

Delivery via email to: mharper@enlivant.com

December 5, 2022

License Number: AL1602

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

RE: Survey Event ID: GWL811

Dear Ms. Harper:

On **November 21, 2022**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on November 21, 2022.

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

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

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

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

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

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

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

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

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

Katie Stagner, 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: AL1602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2022
NAME OF PROVIDER OR SUPPLIER TEN OAKS PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501		
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C 000	INITIAL COMMENTS A relicensure survey was conducted from 11/16/22 through 11/21/22. Listed below are abbreviations that will be used throughout this document. Acetamin- Acetaminophen ACMA- Advanced Certified Medication Aide CAP- Capsule CNA- Certified Nurse Aide CMA- Certified Medication Aide COD- Codeine CPLT- Caplet CPR- Cardiopulmonary Resuscitation ER- Emergency Room GDR's- Gradual Dose Reductions hrs- hours HTN- High blood pressure mg- milligrams mmol/L- millimoles per liter PIG- Punch/Initial/Give PO- By mouth PM- Nighttime PVC- Polyvinyl chloride RN- Registered Nurse	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the center failed to: a) ensure cleaning and sanitation of the ice	C 391		

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 391	Continued From page 1 machine to prevent contamination of the ice machine in accordance with Chapter 257 Food service Establishment Regulations. b) ensure staff wear a beard covering during food preparation in accordance with Chapter 257 Food service Establishment Regulations. The Administrator reported 70 residents resided in the center. Findings: "...310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (a) Pf Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris..." On 11/17/22 at 10:37 a.m., the head chef was asked what was on the ice guard inside the ice machine. He stated it looked like something spilled on it. He was asked about the color. He stated, pink. He was asked if it was slimy. He stated, a little bit. He was asked about a cleaning log for the ice machine. He stated, "We don't have a log for that." The cleaning schedule presented by the dietary supervisor did not include the ice machine. There was no policy submitted for cleaning the ice machine. On 11/18/22 at 9:40 a.m., the ice machine in the kitchen area had black spotted residue on the	C 391		

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C 391	Continued From page 2 PVC from the wall to the ice machine, heavy buildup of brown, black, slimy, residue on the ice guard inside of the ice machine. 310:257-3-20. Effectiveness "... (a) Except as provided in (b) of this Section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles..." The "Hair Restraints and Jewelry" policy, not dated, read in parts, "...Wear a hairnet or bonnet in any food production area so that all hair is completely covered. Keep beards and mustaches neat and trimmed. Beard restraints are required..." On 11/17/22 at 10:30 a.m., the chef #1 was asked about wearing a beard covering when preparing food. He stated, "I have before, but recently started growing one out." He then stated, "I heard you do not have to wear one unless it is out over an inch."	C 391		
C 911 SS=F	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged:	C 911		

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C 911	Continued From page 3 (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide RN supervision to implement the quarterly pharmacy recommendations for February 2022, May 2022, and August 2022. The Administrator reported 70 residents resided in the center. Findings: The "Consultant Pharmacist Services" policy, dated 06/21/2017, read in parts, "...The consultant pharmacist reviews and evaluates the pharmaceutical services by helping the facility identify, evaluate, and address medication issues that may affect resident care, medical care, and quality of life. The pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs, that are consistent with current standards of practice, and that meet State and Federal requirements..." The pharmacist's recommendations made in the February, May, and August 2022 quarterly reviews made were not addressed by the center's RN.	C 911		

