OKLAHOMA
State Department
of Health

Delivery via email to: tkuhlman@enlivant.com

November 10, 2020

License Number: AL1602

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

Survey Event ID: ZCN411

Dear Ms. Kuhlman:

On **October 22, 2020**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

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

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

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

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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

OKLAHOMA
State Department
of Health

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,

Users, Lisa D Calvin

Digitally signed by Users, Lisa D Calvin
Date: 2020.11.10 15:04:40 -06'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Ten Oaks Place**
Address: **3610 Southeast Huntington Circle**
City, State, Zip: **Lawton, OK 73501**
Provider #: **AL1602**
Complaint #: **OK00056145**
Investigation Date(s): **10/16/20, 10/17/20, and 10/22/20**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center has failed to provide sufficient staff to provide the needed care and supervision of residents.	S

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

An unannounced on-site investigation was initiated 10/16/2020 at 9:05 p.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag L0911 and L1505 for details.

Determination Summary and Follow-Up Action:

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

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Shelia Williamson RN

Shelia Williamson, R.N.

Date report completed: 10/26/2020

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	10/22/2020

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
C 000	INITIAL COMMENTS On 10/16/20, 10/17/20, and 10/22/20 an abbreviated survey was conducted to investigate complaint #OK00056145.	C 000		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide adequate registered nurse supervision to ensure residents were weighed and variances addressed as indicated for two (#1 and #4) of two residents reviewed for accurate weights, and the facility failed to administer a medication as ordered to one (#2) of two residents reviewed for medication administration. Findings: 1. Resident #1 had a physician's order, dated 04/29/20, to obtain weights weekly. The clinical	C 911		

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C 911	Continued From page 1 record was reviewed and did not document weekly weights. A review of the facility's weight log documented: July 2020, 75.0 pounds (lbs) and September 67.8 lbs. The ADON provided a weight record of 92.8 lbs for August 2020 and 93.1 lbs for September. Hospice records documented a weight of 74.0 lbs in August. On 10/22/20 at 3:45 p.m., CMA #1 reported no knowledge of any resident who was supposed to be weighed weekly. The aide reviewed the resident's chart and stated the resident did have an order to weigh weekly but reported there was no documentation of consistent weekly weights. 2. Resident #4 had physician orders to receive Ensure twice a day and Megace twice daily for appetite. A review of the facility's weight log documented: July 2020, 157.8 lbs, August 130.1 lbs, and September 137.6 lbs. The ADON provided a weight record of 130.9 lbs for September. The ADON reported she thought the July weight included the resident's wheelchair. On 10/22/20 at 2:38 p.m., an interview was conducted with CMA #1 and CNA's #1, #2, and #3 regarding documentation of weights. All of the aides reported weights were not rechecked when a significant variance was noted. The aides reported they had not been told to re-weigh residents or report weight differences. On 10/22/20 at 2:45 p.m., CMA #1 reported maintenance staff was in charge of bringing the scale to the memory unit when they needed to weigh residents. The aide voiced a concern that	C 911		

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C 911	Continued From page 2	C 911		

the scale was not being calibrated each time it was moved from unit to unit.

On 10/22/20 at 3:10 p.m., during a telephone interview, a hospice social worker reported hospice staff normally used the facility's machine to weigh hospice residents but stated recently it had not been made available for hospice staff to use.

On 10/22/20 at 4:05 p.m., the ADM reported the facility had one platform scale for the whole facility and it had to be moved from unit to unit as needed.

3. Resident #2 had a physician order, dated 10/22/20, to give Coumadin (a blood thinner) 6 mg, one 5 mg tablet and one 1 mg tablet to equal 6 mg daily.

Medication administration records and the clinical record were reviewed and documented frequent changes to the Coumadin dosage based on blood test results. The medication administration records documented missed doses of the medication during the month of October 2020.

On 10/22/20 at 2:05 p.m., the ADON reported the hospice nurse was responsible for obtaining a point-of-care PT/INR (a prothrombin time test/international normalization ratio) to determine if the resident's Coumadin dose was therapeutic. The ADON reported the hospice physician had been adjusting the resident's dose almost weekly and she had noted it appeared the resident had missed some doses. The ADON stated she had recently required CMA's to initial the medication card when the medication was given in order to double-check the cards and ensure the medication was given appropriately. The ADON

