

Delivery via email to: mharper@enlivant.com

November 12, 2021

License Number: AL1602

Ms. Micah Harper, Administrator
Ten Oaks Place
3610 Southeast Huntington Circle
Lawton, OK 73501

Survey Event ID: G4DV11

Dear Ms. Harper:

On **October 29, 2021**, 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.



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

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

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

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

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

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

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



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

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

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

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

Sincerely,

Lisa Calvin

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

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73505
Provider #: AL1602
Complaint #: OK00055573
Investigation Date(s): 10/26/21 through 10/29/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate and appropriate medical care and failed to notify family with a change in condition.	US
2. The center failed to have adequate staff to provide care as contracted	US

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

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to provision of adequate and appropriate medical care, as well as notification of changes in condition was conducted.

A tour of the facility was conducted upon entrance and throughout the investigation. Residents were observed to be neat, clean, and well-groomed. Residents were observed during meal times, while receiving personal care, and during activities. Residents were observed to receive assistance as needed with eating and meal set-up.

The facility was observed to have four different types of weight scales including a standard scale, a stand-up scale with a device to measure height, a chair scale on wheels, and a scale to be used for residents confined to a wheel chair.

Sampled residents reported they were weighed on a regular basis. Residents stated their family members or representatives were notified related to any change in condition. Staff reported weight records were maintained on a log in the memory care unit for those residents. Staff reported the facility was now requiring resident weights to be entered into the E-MAR (electronic medication administration record) for each individual resident.

Sampled clinical records, including closed records, were reviewed for weights, physician orders, care plans, and assessments. Discharge hospital records were reviewed. Incident reports were reviewed and documented appropriate notification. Facility policies were reviewed.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to provision of adequate staff to provide care as contracted was conducted.

Residents were observed on all units throughout the facility. Residents were observed to receive care as needed in a timely manner. Staff was observed to answer call lights and assist residents with eating, personal care and toileting, and with transfers as needed.

Residents reported no complaints or concerns related to adequate staff to meet their needs. Staff members reported the facility continued to utilize agency staff to ensure adequate staffing for the reported resident census. Facility administration reported recent new-hires and continued efforts in hiring staff to reduce the need for agency assistance.

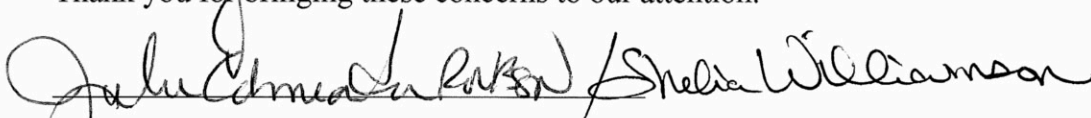
Sampled clinical records, including closed records, were reviewed for physician orders, care plans, and assessments. Incident reports were reviewed and documented appropriate assessments and interventions related to resident falls and/or accidents. Incident reports documented thorough investigations in regard to fall prevention. Facility staffing schedules and records were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Julie Edmiaston RN, BSN

Sheila Williamson RN, Clinical Facility Health Surveyor

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK, 73501
Provider #: AL 1602
Complaint #: OK00055744
Investigation Date(s): 10/26/21, 10/27/21, 10/28/21, and 10/29/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate medical care and services, and failed to ensure staff wore identifying name tags.	US

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

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to adequate medical care and services, and staff with name tags was conducted.

Upon entrance to the facility and throughout all days of the investigation, residents were observed to be assisted by staff with activities of daily living in a respectful and timely manner. Residents wore clean clothing and were well groomed with no lingering odors noted. Staff members were observed to assist residents with timely care as needed. Facility staff was observed to wear name badges appropriate to positions.

Residents were interviewed and reported no concerns with prompt care from staff for assistance of needs. Staff reported a consistent schedule for toileting needs and bed linen changes.

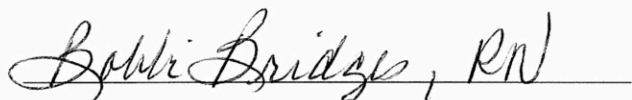
Sampled clinical records, including closed records, were reviewed for assessments, care plans, physician orders, skin assessments, and treatment records. Facility incident reports, staffing schedules, resident council meeting minutes, and infection control records were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script that reads "Bobbi Bridges, RN". The signature is written in dark ink and is positioned above a horizontal line.

