (medication administration technician) #6 in July, 2019 and five times in August, 2019. Resident #6's MAR documented employee/CMA #5 administered the albuterol inhaler to resident #6 nine times in July, 2019, six times in August, 2019 and four times in September, 2019. On 09/03/19, the employee records were reviewed. CMA/employee #5 did not have any advanced training approved by the Department to administer inhaled medication. On 09/04/19 at 1:50 p.m., registered nurse #2 was shown the resident's MAR. She looked at the MAR and stated employee/MAT #6 should not have administered the inhaled medication as she was not qualified to administer inhaled medication. At 2:30 p.m., employee/CMA #5 stated she did not have any advanced training, but she was scheduled to start training in a few weeks. Resident #1 Resident #1 had a physician's order for Lantus (insulin) 35 units to be injected daily at 5:00 p.m. The resident's MAR documented employee/CMA #5 administered Lantus (insulin) on July 14, 2019, and administered Lantus on August 25, 2019	C 921		

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C 921	Continued From page 7 On 09/03/19, the employee records were reviewed. CMA/employee #5 did not have any advanced training approved by the Department to administer insulin. On 09/04/19 at 1:50 p.m., registered nurse #2 was shown the resident's MAR. She looked at the MAR and stated employee/CMA #5 should not have administered the insulin as she was not qualified.	C 921		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, it was determined the center failed to maintain an	C1923		

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C1923	Continued From page 8 accurate written record of inhaled medications for one (#6) of one sampled resident that was administered inhaled medication by the center's staff. This failed practice had the potential for more than minimal harm, at a pattern. Findings: The center's employment records were reviewed on 09/03/19. Four long term care aides had the same initials. One did not have any certifications beyond long term care aid, one had a medication administration technician certificate and two had Department approved advanced training in administering inhaled respiratory medications. Resident #6 had a physician's order for albuterol sulfate 2.5 milligrams to be administered via nebulizer four times daily. A review of the resident's EMAR (electronic medication administration record) revealed that the initials of the four individuals above documented that one of them had administered the inhaler to resident #6. At 2:00 p.m., RN (registered nurse) #2 stated she did not know who actually gave the inhaler to resident #6. She asked RN #1 and RN #1 stated she did not know who actually gave the inhaler and there was no way to tell since they all had the same initials.	C1923		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act.	C5010		

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C5010	Continued From page 9 B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to coordinate care with home health for 1(#3) of 1 sampled resident that required wound care and had attended a wound care clinic. This deficient practice had the potential for more than minimal harm at a pattern. Findings:	C5010			

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C5010	Continued From page 10 On 09/04/19 at 09:10 a.m., resident #3 was sitting in his recliner, both legs were wrapped with gauze and coban up to his knees. Resident #3 reported a wound culture was taken at the wound care clinic the week prior and he had started antibiotics. He stated he does his own medication administration, but was unable to name the antibiotic he was taking. An order for Ciprofloxacin 500 milligrams (mg) one tablet by mouth twice daily for 14 days on 08/27/19, was found in the resident's chart. The final wound culture on 08/30/19 documented Proteus Mirabalis (infectious organism), which is resistant to Ciprofloxacin. A physician's order was sent by the wound care clinic to the pharmacy on 08/30/19 to start a new antibiotic, Cefuroxime Axetil 500 mg one tablet by mouth twice daily for 10 days. On 09/04/19 at 12:18 p.m., RN (registered nurse) #1 reported that Ciprofloxacin was not on the medication administration record. When asked if Ciprofloxacin was the drug of choice for this wound care, she replied no, because it was resistant. RN #1 stated herself or RN #2 should have followed up with home health. Review of the August and September MAR's revealed that Cipro was not included on the August MAR, and Cefuroxime was not added to the August or September MAR when ordered 8/30/19. At 12:35 p.m., RN#1 stated she was aware resident #3 had gone to the wound care clinic but she did not know the wound care clinic had done a culture or had noticed the new order for Ciprofloxacin. The center failed to follow-up with resident #3, after he attended the wound care clinic, regarding the physician ordered treatment	C5010		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL1602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2019
NAME OF PROVIDER OR SUPPLIER TEN OAKS PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501		
(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	
C5010	Continued From page 11 plan. The resident was assessed by the center as being alert and oriented times 3. At 3:50 p.m., LPN #7 stated that the center only had weekly meetings with home health and hospice companies. At 4:10 p.m., Resident #3 was setting his medication up and reported he was taking both antibiotics Cipro and Cefuroxime Axetil because he thought that was what he was suppose to do. At 4:26 p.m., RN #1 stated the home health communication sheet dated 09/03/19 had no documentation that the resident had started a new antibiotic. RN#1 called the home health nurse to ask why the information was not communicated to her on 09/03/19 and the home health nurse stated because RN#1 had left for the day.	C5010			