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C 911	Continued From page 4 On 11/18/22 at 3:30 p.m., the assistant care service manager was asked if she performed or monitored the quarterly pharmacy recommendations. She stated she did not. She stated the RN should have done them and stated the RN was employed at the center from March through September 2022. On 11/21/22 at 10:23 a.m., the regional RN was asked if she followed the pharmacist's quarterly recommendations. She stated, yes, if they were given to her. She was asked if she received the pharmacist quarterly review dated August 2022. She stated, "I have not." She was asked if she followed the various recommendations made by the pharmacist. She stated, no, she did not. She was asked if she received the quarterly reviews for February or May of 2022. She stated, "I have not and at that time the center had a RN." She was asked if the previous RN followed the pharmacist's recommendations. She stated, "I don't know." She was asked if there was documentation to show the RN had followed up on the pharmacist recommendations. She stated, "I do not know." The center did not submit evidence from the RN to show the physician was notified of the pharmacist's recommendations. On 11/21/22 at 3:00 p.m., the Administrator was asked if the pharmacy recommendations were sent to the RN. He stated they were sent directly to the RN. He was asked if the RN followed up on the pharmacists' recommendations. He stated, "I do not know."	C 911		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications	C 921		

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C 921	Continued From page 5 based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure monthly medication reviews were completed by the RN or pharmacy consultant at least monthly. The Administrator reported 70 residents resided in the center. Findings: On 11/17/22 at 2:18 p.m., the regional RN was asked was asked about the RN monthly medication reviews. She stated, "I'm assuming not, but she had not been given anything to sign." She was asked how long she had been the regional RN. She stated two years. She was asked how long she had been filling in for the center's RN. She stated a month or so. She was asked how often the pharmacy performed medication reviews. She stated, "Quarterly."	C 921		
C 922 SS=E	310:663-9-2(b) MEDICATION STAFFING (b) Unlicensed personnel administering medications shall have completed a training program that has been reviewed and approved by the Department.	C 922		

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C 922	Continued From page 6 This Rule is not met as evidenced by: Based on interview and record review, the center failed to provide evidence of a completed training program for one advanced certified medication aide (#8) of five advanced certified medication aides who administered medications at the center. The Administrator reported 70 residents resided in the center. Findings: A policy titled, "Medication Administration Policy" dated 03/01/22, read in parts, "...Medications and treatments are only administered by personnel who are legally authorized to do so, such as...Employees who have received appropriate state training..." On 11/16/22 at 3:35 p.m., the assistant care service manager was asked if ACMA #8 was still employed at the center. She reported yes and was on the medication cart. On 11/18/22 at 10:25 a.m., the assistant care service manager was asked about ACMA #8's certification. She reported ACMA #8 had an expired ACMA certification and was not currently working until his certification is renewed.	C 922		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be	C 954		

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C 954	Continued From page 7 trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide evidence of CPR and first aid training for 11 employees and failed to submit first aid training for one transport driver. The Administrator reported 34 direct care staff members were employed by the center. Findings: The "Cardiopulmonary Resuscitation (CPR) Policy", dated 03/01/22, read in parts, "...If a resident is found without pulse and/or is not breathing, staff will respond to the emergency following established first aid procedures and in compliance with state regulations..." The "First Aid Policy", dated 03/01/22, read in parts, "...Staff members will be required to be first aid certified in states which require employees to obtain and maintain certification based on the state regulatory requirements...Basic first aid practices will help minimize potential further injury and provide stabilization until emergency medical services are provided..." CNA #1 hired 04/06/22 CNA #2 hired 08/29/22	C 954		

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C 954	Continued From page 8 CNA #3 hired 10/26/22 CNA #8 hired 06/27/22 CNA #9 hired 10/25/22 CNA #10 hired 07/12/22 CNA #11 hired 05/17/22 CMA #1 hired 01/24/22 CMA #2 hired 09/09/21 CMA #3 hired 07/15/22 ACMA #9 hired 01/21/22 Transport Driver hired 07/05/22 On 11/18/22 at 9:47 a.m., the assistant care service manager reported the employees listed above did not have CPR and first aid. She reported the transport driver did not have first aid.	C 954		
C1330 SS=D	310:663-13-2(10) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (10) a provision in the event that a resident's condition merits transfer, the transfer shall be initiated within five (5) working days and progress on the transfers shall be noted in the resident's record. This Rule is not met as evidenced by: Based on record review and interview, the center failed to include a provision in the contracts in the event that a resident's condition merits transfer, the transfer shall be initiated within five (5) working days for ten (#1- #10) of ten sampled resident contracts.	C1330		