Bobbi Bridges, RN

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK, 73501
Provider #: AL1602
Complaint #: OK00055850
Investigation Date(s): 10/26/21, 10/27/21, 10/28/21, and 10/29/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate medical care, as well as a clean environment.	US

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

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

A sample of three 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 statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to adequate medical care and a clean environment was conducted.

Upon entrance and throughout all days of the investigation the facility was observed to be clean and free of lingering odors. Housekeeping and other staff members were observed to clean all areas and empty trash as needed. Residents were observed to be dressed appropriately, clean, and well-groomed. Residents were observed to be assisted by staff with activities of daily living in a respectful and timely manner. Residents were observed during mealtime, group activities, and during medication pass.

Residents were interviewed and denied any concerns with a clean environment and care provided by the staff. Staff members could identify assistance needed of residents with all areas of activities of daily living. Staff reported cleaning products were available for use on all shifts.

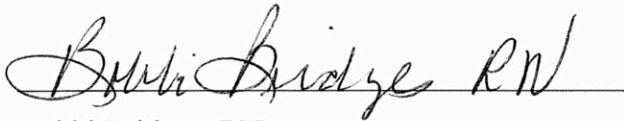
Clinical records, including closed records, were reviewed for assessments, care plans, nutritional records, physician orders, and skin assessments. Incident reports, resident council minutes, and hospice services were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script that reads "Bobbi Bridges RN". The signature is written in dark ink and is positioned above the printed name.

Bobbi Bridges, RN

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK, 73501
Provider #: AL1602
Complaint #: OK00055947
Investigation Date(s): 10/26/21, 10/27/21, 10/28/21, and 10/29/21

ALLEGATION	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide sufficient staff to provide care according to residents' contracts.	US

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

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

A sample of nine residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to sufficient staff to provide care according to resident's contracts was conducted.

A tour of the facility was conducted upon entrance and throughout the investigation. The facility was observed to be clean and without lingering odors. Residents were observed in their rooms, during activities, during meals, and receiving personal care. Residents were observed to be neat, clean, and well-groomed. Staff was observed to respond to call lights and provide assistance to residents. The facility was observed to be sufficiently staffed to safely meet the needs of residents.

Residents were interviewed and reported they received adequate care from staff. Residents reported no complaints related to staff assisting them with activities of daily living. Staff were interviewed and reported being adequately staffed to safely assist residents with activities of daily living. Facility administration reported using agency staff to provide sufficient staffing, with ongoing efforts to hire additional staff.

Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and progress notes. Resident council meeting minutes documented no complaints related to sufficient staffing to provide care. Incident reports and facility staffing records were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Leah Mays, LPN, Clinical Health Facility Surveyor

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL1602
Complaint #: OK00056149
Investigation Date(s): 10/26/21 through 10/29/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have adequate staff to meet the needs of the residents/provide care as contracted/ordered by the physician.	US

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

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

A sample of nine 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 statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to adequate staff to meet the needs of residents, and provision of care as contracted and ordered by the physician, was conducted.

A tour of the facility was conducted upon entrance and throughout the investigation. Residents were observed during meal times, during medication administration, while participating in activities, and while receiving personal care. Residents were observed to be clean and well-groomed. Residents who required assistance with

eating were observed to receive assistance with meals. Call lights were observed to be answered in a timely manner.

Residents, including sampled residents, reported they received assistance as needed with eating and meal set-up. Residents voiced no complaints related to adequate staffing. Sampled residents reported they received medications on time and as ordered by their physician. Family members reported no complaints or concerns related to feeding assistance or medications. Staff members reported the facility continued to utilize agency staff to ensure adequate staffing for the reported resident census. Staff members reported numerous interventions had been implemented to ensure timely administration of medications.

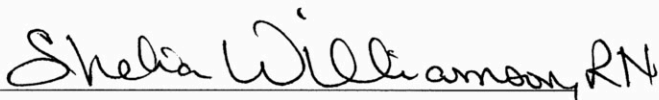
Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, weights, and medication administration records. Hospice records were reviewed. Incident reports were reviewed. Resident council minutes were reviewed and documented no complaints or concerns related to adequate staffing. Facility policy and procedures were reviewed. Staffing schedules and records were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink that reads "Shelia Williamson RN". The signature is written in a cursive, flowing style.