STATE WORKLOAD REPORT

 Provider/Supplier Number
 AL1602

 Provider/Supplier Name
 TEN OAKS PLACE

Type of Survey (select all that apply)

☒ 2 ☐ ☐ ☐ ☐

 A Complaint Investigation
 B Dumping Investigation
 C Federal Monitoring
 D Follow-up Visit
 M Other

 E Initial Certification
 F Inspection of Care
 G Validation
 H Life Safety Code

 I Recertification
 J Sanctions/Hearing
 K State License
 L CHOW

Extent of Survey (select all that apply)

☒ A ☐ ☐ ☐ ☐

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 36967	09/03/2019	09/04/2019	0.25	0.00	13.00	0.00	7.00	4.50
2. 30875	09/03/2019	09/04/2019	0.00	0.00	7.00	0.00	1.50	0.00
3. 41872	09/03/2019	09/04/2019	0.75	0.00	14.00	0.00	3.00	5.00
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

OCT 04 2019

jm



Oklahoma State Department of Health
Creating a State of Health

November 4, 2019

License Number: AL1602

Ms. Tammy Brown, Administrator
Ten Oaks Place
3610 Southeast Huntington Circle
Lawton, OK 73501

RE: Survey Event SE2M11

Dear Ms. Brown:

On September 4, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **November 16, 2019**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/ks

Board of Health

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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/17/2019

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: SE2M11

Date Survey Completed: 9/4/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 SS=F

Based on: observation, interview and record review it was determined that center failed to comply with the requirements outlined in Chapter 257. This deficient practice had the widespread potential for more than minimal harm for all 76 residents who ate from the kitchen.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Maintenance person cleaned emergency fire sprinkler system for stove on October 17, 2019.

Kitchen staff cleaned the stove vent hoods and ice machine on October 17, 2019.

Current residents have the potential to be affected by the alleged deficient practice.

Enter corrective action for residents affected. Dining Services Manager, Assistant Executive Director and Maintenance person were inserviced on requirement 310:257-8-82: non-food contacts surfaces of equipment shall be kept free of accumulation of dust, dirt, food residue, and other debris and 310-257-7-83(e)(4)(B): cleaning of surfaces of utensils and equipment, including ice bins and ice makers, and frequency necessary to preclude accumulation of soil or mold, on October 11, 2019 by Regional Director of Care Services.

Dining Services Manager and/or designee will inservice current kitchen staff on 310:257-8-82: non-food contacts surfaces of equipment shall be kept free of accumulation of dust, dirt, food residue, and other debris and 310-257-7-83(e)(4)(B): cleaning of surfaces of utensils and equipment, including ice bins and ice makers, and frequency necessary to preclude accumulation of soil or mold, on November 1, 2019.

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.	Dining Services Manager and/or designee will be responsible for sustained compliance. Dining Services Manager and/or designee will audit stove vent hoods, emergency fire sprinkler system for stove and ice machine for cleanliness 2 times per week for 4 weeks, then weekly for 4 weeks; then 2 times per month for 1 month. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring records will be maintained by Executive Director or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/16/2019
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310-663-25-4(F)	Date 10/17/2019
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.	
Addendum Date	Enter a date of addendum.
Submitted by	Enter name of person submitting addendum.
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Facility in Compliance by: Click here to enter a date.	



