OKLAHOMA
State Department
of Health

Delivery via email to: mharper@enlivant.com

July 5, 2022

License Number: AL1602

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

Survey Event ID: I7RN11

Dear Ms. Harper:

On **June 28, 2022,** 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,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.07.05 14:57:46 -05'00'

Katie Stagner, 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 #: **OK00059017**
Investigation Date(s): **06/27/22 and 06/28/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to protect residents from injuries as a result of abuse.	S

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

An unannounced on-site investigation was initiated 06/27/2022 at 9:30 a.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:

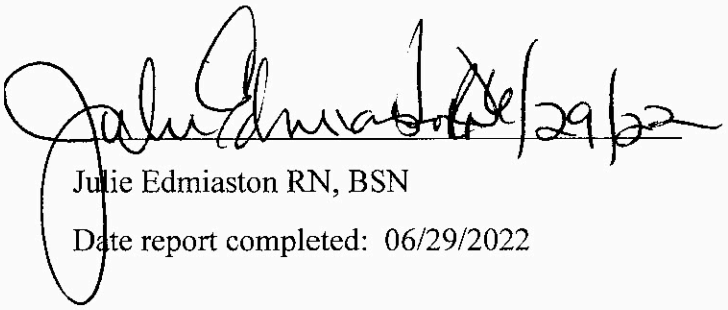
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C6000 for details.

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.



Julie Edmiaston RN, BSN

Date report completed: 06/29/2022

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 #: **OK00058625**
Investigation Date(s): **06/27/22 and 06/28/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide medications as ordered by the physician.	S

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

An unannounced on-site investigation was initiated 06/27/2022 at 9:30 a.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:

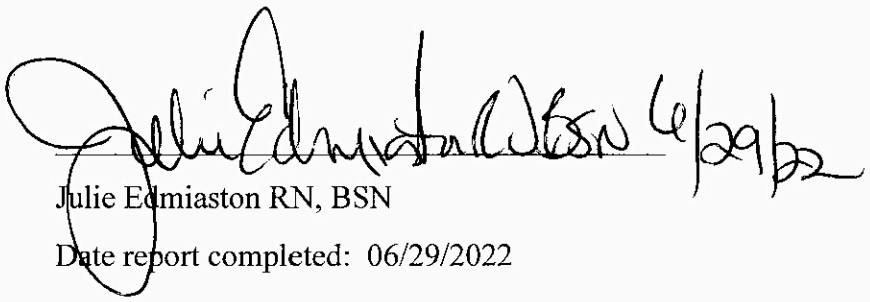
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 and N1442 for details.

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.



Julie Edmiaston RN, BSN

Date report completed: 06/29/2022

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 _____	06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEN OAKS PLACE	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments Complaint investigations (#OK00059017 and #OK00058625) were conducted on 06/27/22 and 06/28/22. The following are abbreviations which may be included in this document: ACMA - Advanced Certified Medication Aide APAP- Acetaminophen CMA - Certified Medication Aide FBI- Federal Bureau of Investigation NSP- Nursing Service Plan Summary OK- Oklahoma PRN- As Needed RN - Registered Nurse R/O- Reorder	N 000		
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to validate CMA skills prior to medication administration for five (#2, 4, 5, 6, and #7) and one ACMA (#3) of nine sampled ACMA's/CMA's who administered medications at the center.	N1442		

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N1442	Continued From page 1 The Executive Director identified 64 residents who resided at the center. Findings: On 06/28/22 at 11:16 a.m., the RN was asked to submit and review the CMA's medication skills validations. The RN was asked if the skills validations included reordering of medications. She stated the skills validation did not include reordering of medications. She stated the staff would learn that during the orientation process. The RN was asked to submit the medication skills validations for CMA #2, 4, 5, 6, and #7. She reported she did not have any skills validations for them. She was asked to submit the skills validation for ACMA #3. She reported it was not here. She reported there must be another binder somewhere, but she could not locate it.	N1442		

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C 000	INITIAL COMMENTS Complaint investigations (#OK00059017 and #OK00058625) were conducted on 06/27/22 and 06/28/22. The following are abbreviations which may be included in this document: ACMA - Advanced Certified Medication Aide APAP- Acetaminophen CMA - Certified Medication Aide FBI- Federal Bureau of Investigation NSP- Nursing Service Plan Summary OK- Oklahoma PRN- As Needed RN - Registered Nurse R/O- Reorder	C 000		
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 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	C1505		

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	AL1602	A. BUILDING: _____ B. WING _____	06/28/2022

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C1505	Continued From page 1 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 record review, observation, and interview the center failed to have physician ordered pain medications available for administration for one (#5) of three sampled residents reviewed for medications. The Executive Director identified 64 residents who resided at the center. The "Ordering and Receipt of Medications," policy, dated 06/16/17, read in parts, "...Licensed nurses and/or medication aides will re-order medications at or about the time when medication reaches a 7-day supply on-hand. The Resident's pharmacy will be notified via fax for re-order..." A "Physician's Order," dated 01/11/22, for Resident (Res) #5, read in parts, "... Hydrocod/APAP 5/325 mg... Norco... 1 Tablet every six hours as needed for pain...PRN..."	C1505		