Shelia Williamson, RN, Clinical Health Facility Surveyor

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK, 73501
Provider #: AL1602
Complaint #: OK00056292
Investigation Date(s): 10/26/21, 10/27/21, 10/28/21, and 10/29/21

ALLEGATION	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate staff to meet the needs of the residents.	US

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

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

A sample of nine 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 statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to adequate staffing to meet the needs of residents was conducted.

A tour of the facility was conducted upon entrance and throughout the investigation. The facility was observed to be clean and without lingering odors. Residents were observed in their rooms, during activities, during meals, and receiving personal care. Residents were observed to be neat, clean, and well-groomed. Staff was observed providing incontinent care, assisting residents with activities of daily living, and responding to call lights in a timely manner. The facility was observed to be adequately staffed to meet the needs of residents.

Residents were interviewed and reported they received adequate care in a timely manner. Residents reported no complaints related to nursing care. Staff members were interviewed and reported being adequately staffed to provide adequate care to residents. Facility administration reported using agency staff to provide sufficient staffing, with ongoing efforts to hire additional staff.

Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and progress notes. Resident council meeting minutes documented no complaints related to staffing and adequate care. Incident reports and facility staffing records were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Leah Mays, LPN, Clinical Health Facility Surveyor

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL1602
Complaint #: OK00056297
Investigation Date(s): 10/26/21, 10/27/21, 10/28/21, and 10/29/21

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The center failed to ensure staff followed proper infection control procedures.	US
2. The center failed to ensure medications were properly administered.	US

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

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

A sample of three residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to proper infection control procedures was conducted.

A tour of the facility was conducted upon entrance and throughout the investigation. The facility was observed to be clean and without lingering odors. Appropriate screening of visitors and staff was conducted upon entrance to the facility. Personal protective equipment (PPE) was observed to be utilized appropriately and as indicated. PPE was observed to be disposed of properly.

Residents, including sampled residents, reported no complaints or concerns related to proper infection control procedures. Residents reported they were provided masks as needed and encouraged to perform hand hygiene. Staff reported no issues related to appropriate disposal of PPE or other wastes. Housekeeping staff reported schedules for cleaning and proper waste disposal.

Sampled clinical records were reviewed for physician orders, care plans, and assessments. Infection control records, including COVID-19 logs, were reviewed. Facility policy and procedures were reviewed.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to proper administration of medications was conducted.

Residents were observed during medication administration. Certified medication aides (CMAs) were observed to prepare and administer medications per physician orders.

Sampled residents were interviewed and reported no complaints related to medication administration. Residents reported they received their medications on time and as ordered by their physician. Staff reported a process for counting narcotics, as well as procedures for narcotic destruction. Staff reported a process and procedure for reporting medication errors.

Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and medication administration records. Incident reports were reviewed. Facility policy and procedures were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Shelia Williamson, R.N., Clinical Health Facility Surveyor

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL1602
Complaint #: OK00056457
Investigation Date(s): 10/26/21, 10/27/21, 10/28/21, and 10/29/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate staff to meet the needs of the residents.	US

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

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to adequate staff to meet the needs of residents was conducted.

A tour of the facility was conducted upon entrance and throughout the investigation. The facility was observed to be clean and without lingering odors. Residents were observed to be neat, clean, and well-groomed. Residents were observed on all units during meal times, during medication administration, and while participating in activities. Residents were observed to receive assistance as needed with eating, meal set-ups,

toileting, transfers, and other activities of daily living. Staff members were observed to answer call lights in a timely manner and anticipate the needs of residents.

Residents, including sampled residents, reported no complaints related to adequate staffing. Residents reported they received assistance as needed in a timely manner. Staff members reported the facility continued to utilize agency staff to ensure adequate staffing for the reported resident census. Administration reported recent newly hired employees and ongoing efforts to decrease use of agency staff.