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/17/2019

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: SE2M11

Date Survey Completed: 9/4/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C552 SS=E

Based on: interview and record review, it was determined the center failed to use the results of the residents' assessment to develop individualized care plans with interventions and goals to 4 (#3, 6, 7, and #9) of 4 sampled residents. The failed practice had the potential for more than minimal harm, at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

CSM (Care Services Manager) updated the care plan for residents #3, #6, #7, and #9 with interventions and goals for each resident on October 17th, 2019.

Current residents have the potential to be affected by the alleged deficient practice.

CSM and Assistant Executive Director were inserviced on the requirement to develop a care plan for the resident, in consult with resident on October 11, 2019.

Care Services Manager and/or licensed designee will be responsible for sustained compliance.

Care Services Manager and/or licensed designee will audit resident records for care plan to include interventions and goals as needed for 4 residents twice per week for 4 weeks, then for 4 residents weekly for 4 weeks; then records for 1 resident per week for 4 weeks.

Audits results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Monitoring records will be maintained by Executive Director or designee as evidence of correction.

11/16/2019

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			Date 10/17/2019
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
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If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/16/2019

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: SE2M11

Date Survey Completed: 9/4/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 921 SS=E

Based on: interview and record review, it was determined the center failed to use qualified staff to administer inhaled medication for 1 (#6) of 1 sampled resident who had inhaled medication prescribed by a physician and administer insulin for 1 (#1) sampled resident who had insulin prescribed by a physician. This failed practice had the potential for more than minimal harm, at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Care Services Manager/ Registered Nurse reviewed medication orders and implemented a written FSBS (Finger stick Blood Sugar) and Insulin log was put in place for resident #1 to ensure that only licensed nurses are performing FSBS and Insulin administration on October 17, 2019.

Care Services Manager/ Registered Nurse reviewed resident orders and obtained orders to add verbiage to the breathing treatment orders for resident #6 Electronic Medication Record stating "Treatment may ONLY be administered by ACMA with respiratory endorsement or licensed nurse" on October 17, 2019.

CSM (Care Services Manager) or Registered Nurse designee will audit current residents records for FSBS, insulin, if orders for such are present then FSBS/Insulin log will be put in place by November 1, 2019.

CSM (Care Services Manager) and/or Registered Nurse designee will audit current resident records for breathing treatment orders, if orders for such are present then orders will be obtained to add verbiage "Treatment may ONLY be administered by ACMA with respiratory endorsement or licensed nurse" by November 1, 2019.

Current medication staff will be inserviced on requirement that Certified Medication Aides shall not administer medications or nutrition via nasogastric tubes, or administer oral metered dose inhalers or nebulizers, unless the CMA has completed a Department –approved

	advanced training program and has demonstrated competency for such services. Inservice will also include that only licensed nurses may administer insulin and review of FSBS/insulin log in place for licensed staff only by November 1st, 2019. CSM and Assistant Executive Director were inserviced on requirement that Certified Medication Aides shall not administer medications or nutrition via nasogastric tubes, or administer oral metered dose inhalers or nebulizers, unless the CMA has completed a Department-approved advanced training program and has demonstrated competency for such services. Inservice also included that only licensed nurses may administer insulin and orders should be reviewed monthly by a registered nurse or pharmacist and quarterly by a consult pharmacist on 10/11/2019.
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?	CSM and/or designee will review future resident orders for FSBS, Insulin or breathing treatments upon admission, if applicable will add FSBS/Insulin log and/or request orders to add verbiage that only qualified staff to administer breathing treatment. Registered Nurse, CSM, pharmacist and/or other company Registered Nurse with review Medication Records for current residents monthly. CSM and/or designee will review current resident orders for addition of FSBS, Insulin or breathing treatments, if applicable will add FSBS/Insulin log and/or request orders to add verbiage that only qualified staff to administer breathing treatment.
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.	Care Services Manager, Registered Nurse and/or licensed designee will be responsible for sustained compliance. Care Services Manager, Registered Nurse and/or licensed designee will audit 3 resident records for FSBS/ Insulin log and/or signature of qualified staff for breathing treatments biweekly for 4 weeks, then weekly for 4 weeks then monthly for 3 months. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring records will be maintained by Executive Director of designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/16/2019