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C 911	Continued From page 3 reported she had talked with the hospice nurse and stated the nurse was going to order a blood draw for the resident to compare those lab results with the ones obtained by the point of care machine. On 10/22/20 at 2:35 p.m., the ADON reported staffing had been tight but they managed to cover shifts as needed. She stated she often helped out on the floor to ensure resident's needs were met and was also filling in as DON while the facility DON was out on medical leave. She stated she starting working at the facility in July and immediately noticed an issue with documentation of resident weights. She stated she did a hands-on inservice with aides to discuss not weighing wheelchairs and to re-weigh residents if significant variances were identified. Multiple staff members were interviewed throughout the investigation on 10/16/20, 10/17/20, and 10/22/20. Staff reported the facility was not staffed adequately on most shifts and recently several staff had resigned. The ADM reported several staff had resigned recently due to a change in schedules and more staff would be leaving as they completed their notices. The ADM stated new staff had been hired and some were awaiting background checks. The ADM reported the facility DON is out on medical leave and the ADON (an RN) was covering as DON.	C 911		
C1505 SS=E	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	C1505		

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C1505	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide sufficient staff to ensure residents were weighed and variances addressed as indicated for two (#1 and #4) of two residents reviewed for accurate weights, and the facility failed to	C1505		

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C1505	Continued From page 5 administer a medication as ordered to one (#2) of two residents reviewed for medication administration. Findings: 1. Resident #1 had a physician's order, dated 04/29/20, to obtain weights weekly. The clinical record was reviewed and did not document weekly weights. A review of the facility's weight log documented: July 2020, 75.0 pounds (lbs) and September 67.8 lbs. The ADON provided a weight record of 92.8 lbs for August 2020 and 93.1 lbs for September. Hospice records documented a weight of 74.0 lbs in August. On 10/22/20 at 2:05 p.m., the resident was observed reclining in a chair in the common area with other residents on the memory care unit. The resident was observed to interact with staff and answer, "yes", when asked if she wanted some chocolate. Staff reported the resident required feeding assistance but had a real good appetite and liked to drink chocolate Ensure. On 10/22/20 at 3:45 p.m., CMA #1 reported no knowledge of any resident who was supposed to be weighed weekly. The aide reviewed the resident's chart and stated the resident did have an order to weigh weekly but reported there was no documentation of consistent weekly weights. 2. Resident #4 had physician orders to receive Ensure twice a day and Megace twice daily for appetite. A review of the facility's weight log documented: July 2020, 157.8 lbs, August 130.1 lbs, and	C1505		

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C1505	Continued From page 6 September 137.6 lbs. The ADON provided a weight record of 130.9 lbs for September. The ADON reported she thought the July weight included the resident's wheelchair. On 10/22/20 at 2:38 p.m., an interview was conducted with CMA #1 and CNA's #1, #2, and #3 regarding documentation of weights. All of the aides reported weights were not rechecked when a significant variance was noted. The aides reported they had not been told to re-weigh residents or report weight differences. On 10/22/20 at 2:45 p.m., CMA #1 reported maintenance staff was in charge of bringing the scale to the memory unit when they needed to weigh residents. The aide voiced a concern that the scale was not being calibrated each time it was moved from unit to unit. On 10/22/20 at 3:10 p.m., during a telephone interview, a hospice social worker reported hospice staff normally used the facility's machine to weigh hospice residents but stated recently it had not been made available for hospice staff to use. On 10/22/20 at 4:05 p.m., the ADM reported the facility had one platform scale for the whole facility and it had to be moved from unit to unit as needed. 3. Resident #2 had a physician order, dated 10/22/20, to give Coumadin (a blood thinner) 6 mg, one 5 mg tablet and one 1 mg tablet to equal 6 mg daily. Medication administration records and the clinical record were reviewed and documented frequent changes to the Coumadin dosage based on blood	C1505		

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C1505	Continued From page 7	C1505		

test results. The medication administration records documented missed doses of the medication during the month of October 2020.

On 10/22/20 at 2:05 p.m., the ADON reported the hospice nurse was responsible for obtaining a point-of-care PT/INR (a prothrombin time test/international normalization ratio) to determine if the resident's Coumadin dose was therapeutic. The ADON reported the hospice physician had been adjusting the resident's dose almost weekly and she had noted it appeared the resident had missed some doses. The ADON stated she had recently required CMA's to initial the medication card when the medication was given in order to double-check the cards and ensure the medication was given appropriately. The ADON reported she had talked with the hospice nurse and stated the nurse was going to order a blood draw for the resident to compare those lab results with the ones obtained by the point of care machine.