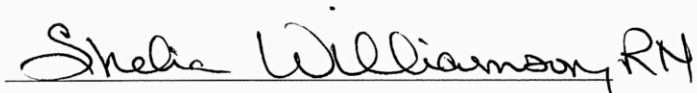
Sampled clinical records were reviewed for physician orders, care plans, and assessments. Incident reports were reviewed. Staffing schedules and records were reviewed and documented adequate staffing for the reported resident census. Resident council minutes were reviewed and documented no complaints or concerns related to adequate staffing.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Shelia Williamson, R.N., Clinical Health Facility Surveyor

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL1602
Complaint #: OK00056506
Investigation Date(s): 10/26/21, 10/27/21, 10/28/21, and 10/29/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to ensure medications were administered as prescribed.	US
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to medication administration was conducted.

A tour of the facility was conducted upon entrance and throughout the investigation. Residents were observed to receive medications on time and as prescribed by their physician. Certified medication aides were observed to prepare and administer medications appropriately.

Residents reported no complaints related to receiving their medications as ordered. Staff members reported a process for ordering and obtaining medications in a timely manner. Administration provided an incident report and investigation related to missed medications on a resident previously discharged from the facility. The report documented a thorough investigation with appropriate actions taken.

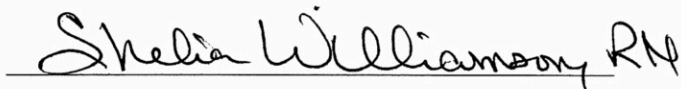
Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and medication administration records. Incident reports were reviewed. Facility policy and procedures were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script that reads "Shelia Williamson RN". The signature is written in black ink and is positioned above a horizontal line.

Shelia Williamson, R.N., Clinical Health Facility Surveyor

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL1602
Complaint #: OK00056621
Investigation Date(s): 10/26/21, 10/27/21, 10/28/21, and 10/29/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to provide adequate care and services.	US
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to provision of adequate care and services was conducted.

A tour of the facility was conducted upon entrance and throughout the investigation. Residents were observed to be neat, clean, and well-groomed. The facility was observed to be clean and without lingering odors. Residents were observed on all units during meal times, medication administration, and while participating in activities. Residents were observed to receive assistance as needed with activities of daily living.

Residents were interviewed and reported no complaints related to care provided. Residents stated they received assistance in a timely manner. Staff members reported residents were checked every two hours and as needed. Staff stated residents at risk for falls were monitored more closely as necessary.

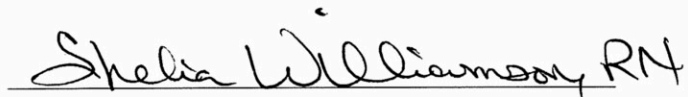
Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and medication administration records. Incident reports were reviewed and documented appropriate assessment of residents following falls, with intervention and treatment per physician orders. Facility policy and procedures were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script that reads "Shelia Williamson RN". The signature is written in black ink and is positioned above a horizontal line.

Shelia Williamson, R.N., Clinical Health Facility Surveyor

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL1602
Complaint #: OK00056743
Investigation Date(s): 10/26/21, 10/27/21, 10/28/21, and 10/29/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to maintain residents' rights, including visitation; failed to provide care and services according to resident contracts; and failed to have a plan in place to track residents' belongings.	US

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

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to resident rights, visitation, provision of care according to resident contracts, and tracking of resident belongings was conducted.

A tour of the facility was conducted upon entrance and throughout the investigation. Residents were observed to be neat, clean, and well-groomed. The facility was observed to be clean, homelike, and without lingering odors. Residents were observed on all units during meal times, medication administration, and while

participating in activities. Residents were observed to receive visitors without restrictions or limitations. Residents were observed to be treated with dignity and respect.

Residents were interviewed and reported no complaints related to care provided. Residents reported they could have visitors at any time without restrictions. Residents reported no complaints or concerns related to personal belongings. Family members reported they could visit their loved ones at any time without restrictions. One family member voiced a concern related to their loved one falling and requiring hospitalization.

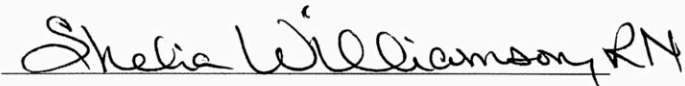
Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and medication administration records. Incident reports were reviewed and documented appropriate assessment of residents following falls, with intervention and treatment per physician orders. Facility policy and procedures were reviewed. Resident council minutes were reviewed. Visitation logs were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink that reads "Shelia Williamson RN". The signature is fluid and cursive, with the "RN" at the end being more distinct.