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C1505	Continued From page 2 Res #5's "Assessment & NSP Summary," dated 06/10/22, read in parts, "... Medication Assistance... Staff Assistance- Resident requires staff to administer medications..." On 06/27/22 at 3:22 p.m., Res #5 was asked about any concerns related to her care. She reported being out of her breakthrough pain medication yesterday (06/26/22). She stated she had Morphine routinely and Norco to manage pain in her hands, shoulders, and legs. On 06/27/22 at 4:15 p.m., CMA #6 was asked about the center's policy to reorder narcotics. She stated when the medications run low, they would send a fax to the pharmacy for refill. She was asked when would she send the fax to the pharmacy. She stated when the resident had about five pills left. She was asked about Res #5's empty card for hydrocodone located in the basket for reorder. The empty card for Res #5's hydrocodone, documented, "R/O (Reorder) 06/27" written on the bottom of the card. She was asked what would she do if Res #5 requested a pain pill today. She stated, "I would not have it to give." On 06/27/22 at 4:35 p.m., assistant care services manager #8 was asked about the center's policy to reorder narcotics. She stated the medication aides are to reorder within 7 days of being out. On 06/27/22 at 5:00 p.m., the Executive Director and ACMA #3 was asked why Res #5's pain medication had not been ordered within the 7 days, before the resident was out of medication. ACMA #3 reported it should have been ordered before they run out and he did not know why it was not ordered.	C1505		

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C1505	Continued From page 3 On 06/28/22 at 10:50 a.m., the RN was asked about Res #5 being out of her hydrocodone. She stated she was just made aware of it this morning. She was asked about the system in place to reorder medications and the system to follow up to ensure medications arrive to the center. She stated she understood the staff ordered the medication over the phone so there was no record of the fax to indicate when or who contacted the pharmacy. She was asked if the medication was ordered per policy and procedure of the center. She reported the staff did not follow the center policy and she would follow up on it.	C1505		
C6000 SS=E	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the	C6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C6000	Continued From page 4 same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services.	C6000		

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C6000	Continued From page 5	C6000		

This Rule is not met as evidenced by:
Based on record review, observation, and interview the center failed to obtain criminal background checks for sitter/companions for two (#1 and #5) of three sampled residents with current sitters/companions or with a history of having sitters/companions.

The Executive Director identified two residents with sitters who currently resided in the center.

The "Standards for Private Duty Caregivers and Companions," third party caregiver agreement, dated 10/2005, read in parts, "... CHECKLIST...These items should be completed by a residence management team member prior to the commencement (start date) of the services. This process must be completed for all Caregivers such as sitter/companions, aides, private duty nurses and aides employed by a home health agency... Criminal background check completed, reviewed, and approved, or agency certification that is has been done. (Criminal history will be judged on the same criteria as residence employees.) ..."

1. On 06/27/22 at 2:55 p.m., Resident (Res) 1's sitter/companion was asked if she was paid by

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C6000	Continued From page 6 Res #1's family. She stated, "Yes." She reported she had been her sitter for a year and reported Res #1 also had another sitter. Res #1's sitter reported she had completed the volunteer paperwork at the center. Res #1's sitter "Volunteer Application Form," dated June 27, 22 (on the day of survey), read in parts, "...You must be fingerprinted to work with this employer. We will do a national background check and an arrest in any state is reviewed. Your fingerprints will be used to check the criminal history records of the FBI..." Consent and Release Form contained Res #1's sitter name and contact information. On 06/28/22 at 10:50 a.m., the Executive Director was asked if Res #1 had another sitter who had not completed the volunteer paperwork. He stated she did have another sitter and to his knowledge she had not been given the paperwork to fill out. 2. On 06/27/22 at 2:45 p.m., Res #5 was asked about a sitter/companion. She stated she did not, but had a very good friend that visited and had helped her unpack all these boxes. She stated she did pay the sitter for gas. She stated the sitter was working at her own house today. On 06/28/22 at 10:50 a.m., the Executive Director was asked if he had located the national background check for Res #5's sitter. He stated the center was required to obtained a different kind of background check first from another agency, then do the national background check. The Executive Director was asked about the national background check from OK Screen. He stated, "No, I do not have one in here for her."	C6000		

OKLAHOMA
State Department
of Health

Delivery via email to: mharper@enlivant.com

July 22, 2022

License Number: AL1602

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

Survey Event ID: I7RN11

Dear Micah Harper:

On **June 28, 2022,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **September 2, 2022**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2022.07.22 09:38:16 -05'00'

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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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: 7/19/2022** **Facility Name:** Ten Oaks Place **License Number:** AL1602 **Survey Event ID:** I7RN11 **Date Survey Completed: 6/28/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: record review, observation, and interview the center failed to have physician ordered pain medications available for administration for one (#5) of three sampled residents reviewed for medications.