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C1330	Continued From page 9 The Administrator reported 70 residents resided in the center. Findings: The center's "State of Oklahoma Assisted Living Residency Agreement" not dated, read in parts, "...In addition to the discharge criteria above, if Your emergency termination of this Agreement is mandated by Your immediate health needs or termination of this Agreement is necessary for the physical safety of You or other residents, the Residence by terminate with less than thirty (30) days' notice. Under these circumstances, the Residence will provide You with the notice of termination as soon as is practicable. The notice of termination will include the reason(s) and the effective date..." The contracts were reviewed and did not contain a clear statement in the event a resident's condition merits transfer, the transfer shall be initiated within five (5) working days. Resident #1 contract dated 03/04/21 Resident #2 contract dated 10/25/17 Resident #3 contract dated 11/02/22 Resident #4 contract dated 09/30/22 Resident #5 contract dated 08/31/22 Resident #6 contract dated 11/30/21 Resident #7 contract dated 08/26/21 Resident #8 contract dated 05/27/20 Resident #9 contract dated 02/02/21 Resident #10 contract dated 07/14/22 On 11/18/22 at 2:40 p.m., the community relations specialist was asked if the above contracts documented if a resident's condition merits transfer, the transfer shall be initiated within five (5) working days and noted in the	C1330		

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C1330	Continued From page 10 resident's record. She stated, no, it did not. She reported the contracts were created by Corporate.	C1330		
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 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.	C1505		

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C1505	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to provide adequate and appropriate medical care to: a) secure medications for two (#9 and #11) of two sampled residents with insulin. b) administer medications to one resident at a time for two (#1 and #12) of ten sampled residents with medication assistance. c) implement the 2022 quarterly pharmacy recommendations for seven (#13, 14, 15, 16, 17, 18 and #19) of seven sampled residents with medication recommendations. d) not exceed recommended dosage for one (#1) for scheduled and PRN pain medication. The Administrator reported 70 residents resided in the center. Findings: The "Storage of Medications Policy" dated 03/01/22, read in parts, "...All medications stored by the community must be maintained in a clean, neat, locked container or area...The medication cart, bins, or cabinet(s), and the Wellness area should be kept locked when not used..." The "Medication Administration Policy" dated 03/01/22, read in parts, "...Medication and treatments are administered to residents as	C1505		

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(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
C1505	Continued From page 12 determined by review of their medication status, and in accordance with physician order, state laws, and assisted living regulations..." The "Consultant Pharmacist Services" policy, dated 06/21/2017, read in parts, "...The consultant pharmacist reviews and evaluates the pharmaceutical services by helping the facility identify, evaluate, and address medication issues that may affect resident care, medical care, and quality of life. The pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs, that are consistent with current standards of practice, and that meet State and Federal requirements..." a) On 11/16/22 at 08:20 a.m., two zipper bags were observed sitting on top of the medication cart unattended. One zipper bag contained an insulin pen for resident #9 and the other zipper bag contained an insulin pen for resident # 11. At 08:30 a.m., ACMA #7 was asked about the insulin pens that were left unattended on top of the medication cart. She stated she left them there because home health complains, because they cannot find anybody and they only have 30 minutes to do an insulin visit. She was asked if she left the insulin unattended. She stated, "Not the whole time, I had just run to a room." She was asked how long she left the insulin pens unattended. She stated she got back to the medication cart at 8:30 a.m. Resident #9's "Physician Order" dated 05/09/22, read in parts, "...Aspart Flex (insulin)...use per sliding scale...Levemir...Give 12 units subcutaneously one time a day for Diabetes Mellitus..."	C1505		