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			Date 10/17/2019
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Facility in Compliance by: Click here to enter a date.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/17/2019

Facility Name: Ten Oaks Place

License Number: AL 1602

Survey Event ID: SE2M11

Date Survey Completed: 9/4/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923 SS=E

Based on: record review and interview, it was determined the center failed to maintain an accurate written record of inhaled medications for one (#6) of one sampled resident that was administered inhaled medication by the center's staff. The failed practice had the potential for more than minimal harm, at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Electronic Medication Administration Record was updated to reflect the 2 initials of each medication staff that differentiates each ones personal identity to ensure accurate written record of medication staff on October 17, 2019 for resident #6.

Current residents have the potential to be affected by the alleged deficient practice.
Enter corrective action for residents affected.

CSM and Assistant Executive Director were inserviced on requirement for accurate written record of medications administered shall be maintained. The medication record shall include: the identity and signature of the person administering the medication on October 11, 2019.

CSM and/ or designee will audit the current Electronic Medication Administration Record of current residents for accurate identity of medication staff that administer medication by November 1, 2019.

Community has identified medication staff that require additional certification for specialized areas. Community offered to cover cost of additional certification of staff in order to receive respiratory endorsement.

CSM and or designee will schedule ACMA's (Respiratory Certified) and/or licensed nurses to cover the administration of these specialized treatments.

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.	Care Services Manager and/or designee will be responsible for sustained compliance. Care Services Manager and/or designee will conduct MAR audits 2 times a week for 4 weeks, then 1 time a week for 4 weeks, then twice per month for 1 month to ensure corrections are sustained. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring records will be maintained by Executive Director or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/16/2019
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310.663-25-4(F)	Date 10/17/2019
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/17/2019

Facility Name: Ten Oaks Place

License Number: AL 1602

Survey Event ID: SE2M11

Date Survey Completed: 9/4/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 5010 SS=E

Based on: observation, interview and record review, it was determined the center failed to coordinate care with home health for 1(#3) of 1 sampled resident that required wound care and had attended a wound care clinic. This deficient practice had the potential for more than minimal harm, at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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 ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

CSM (Care Services Manager) reconciled orders with home health and physician for resident #3 on October 17, 19.

CSM (Care Services Manager) and/or designee will audit current resident records with third parties to ensure communication of skin changes, abnormal findings, and concerns by November 1st, 2019.

Third Parties will be inserviced on requirement to contact CSM (Care Services Manager) and/or designee with any skin changes, potential skin concerns will be addressed on the home health charting form and discussed immediately with nurse on duty by November 1, 2019.

Care Services Manager and/or designee to inservice current staff on policy to report changes in skin condition to CSM and/or designee by November 1, 2019. New hire staff will be oriented to policy to report skin changes to CSM and/or designee.

CSM and Assistant Executive Director were inserviced by Regional Director of Care Services on requirement that assisted living center shall monitor and assure delivery of home health and hospice services. All nursing services shall be in accordance with written orders of the personal or attending physician of the resident on October 11, 2019.