On 10/22/20 at 2:15 p.m., the resident was observed ambulating in her room on the memory care unit. The resident was noted to have a right black eye and stated she ran into the bathroom door. The resident was observed to be alert, oriented to person and place, and very independent.

On 10/22/20 at 2:35 p.m., the ADON reported staffing had been tight but they managed to cover shifts as needed. She stated she often helped out on the floor to ensure resident's needs were met and was also filling in as DON while the facility DON was out on medical leave. She stated she starting working at the facility in July and immediately noticed an issue with documentation of resident weights. She stated

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C1505	Continued From page 8 she did a hands-on inservice with aides to discuss not weighing wheelchairs and to re-weigh residents if significant variances were identified. Multiple staff members were interviewed throughout the investigation on 10/16/20, 10/17/20, and 10/22/20. Staff reported the facility was not staffed adequately on most shifts and recently several staff had resigned. The ADM reported several staff had resigned recently due to a change in schedules and more staff would be leaving as they completed their notices. The ADM stated new staff had been hired and some were awaiting background checks. The ADM reported the facility DON is out on medical leave and the ADON (an RN) was covering as DON.	C1505		

OKLAHOMA
State Department
of Health

Delivery Via Email: Bratcliff@enlivant.com

December 9, 2020

License Number: AL1602

Ms. Brandy Ratcliff, Interim Administrator
Ten Oaks Place
3610 Southeast Huntington Circle
Lawton, OK 73501

Survey Event ID: ZCN411

Dear Ms. Ratcliff:

On **October 22, 2020**, complaint investigation #OK00056145 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 **December 25, 2000**.

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.

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State Department of Health, ou=Long Term Care, email=katies@health.ok.gov, c=US
Date: 2020.12.09 08:00:30 -06'00'

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/25/2020** **Facility Name:** Ten Oaks Place **License Number:** AL1602 **Survey Event ID:** ZCN411 **Date Survey Completed: 10/22/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 911 SS=E	Based on: Based on interview and record review it wasdetermined the facility failed to provide adequate registered nurse supervision to ensure residents were weighed and variances addressed as indicated for two (#1 and #4) of two residents reviewed for accurate weights, and the facility failed to administer a medication as ordered to one (#2) of two residents reviewed for medication administration.

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	**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 #1 no longer resides in community. For resident #4, a current weight was obtained on November 25, 2020 and Registered Nurse/ Care Services Manager (CSM) requested an order to clarify weight frequency from resident's physician. For resident # 2, Registered Nurse/Care Services Manager (CSM) requested an order on November 25, 2020 to clarify current Coumadin order and next PT/INR (a prothrombin time test/international normalization ratio) lab draw from resident's physician. On November 25, 2020 Registered Nurse/Care Services Managaer (CSM) notified physician of missed doses of Coumadin in the month of October 2020 and completed a incident report for missed doses of Coumadin.
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. Two new scale were ordered by community on November 25, 2020. Registered Nurse/ Care Services Manager (CSM) and/or designee will audit current residents physician orders for weight orders by December 18, 2020. Any residents noted to have orders for weight frequency greater than monthly will be identified in the weight binder as per the frequency of the physician's orders. Registered Nurse/ Care Services Manager (CSM) and/or designee will audit current resident Medicaton

	weeks then 3 resident Medication Administration Record (MAR) for Coumadin and PT/INR orders for 4 weeks then 1 resident Medication Administration Record (MAR) for Coumadin and PT/INR orders for 4 weeks. If any discrepancies or missed doses are noted then physician will be contacted. 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 and/or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/25/2020
OSDH Response: Element accepted Yes ☐ No ☐	

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

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

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	Administration Records (MAR) for Coumadin and PT/INR orders by December 18, 2020. Phyisican will be notified of residents noted to have any missed doses of Coumadin in current month or discrepancies.
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?	Registered Nurse/ Care Services Manager (CSM) and/ or designee will audit 4 resident records for weight log and weight orders for 4 weeks then 3 resident records for weight log and weight orders for 4 weeks then 2 resident records for weight log and weight orders for 4 weeks. If any discrepancies are noted then they will be rectified. Registered Nurse/ Care Services Manager (CSM) and/or designee will audit 4 resident Medication Administration Record (MAR) for Coumadin and PT/INR orders for 4 weeks then 3 resident Medication Administration Record (MAR) for Coumadin and PT/INR orders for 4 weeks then 1 resident Medication Administration Record (MAR) for Coumadin and PT/INR orders for 4 weeks. If any discrepancies or missed doses are noted then physician will be contacted. Regional Director of Care Services inserviced the Registered Nurse/ Care Services Manager (CSM) and Area Executive Director (AED) on November 25, 2020 on the requirement to nurse staffing shall be provided or arranged (1) registered nurse supervision of skilled nursing interventions. Care Services Manager (CSM) and /or designee will inservice Medicaton Administration Staff and Certified Nurse Aides on documentation of weights, calibration of scale if needed, requirement to recheck weights when a significant variance is noted and report weight differences to nurse by December 18, 2020.
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. Registered Nurse/ Care Services Manager (CSM) and/ or designee will audit 4 resident records for weight log and weight orders for 4 weeks then 3 resident records for weight log and weight orders for 4 weeks then 2 resident records for weight log and weight orders for 4 weeks. If any discrepancies are noted then they will be rectified. Registered Nurse/ Care Services Manager (CSM) and/or designee will audit 4 resident Medication Administration Record (MAR) for Coumadin and PT/INR orders for 4