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C1505	Continued From page 13 Resident #11's "Physician Order" dated 11/02/22, read in parts, "...Levemir FlexTouch...25 units subcutaneously one time a day..." On 11/17/22 at 2:19 p.m., the RN was asked about the storage of insulin. She stated the procedure would be for the medication aide to give it to home health nurse and the home health nurse would return it to the medication aide to be locked up. She was asked if it should be left out on top of the medication cart. She stated, the medication should not be left out on top of the medication cart. b) On 11/17/22 at 11:35 a.m., ACMA #7 was observed during a medication pass. She prepared two medication cups at the same time with no labels. One cup with resident #1's medication and another cup with resident #12's medications. Resident #1's "Physician Orders" dated 02/10/22, read in parts, "...Acetaminophen CPLT 500 mg...1 tablet by mouth every six hours (not to exceed 2,000 mg/24 hrs) ..." Resident #12's "Physician Order" dated 10/18/22, read in parts, "...Benzonatate cap 100 mg 1 capsule by mouth three times a day as needed for cough...Tramadol tab 50 mg...1 tablet by mouth every four hours as needed for breakthrough pain..." She placed one tablet of acetaminophen 500 mg in one cup for resident #1. She placed one tablet of tramadol 50 mg and one Benzonatate 100 mg capsule for resident #12 in another cup. She administered resident #12's medications first and left resident #1's locked in the medication cart.	C1505		

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C1505	Continued From page 14 On 11/17/22 at 11:40 a.m., ACMA #7 was asked if they would customarily prepare medications for two residents at the same time. She stated, yes, but would always do the narcotics first. She was asked if she followed the PIG method. In my words yes. She was asked if she initialed or labeled the cups. She stated, "No, I did not." On 11/17/22 at 3:30 p.m., the RN was asked if it would be acceptable for a medication aide to prepare more than one resident medication at a time. She stated no, they should only prepare medication for one resident at a time. She was asked if the center should follow the PIG method. She stated, yes. c) The "Nursing/Physician Combination Report" was reviewed and included the pharmacist recommendations for Feb 2022, May 2022, and August 2022. 1) Resident #13's "Nursing/Physician Combination Report," dated 05/01/22 and 05/18/22, read in parts, "...Please make sure the resident is not on omeprazole (heartburn) and pantoprazole..." The recommendation made by the pharmacist was not acknowledged by the RN to determine if the physician wanted to follow the pharmacist recommendation. Resident #13's "Physician Orders," dated 05/10/22, read in parts, "...Omeprazole Cap 40 mg...1 capsule by mouth one time a day... Pantoprazole tab 40 mg 1 tablet by mouth one time for hiatal hernia..." Resident #13 had those medications listed on the current physician's orders.	C1505		

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C1505	Continued From page 15 2) Resident #14's "Nursing/Physician Combination Report" dated 05/01/22 and 05/18/22, read in parts, "...Is there a stop date for the Macrochantin?" The pharmacist inquired about the stop date for Macrochantin during the quarterly pharmacy review. Resident #14's "Physician Orders" dated 02/18/22, read in parts, "...Nitrofurantoin... (For Macrobid) 1 capsule by mouth two times a day..." On 11/21/22 at 12:30 p.m., the RN was asked to submit the actual prescription for the Macrobid. She stated she would find out if the doctor wanted to stop it and did not find the actual script in the chart. 3) The pharmacist recommendations in Feb 2022, May 2022, and August 2022 required a dosage for Voltaren (joint pain) for the following residents: Resident #15's "Physician Orders" dated 05/01/22, read in parts, "...Diclofenac Gel 1% (For Voltaren) apply to affected area(s) topically as needed..." Resident #16's "Physician Orders" dated 06/25/20, read in parts, "...Diclofenac Gel 1% (For Voltaren) apply to affected area two times a day as needed for joint pain..." Resident #17's "Physician Orders" dated 05/19/22, read in parts, "...Diclofenac Gel 1% (For Voltaren) apply to affected area topically two times a day as needed..." The above physician's orders did not contain the dosage for Voltaren.	C1505		