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.		Care Services Manager and/or designee will be responsible for sustained compliance. Care Services Manager and/or designee will audit 5 resident records for third party documentation of skin changes biweekly for 4 weeks, then weekly for 4 weeks then monthly for 3 months. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring records will be maintained by Executive Director or designee as evidence of correction.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		11/16/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date 10/17/2019	
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 10/16/2019

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: SE2M11

Date Survey Completed: 9/4/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1437 SS=E

Based on: interview and record review, it was determined the center failed to ensure nebulizer treatments and insulin were administered and FSBS (finger stick blood sugar testing) was performed by a CMA (certified medication aide) who had completed a Department approved advanced training program for 1 (#6) of 1 sampled resident resident who received physician ordered nebulizer treatments and 1 (#1) of 1 sampled resident who had physician ordered FSBS testing and insulin injections. This failed practice had the potential for more than minimal harm, at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

CSM and Assistant Executive Director were inserviced on requirement that Certified Medication Aides shall not administer medications or nutrition via nasogastric tubes, or administer oral metered dose inhalers or nebulizers, unless the CMA has completed a Department-approved advanced training program and has demonstrated competency for such services. Inservice also included that only licensed nurses may administer insulin on 10/11/2019.

Care Services Manager obtained orders to add verbiage to the breathing treatment orders for resident #6 Electronic Medication Record stating "Treatment may ONLY be administered by ACMA with respiratory endorsement or licensed nurse" on October 17, 2019.

OSDH Response: Element accepted Yes ☐ No ☐

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

Current residents have the potential to be affected by the alleged deficient practice
Current medication staff will be inserviced on requirement that Certified Medication Aides shall not administer medications or nutrition via nasogastric tubes, or administer oral metered dose inhalers or nebulizers, unless the CMA has completed a Department –approved advanced training program and has demonstrated competency for such services. Inservice will also include that only licensed nurses may administer insulin and review of FSBS/insulin log in place for licensed staff only by November 1st, 2019.

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?		Current medication staff will be inserviced on requirement that Certified Medicaiton Aides shall not administer medications or nutrition via nasogastric tubes, or administer oral metered dose inhalers or nebulizers, unless the CMA has completed a Department –approved advanced training program and has demonstrated competency for such services. Inservice will also include that only licensed nurses may administer insulin and review of FSBS/insulin log in place for licensed staff only by November 1 st , 2019.	
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.		Care Services Manager and/or designee will be responsible for sustained compliance. Care Services Manager and/or designee will audit 3 resident records for signature of qualified staff for breathing treatments biweekly for 4 weeks, then weekly for 4 weeks then monthly for 3 months. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		11/16/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date 10/17/2019	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



Oklahoma State Department of Health
Creating a State of Health

January 9, 2020

License Number: AL1602

Ms. Tammy Kuhlman, Administrator
Ten Oaks Place
3610 Southeast Huntington Circle
Lawton, OK 73501

RE: Survey Event SE2M12

Dear Ms. Kuhlman:

On **December 27, 2019**, a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **September 4, 2019**, have now been corrected effective **November 16, 2019**.

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Kate Stagner

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ks

Board of Health

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Commissioner of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL1602	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING. _____	(X3) DATE SURVEY COMPLETED R 12/27/2019
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TEN OAKS PLACE

**3610 SOUTHEAST HUNTINGTON CIRCLE
LAWTON, OK 73501**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 12/27/19 a follow-up survey was conducted. Census was 76. All deficient practice was cleared.	{N 000}		
{C 000}	INITIAL COMMENTS On 12/27/19 a follow-up survey was conducted. Census was 76. All deficient practice was cleared.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

STATE WORKLOAD REPORT
 Provider/Supplier Number
 AL1602

 Provider/Supplier Name
 TEN OAKS PLACE

Type of Survey (select all that apply)

2	D			
---	---	--	--	--

 A Complaint Investigation
 B Dumping Investigation
 C Federal Monitoring
 D Follow-up Visit
 M Other

 E Initial Certification
 F Inspection of Care
 G Validation
 H Life Safety Code

 I Recertification
 J Sanctions/Hearing
 K State License
 L CHOW

Extent of Survey (select all that apply)

A				
---	--	--	--	--

 A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey
SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30875	12/27/2019	12/27/2019	0.50	0.00	2.00	0.00	2.50	1.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours....

0.00

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