Shelia Williamson, R.N., Clinical Health Facility Surveyor

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL1602
Complaint #: OK00057434
Investigation Date(s): 10/26/21, 10/27/21, 10/28/21, and 10/29/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure food is stored, prepared, and served in accordance with Chapter 257.	S

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

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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:

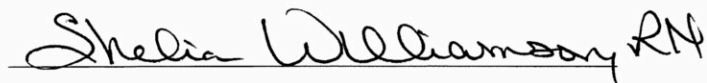
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-0391 for details.

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 surveyor 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 state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script that reads "Shelia Williamson RN". The signature is written in black ink and is positioned above the printed name.

Shelia Williamson, R.N., Clinical Health Facility Surveyor

Date report completed: 11/01/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK, 73501
Provider #: AL1602
Complaint #: OK00057740
Investigation Date(s): 10/26/21, 10/27/21, 10/28/21, and 10/29/21

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to provide sufficient staff to meet the needs of the residents.	US
2. The center failed to provide medical care according to physicians' orders, and failed to provide a clean environment.	US

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 10/26/2021 at 10:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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 unsubstantiated related to this allegation.

An investigation specific to sufficient staff to meet the needs of the residents was conducted.

A tour of the facility was conducted upon entrance and throughout the investigation. The facility was observed to be clean and without lingering odors. Residents were observed in their rooms, during activities, during meals, and receiving personal care. Residents were observed to be neat, clean, and well-groomed. Staff was

observed to respond to call lights and provide assistance to residents. The facility was observed to be sufficiently staffed to safely meet the needs of residents,

Residents were interviewed and reported they received adequate care from staff. Residents reported no complaints related to staff assisting them with activities of daily living. Staff members were interviewed and reported being adequately staffed to safely assist residents with activities of daily living. Facility administration reported using agency staff to provide sufficient staffing, with ongoing efforts to hire additional staff.

Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and progress notes. Resident council meeting minutes documented no complaints related to staffing. Incident reports and facility staffing records were reviewed.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to medical care being provided according to physician orders and providing a clean environment was conducted.

The facility was observed to be clean, without lingering odors, free of visible mold, and free of pests. Residents were observed receiving nursing care from staff. One resident's room was observed to have a lift for staff to transfer the resident. Staff was observed transferring residents in a safe manner. Staff was observed to provide care according to physician orders.

Residents were interviewed and reported no complaints related to nursing care, mold, or pest control. Staff members were interviewed and reported no concerns related to providing nursing care as ordered by the physician. Staff reported only one resident required a lift for transfers and a physician's order was in place for the use of the lift. Staff reported no concerns with pest control or mold in the facility.

Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and progress notes. Resident council minutes documented no concerns related to nursing care, mold, termites, or roaches. Maintenance work orders were reviewed. Incident reported were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Leah Mays, LPN, Clinical Health Facility Surveyor

Date report completed: 11/01/2021

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 C 10/29/2021
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
C 000	INITIAL COMMENTS Complaint investigations (#OK00055573, OK00055744, OK00055850, OK00055947, OK00056149, OK00056292, OK00056297, OK00056457, OK00056506, OK00056621, OK00056743, OK00057434, and #OK00057740) were conducted on 10/26/21, 10/27/21, 10/28/21, and 10/29/21. The following is a list of abbreviations which may be included in this document: ACMA - Advanced Certified Medication Aide ADM - Administrator CMA - Certified Medication Aide CNA - Certified Nurse Aide DON - Director of Nursing LPN - Licensed Practical Nurse NG - Nasogastric POA- Power of Attorney RN - Registered Nurse	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store juices in accordance with Chapter 257, 310:257-5-60, Ready-to-eat, Time/Temperature Control for Safety Food, date marking. The facility failed to clearly mark the date or day, by which the juices should have been consumed or discarded. The Administrator reported 60 residents resided	C 391		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