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C1505	Continued From page 16 On 11/21/22 at 10:19 a.m., the RN was asked if the above orders contained a dosage and she stated no, and they were required to have a dosage. 4) Resident #18's "Physician's Order" dated 11/11/20, read in parts, "...Dementia, Seizures, HTN, Depression...Need monthly lithium levels...Ambulates...walker, min assist...walker... (Name-deleted-home health) ..." Resident #18's "Nursing/Physician Combination Report," dated 08/01/22 and 08/19/22, read in parts, "...Please make sure we have a current lithium level..." The pharmacist made a recommendation above to obtain a monthly lithium level for resident #18 in August 2022. On 11/21/22 at 12:08 p.m., the assistant care service manager was asked to submit the monthly lithium levels for resident #18. She was asked who performed the monthly lithium draws. She stated, home health. She stated, "I guess they have not been drawing it." 5) Resident #19's "Physician Orders" dated 04/16/22, read in parts, "...Lexapro...1 tablet by mouth one time a day...Prozac...1 capsule by mouth one time a day at bedtime..." Resident #19's "Nursing/Physician Combination Report," dated 05/18/22, read in parts, "... [Resident #19] has orders for both Lexapro and Prozac. Please verify the need for both..." The recommendation made by the pharmacist was not acknowledged by the RN to determine if the physician wanted to follow the pharmacist's recommendation. On 11/21/22 at 10:23 a.m., the regional RN was	C1505		

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C1505	Continued From page 17 asked if she followed the pharmacist's quarterly recommendations. She stated, yes, if they were given to her. She was asked if she received the pharmacist quarterly review dated August 2022. She stated, "I have not." She was asked if she followed the various recommendations made by the pharmacist. She stated, no, she did not. She was asked if she received the quarterly reviews for February or May of 2022. She stated, "I have not and at that time the center had a RN." She was asked if the previous RN followed the pharmacist's recommendations. She stated, "I don't know." She was asked if there was documentation to show the RN had followed up on the pharmacist recommendations. She stated, "I do not know." The center did not submit evidence from the RN to show the physician was notified of the pharmacist's recommendations. d) Resident #1 was admitted with diagnoses which included hypertension and osteoporosis. The resident's quarterly assessment, dated 11/01/22, documented the resident required staff assistance with administration of medications. The current physician orders documented: Acetaminophen cpl 500 mg one tablet by mouth every six hours (not to exceed 2000 mg/24 hrs) Acetamin/COD Tab #3 300/30 mg for Tylenol/Codeine #3 One tablet by mouth every six hours as needed Acetamin/COD tab #3 300/30 mg One tablet by mouth every twelve hours Acetaminophen PM tab 500/25 mg One tablet by mouth one time a day at bedtime.	C1505		

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C1505	Continued From page 18 The November medication administration record was reviewed and documented an excess of Tylenol had been administered on four days. On 11/21/22 at 11:45 a.m., the resident was observed in the dining room for the noon meal. On 11/21/22 at 12:30 p.m., the regional RN reviewed the resident's medication administration and reported the resident had exceeded the 2000 mg dose of Tylenol.	C1505		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010		

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C5010	Continued From page 19 This Rule is not met as evidenced by: Based of record review and interview, the center failed to obtain monthly lithium levels and coordinate home health services for one (#18) of three sampled residents with laboratory recommendations and home health services. The Administrator reported 26 residents received home health services. Findings: The "Medication Administration Policy" dated 03/01/22, read in parts, "...Medication and treatments are administered to residents as determined by review of their medication status, and in accordance with physician order, state laws, and assisted living regulations..." Resident #18's "Physician Order" dated 11/11/20, read in parts, "...Dementia, Seizures, HTN, Depression...Need monthly lithium levels...Ambulates...walker, min assist...walker... (name-deleted-home health)..." The center did not submit monthly lithium levels for August, September, and October 2022. A "Hospitalist Progress Note" dated 07/05/22, read in parts, "...Lithium level 0.3 (0.6-1.2 mmol/L)..."	C5010		