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?	On 6/28/2022, Care Service Manager (CSM) requested refill of resident (#5)'s Hydrocodone/APAP 5/325mg 1 tab by mouth every 6 hours as needed order. This medication was delivered to the community and added to resident (#5's) available medication supply on 6/28/2022.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Care Service Manager (CSM) and/or designee will perform an audit by 7/22/22 of Medication Administration Record (MAR) to Medication Cart to ensure the current on-hand supply of medications is 7-days or greater. Any discrepancies identified will be rectified as soon as possible. RDCS inserviced Care Service Manger (CSM) and Executive Director (ED) on requirement to reorder medications when current medication supply reaches a 7-day supply on hand on . CSM and/or designee will inservice current CMAs/ACMAs on requirement to reorder medications when current medication supply reaches a 7-day supply on hand by 7/22/22.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	CSM and/or designee will perform Medication Administration Record (MAR) to Medication Cart audits 3 x week for 4 weeks; weekly x 4 weeks then monthly x 1 month to ensure medications are available for administration.
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.	CSM and/or designee will be responsible for sustained compliance. CSM and/or designee will perform Medication Administration Record (MAR) to Medication Cart audits 3 x week for 4 weeks; weekly x 4 weeks then monthly x 1 month to ensure medications are available for administration. Results of the audits will be discussed during monthly QI meetings The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/2/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Micah Harper** OAC 310:663-25-4(F)	**Date 7/19/2022**

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: 7/19/2022** **Facility Name:** Ten Oaks Place **License Number:** AL1602 **Survey Event ID:** I7RN11 **Date Survey Completed: 6/28/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C6000	Based on: record review, observation and interview the center failed to obtain criminal background checks for sitter/companions for two (#1 and #5)of three sampled residents with current sitter/companions or with a history of having sitters/companions.

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?	Executive Director (ED) and/or designee obtained sitter/companion background checks for resident #1 on 7/14/22. Executive Director (ED) and/or designee obtained sitter/companion background checks for resident #5 on 7/14/22.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Executive Director (ED) and/or designee to complete background check audit for current sitters/companions by 9/02/22. Any discrepancies will be rectified as soon as possible. Resident/resident's responsible party will be asked to make alternative sitter/ companion arraingments until a negative background check is obtained.
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?	When a sitter/companion is needed in the future, they will be directed to ED and/or designee for background check. Once information is obtained, sitter/companion will be allowed in the community.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: 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.	Executive Director (ED) and/or designee will be responsible for sustained compliance. Executive Director (ED) and/or designee will audit community for sitter/companions background checks weekly x 4 weeks, 2 times month for 1 month and then monthly x 1 months. Executive Director (ED) and/or designee will be responsible for sustainged compliance.

	Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/2/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Micah Harper** OAC 310:663-25-4(F)	**Date 7/19/2022**

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

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/19/2022** **Facility Name:** Ten Oaks Place **License Number:** AL1602 **Survey Event ID:** I7RN11 **Date Survey Completed: 6/28/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: N1442	Based on: record review and interview, the center failed to validate CMA skills prior to medication administration for five (#2, 4, 5, 6, and #7) and one ACMA (#3) of nine sampled ACMAs/CMAs who administered medications at the center.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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?	CSM and/or designee to complete and validate medication skills competencies for CMAs #2, 4,5,6, and #7 and ACMA #3 on 7/22/22.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Care Service Manager (CSM) and/or designee will complete audit of current CMAs/ACMAs for complete/validated medication skills competencies by 9/02/22. If any CMAs/ACMAs do not have documentation then a medication skills competency will be completed prior to medication administration.
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?	For future CMAs/ACSMs, Care Service Manager (CSM) and/or designee will complete/validate medication skills competency prior to administering medications. RDCS inserviced Executive Director (ED) and Care Service Manager (CSM) on requirement to validate CMA skills before CMA/ACMA performs medication administration on 9/02/22.
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.	Executive Director (ED) and/or designee will be responsible for sustained compliance. Executive Director (ED) and/or designee will be responsible for sustained compliance. Executive Director (ED) and/or designee will perform audits weekly x 4, twice month x 1 month then monthly 1 month for skills competency files for current ACMAs/CMAs to ensure compliance. All newly hired staff will be reviewed during

	training and not scheduled to work until ED or designee has competency check-off form from CSM or designee. Results of the audit will be discussed during monthly QI meetings The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/2/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Micah Harper** OAC 310:663-25-4(F)	**Date 7/19/2022**

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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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

Delivery via email to: mharper@enlivant.com

October 11, 2022

License Number: AL1602

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

Survey Event ID: I7RN12

Dear Mr. Harper:

On **October 6, 2022,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 28, 2022,** have now been corrected effective **September 2, 2022.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement 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-C 10/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEN OAKS PLACE	3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments A revisit survey was conducted on 10/06/22. All deficiencies from the 06/28/22 survey were cleared.	{N 000}		
{C 000}	INITIAL COMMENTS A revisit survey was conducted on 10/06/22. All deficiencies from the 06/28/22 survey were cleared.	{C 000}		

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