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 C 10/29/2021
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
C 391	Continued From page 1 in the facility. Findings: A facility policy, "Food Storage Guidelines," read in part, prepared foods would be stored in an appropriate container with an airtight lid or cellophane, and labeled with the type of food, date, and use-by date. On 10/26/21 at 1:55 p.m., two unidentified dietary aides reported the dietary cooks usually cleaned and cleared out the refrigerators as part of their regular duties. On 10/28/21 at 9:30 a.m., open containers of prune juice and tomato juice were observed in the mini-fridge in the coffee service area. The prune juice was observed to have a date of "7/20" and the tomato juice was dated "9/24." On 10/28/21 at 2:00 p.m., the Administrator reported he was the acting Dietary Manager. The Administrator reported dining assistants were supposed to follow a task list and were responsible for checking and cleaning the coffee service area. On 10/28/21 at 2:30 p.m., the Regional Executive Director reported she had observed the items in the mini-fridge and spoke with dietary staff. She stated the dates on the containers reflected when the items were received in the kitchen but should have also been dated when opened. She reported she in-serviced the staff on properly dating containers when opened, to indicate a use-by or discard date.	C 391		

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 C 10/29/2021
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
C1912	Continued From page 2	C1912		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement.	C1912		

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 C 10/29/2021
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
C1912	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to report to the State agency a head injury and possible pelvic fracture, which required treatment at a hospital, for one (#2) of three residents reviewed for incident reporting. The Administrator reported 60 residents resided in the facility. Findings: A policy titled, "Incident Reporting Guidelines for Managers," read in part, "...A Critical Event is an unexpected occurrence involving actual or the potential for a significant risk of death, serious injury or psychological distress." The policy documented the Divisional Vice Presidents of Care Services and/or Senior Vice President of Operations would immediately report all "Critical Events" to the Director of Risk Management via telephone for discussion and investigative guidance. The policy did not address reporting of incidents to the State agency. Resident #2 was admitted to the facility Memory Care Unit with diagnoses which included dementia and osteoporosis. A "Universal Incident Report," dated 09/29/21 at 9:06 p.m., documented the resident was found lying on the floor by her recliner. The report documented the resident was bleeding from the left side of her forehead and was transferred to	C1912		

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 C 10/29/2021
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
C1912	Continued From page 4 the hospital via emergency medical services. Hospital discharge records, dated 09/30/21, documented the resident was treated and released with diagnoses which included pubic rami fracture, scalp laceration, and pneumonia. On 10/26/21 at 12:03 p.m., resident #2 was observed in the Memory Care Unit dining room having lunch with other residents and her daughter. The resident's daughter reported the resident had experienced a fall, which required the resident to be on bed rest for about three weeks. The daughter stated they were initially told by the hospital physician the resident had experienced a pelvic fracture, in addition to her head injury. On 10/28/21 at 2:00 p.m., the Administrator stated an incident report was not submitted to the State agency. The Administrator reported the incident should have been reported, as the resident required treatment at the hospital for a head injury and possible fracture.	C1912		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to maintain organized and accurate records to include progress notes, weight records, nursing	C1951		

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 C 10/29/2021
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
C1951	Continued From page 5 notes, and third- party provider records for one (#11) of three closed records reviewed. The Administrator reported 60 residents resided in the facility. Findings: The clinical record for resident #11 was reviewed and did not contain progress notes, nursing notes, individualized weight records, or hospice records. A "Monthly Census Report," dated 01/2020 and 02/2020, included the resident's name and documented she was admitted to a hospital from January 17, 2020 to February 11, 2020. The clinical record contained no documentation to indicate when the resident was hospitalized, why she was hospitalized, or when the resident returned to the facility. A "Monthly Census Report," dated 04/2020, included the resident's name and documented she was admitted to a local hospital from April 24, 2020 to April 28, 2020. The clinical record contained no documentation to indicate when the resident was hospitalized, why she was hospitalized, or when the resident returned to the facility. A "Hospitalist Progress Note," dated 04/26/20, documented the resident had no acute changes overnight and continued on NG tube feedings. The note documented the POA/daughter was contacted to discuss her mother's diagnosis and a discussion related to possible transition to comfort care and hospice. A "Move-In/Move Out Activity Summary,"	C1951		