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C5010	Continued From page 20 Resident #18's "Nursing/Physician Combination Report," dated 08/01/22 and 08/19/22, read in parts, "...Please make sure we have a current lithium level..." The pharmacist made a recommendation above to obtain a lithium level for resident #18 in August 2022. Resident #18's "Physician Order" undated, read in parts, "...Lithium CAP 150 mg by mouth one time a day...Lithium Cap 150 mg...3 capsules (450 mg) by mouth one time a day in the evening..." Resident #18's "Plan of Care" dated 11/01/22, read in parts, "...Do you need us to coordinate care with your Physician (1 points)...Do you receive care from a Home Health care provider (2 points)..." A "Home Health Certification and Plan of Care" dated 10/1/2022-11/29/2022, read in parts, "...Lithium Carbonate 150 mg once a day by mouth (PO)...Lithium Carbonate 450 mg in the evening by mouth (PO)..." The home health certification and plan of care did not address monthly lithium levels. On 11/21/22 at 12:08 p.m., the assistant care service manager was asked to submit the monthly lithium levels for resident #18 for August, September, and October 2022. She was asked who performed the monthly lithium draws. She stated, home health. She stated, "I guess they have not been drawing it." She stated she found nothing about a lithium level every being drawn on the slips left by the home health agency. She stated in July 2022 they sent resident #18 to the ER. [The above lithium level was low at that time].	C5010		

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C5010	Continued From page 21 On 11/21/22 at 2:22 p.m., the assistant care service manager was asked what was resident #18's diagnosis for lithium. She stated resident #18 was on lithium and it was on hold since Friday [November 18, 2022]. She stated he was getting a lithium level drawn today and his doctor was coming to see him today. She stated she did not see a diagnosis. She was asked for the monthly lithium levels. She stated she had requested the monthly lithium levels from home health at noon today. On 11/21/22 at 2:40 p.m., resident #18's family member reported resident #18 went to the ER on Thursday night [November 17, 2022] because he was being aggressive and not sleeping and they wanted to get the lithium level checked. She stated it was 1.6 (mmol/L) [elevated]. She stated the home health nurse was checking the lithium level again today. She was asked why the resident was on lithium. She stated a mood stabilizer. She stated he had a shower today and was cooperative. On 11/21/22 at 3:10 p.m., the assistant care service manager was asked if home health had sent the monthly lithium levels. She stated home health had no orders for monthly lithium levels. She stated home health drew a lithium level today. She stated, she would not get the lithium results until Wednesday and his lithium was on hold right now. She was asked who was responsible to obtain the monthly lithium levels. She stated she had a physician's order in the resident #18's chart to obtain monthly lithium levels.	C5010		

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C6000	Continued From page 22	C6000		
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 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	C6000		

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C6000	Continued From page 23 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. This Rule is not met as evidenced by: Based on record review and interview, the center failed to obtain fingerprint-based background checks within 60 days of hire for 10 employees hired by the center.	C6000		

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C6000	Continued From page 24 The Administrator reported 70 residents resided in the center. Findings: The "Beginning Your Employment" policy, not dated, read in parts, "...Background Screening & Reporting Obligations... To protect our residents, as well as comply with state and Federal law, all employees are required to submit to a job-related background screening upon hire..." On 11/16/22 at 2:50 p.m., the personnel files were reviewed and no evidence was provided to determine eligibility for employment for the following employees: CNA #2 hired 08/29/22 CNA #4 hired 05/24/21 CNA #5 hired 07/13/22 CNA #7 hired 07/26/21 CMA #2 hired 09/09/21 Assistant care service manager hired 03/07/22 Administration specialist hired 08/08/22 Memory care manager hired 08/01/22 Community relations specialist hired 09/20/21 Maintenance hired 06/30/22 On 11/18/22 at 09:47 a.m., the Administrator was asked about the fingerprint-based background checks for the above listed employees. He stated they did not have them and they were in process. He stated the administration specialist was new in the position.	C6000		

Delivery via email to: mharper@enlivant.com

December 21, 2022

License Number: AL1602

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

RE: Survey Event GWL811

Dear Mr. Harper:

On **November 21, 2022**, a relicensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **February 3, 2023**.