	Reference tag C911 SS=E Plan of Correction November 25, 2020.
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.	Area Executive Director (AED) and/or designee will be responsible for sustained compliance. Area Executive Director and/ or designee will audit staffing schedules 3 times a week for 4 weeks then 2 times a week for 4 weeks then 1 time a week for 4 weeks for adequate staff levels. If adequate level of staff is still not present then hiring efforts will continue, agency will continue if indicated. 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 and/or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/25/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 11/25/2020

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	Reference tag C911 SS=E Plan of Correction November 25, 2020.
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.	Area Executive Director (AED) and/or designee will be responsible for sustained compliance. Area Executive Director and/ or designee will audit staffing schedules 3 times a week for 4 weeks then 2 times a week for 4 weeks then 1 time a week for 4 weeks for adequate staff levels. If adequate level of staff is still not present then hiring efforts will continue, agency will continue if indicated. 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 and/or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/25/2020
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 11/25/20

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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: 11/25/2020** **Facility Name:** Ten Oaks Place **License Number:** AL1602 **Survey Event ID:** ZCN411 **Date Survey Completed: 10/22/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1505 SS=E	Based on: Based on observation, interview, and record review it was determined the facility failed to provide sufficient staff to ensure residents were weighed and variances addressed as indicated for two (#1 and #4) of two residents reviewed foraccurate weights, and the facility failed to administer a medication as ordered to one (#2) of two residents reviewed for medication administration.

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	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 #1 no longer resides in community. For resident #4, a current weight was obtained on November 25, 2020 and Registered Nurse/ Care Services Manager (CSM) requested an order to clarify weight frequency from resident's physician. For resident # 2, Registered Nurse/Care Services Manager (CSM) requested an order on November 25, 2020 to clarify current Coumadin order and next PT/INR (a prothrombin time test/international normalization ratio) lab draw from resident's physician. On November 25, 2020 Registered Nurse/Care Services Managaer (CSM) notified physician of missed doses of Coumadin in the month of October 2020 and completed a incident report for missed doses of Coumadin.
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.
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?	Area Executive Director (AED) and/or designee has initiated recruiting efforts to hire and onboard staff to meet required staffing levels as of November 16, 2020 until staffing levels are adequate. Area Executive Director (AED) and/or designee has contracted with two staffing agencies in an effort to meet required staffing levels as of November 16, 2020 until Ten Oaks has adequate level of internal staff members.

	Reference tag C911 SS=E Plan of Correction November 25, 2020.
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.	Area Executive Director (AED) and/or designee will be responsible for sustained compliance. Area Executive Director and/ or designee will audit staffing schedules 3 times a week for 4 weeks then 2 times a week for 4 weeks then 1 time a week for 4 weeks for adequate staff levels. If adequate level of staff is still not present then hiring efforts will continue, agency will continue if indicated. 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 and/or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/25/2020
OSDH Response: Element accepted Yes ☐ No ☐	

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Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department
of Health

Delivery via email to: Bratcliff@enlivant.com

May 24, 2021

License Number: AL1602

Ms. Brandy Ratcliff, Interim Administrator
Ten Oaks Place
3610 Southeast Huntington Circle
Lawton, OK 73501

RE: Survey Event ZCN412

Dear Ms. Ratcliff:

On **May 6, 2021,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 22, 2020,** have now been corrected effective **December 25, 2020.**

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

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.05.24 10:55:51
-05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	R 05/06/2021

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
{C 000}	INITIAL COMMENTS An offsite/paper visit was completed on 05/06/21. Credible evidence of correction was submitted for all deficiencies.	{C 000}		

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