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 C 10/29/2021
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
C1951	Continued From page 6 documented the rent-effective date as 11/27/19 and the charge through date was 04/30/20. The clinical record contained no nurse notes related to when the resident returned from her hospital stay and no information related to her passing away at the center. Weight records were obtained from a list of other resident weights recorded in 2020. The resident's weight records were not maintained in an individualized clinical record. On 10/28/21 at 9:15 a.m., an advanced certified medication (ACMA) reported she was employed during the time the resident resided at the center. She was asked if the resident received third party provider services. She stated yes, but did not recall the name of the provider. The ACMA reported the resident passed away at the facility. The clinical record contained no nurse notes related to when the resident returned from her hospital stay and no corresponding third-party provider information. At 10:20 a.m., the center's licensed practical nurse (LPN) was asked to provide home health or hospice agency records for resident #11. The center did not provide records from any third-party providers.	C1951		

Delivery via email to: mharper@enlivant.com

November 30, 2021

License Number: AL1602

Ms. Micah Harper, Administrator
Ten Oaks Place
3610 Southeast Huntington Circle
Lawton, OK 73501

Survey Event ID: G4DV11

Dear Ms. Harper:

On **October 29, 2021**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

Tags C1951, C1912 & C0391 - The Plan of Correction has the date **October 29, 2021** for each deficient practice and this day was part of the survey. The POC needs to ensure what measures will be put into place and what systemic changes will be made to ensure the deficient practices will not recur, while including all appropriate staff along with dates outside the survey dates.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Katie Stagner
Digitally signed by Katie
Stagner
Date: 2021.11.30 08:22:12
-06'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

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: 11/29/2021

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: G4DV11

Date Survey Completed: 10/29/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391

Based on: Based on observation, interview, and record review, the facility failed to store juices in accordance with Chapter 257, 310:257-5-60, Ready-to-eat, Time/Temperature Control for Safety Food, date marking. The facility failed to clearly mark the date or day, by which the juices should have been consumed or discarded.

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?

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.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

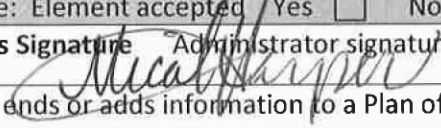
On 10/28/21 the Regional Executive Director discarded the prune juice and tomato juice.

On, 10/29/2021 Regional Executive Director, conducted audit of community food storage areas to ensure food was stored, prepared and served in accordance with Chapter 257, 310:257-5-60 including clearly marking the date or day, by which the food should be consumed or discarded. No additional items of concern identified OR Additional items of concern discarded at time of discovery.

By 10/29/2021, Executive Director conducted re-education with current staff on proper food storage in accordance with Chapter 257, 310:257-5-60

The Dietary Staff and/or designee will conduct audit of communities food storage 5 times a week for 4 weeks, 3 times a week for 4 weeks, then 1 time a week for 4 weeks to ensure food is properly stored and marked.

Effectiveness of corrections will be evaluated through review of weekly audits by the Executive Director at the time of audit completion with auditing frequency revisions made and staff re-education provided as necessary.

		Results of the audits will be discussed during the monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing.	
		The QI Committee will retain auditing records.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		11/29/2021	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) 		Date 11/29/2021	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/29/2021

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: G4DV11

Date Survey Completed: 10/29/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1912

Based on: Based on observation, interview, and record review, the facility failed to report to the State agency a head injury and possible pelvic fracture, which required treatment at a hospital, for one (#2) of three residents reviewed for incident reporting.

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?

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.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 11/18/2021, ED reported Resident #2 incident (head injury and possible pelvic fracture) to the State agency.

On 10/29/2021, Regional Executive Director and Executive Director conducted audit of current residents who experienced and incident in the past 30 days to ensure incident was reported to the State agency as required. Audit revealed no additional incidents in need of reporting.

On 10/29/2021, Regional Executive Director re-educated the Executive Director (ED) on incident reporting requirements. On 10/29/2021, ED re-educated current staff on incidents requiring reporting. ED, Care Service Manager (CSM) and/or designee will complete daily review of incidents to ensure incidents that requiring reporting to State agency are reported accordingly.

The CSM and/or designee will conduct audit of resident records who have had incidents weekly for 4 weeks, biweekly for 4 weeks, then monthly for one month to ensure incidents are reported to the State agency as required.

Effectiveness of corrections will be evaluated through review of audits by the Executive Director at the time of