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: 2022.12.21 15:06:57 -06'00'

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

enc



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/19/2022

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: GWL811

Date Survey Completed: 11/21/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: Based on record review, observation, and interview, the center failed to: a) ensure cleaning and sanitation of the ice machine to prevent contamination of the ice machine in accordance with Chapter 257 Foodservice Establishment Regulations. b) ensure staff wear a beard covering during food preparation in accordance with Chapter 257 Food service Establishment Regulations.

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 an 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

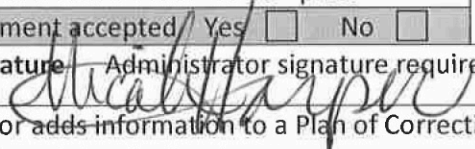
ASSISTED LIVING CENTER'S PLAN ELEMENTS

Ice Machine was emptied and cleaned on 12/03/22 by the dining assistant. Chef #1 donned a beard cover immediately and will continue to wear while working and as long as beard is present.

ED completed observation audit of ice machine and use of beard coverings on 12/15/2022 and no deficient practice was found. There are no additional ice machines in the community.
ED and/or designee to implement Ice machine cleaning schedule. Maintenance, all chefs, and dining assistants educated on need to wear beard net on 12/15/22. ED and/or designee will train all new hires on ice machine cleaning schedule and beard nets requirements.

ED educated ice machine cleaning schedule with Maintenance and Head Chefs and use of beard nets with Head Chefs during 1:1 in-service on 12-15-2022. Head Chefs then held in-service with Dining Assistants on 12-15-2022 reviewing cleaning schedules and use of beard nets.

ED and/or designee will review Ice Machine Cleaning Schedule, cleanliness of the ice machine and observational use of beard covers on a weekly basis for four weeks, biweekly for four weeks and monthly thereafter. Results and observations of these audits will be reviewed and discussed along the same timelines via QI meetings.

c. How monitoring records will be kept to evidence the correction.		Enter methods to evaluate for effectiveness: Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring records will be maintained by Chef, Executive Director and/or designee as evidence of correction.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/3/2023	
OSDH Response: Element accepted/ Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 		Date Enter a date of signature. 12-19-2022	
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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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/19/2022

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: GWL811

Date Survey Completed: 11/21/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C911

Based on: Based on record review and interview, the center failed to provide RN supervision to implement the quarterly pharmacy recommendations for February 2022, May 2022, and August 2022.

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 an 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 12/16/22 CSM and/or designee reviewed pharmacist consultation reports from Feb 2022., May 2022 and Aug. 2022 and clarify any pharmacist recommendations with resident physicians.

On, 12/16/22 CSM and/or designee reviewed pharmacist consultation reports from Feb. 2022, May2022, and Aug. 2022 and clarified any pharmacist recommendations with resident physicians and documented follow up of the recommendation.

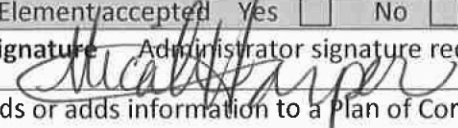
When new pharmacist consultation reports are received, community will provide copy of the report to Regional Care Specialist RN and/or designee for review, follow up with the physician and documentation of the follow up. Regional Care Specialist RN to provide education to CSM by 1/13/2023 on the above processes.

ED and/or designee to monitor progress of pharmacist consultation reports and their communication to PCPs and RCS via QA meetings monthly.

Enter methods to evaluate for effectiveness:

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

Enter methods to keep monitoring records: Records will be maintained in the Pharmacy consultation binder.

		Communication to PCP will be maintained in the resident file.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/3/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 		Date Enter a date of signature. 12-19-2022	
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/19/2022

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: GWL811

Date Survey Completed: 11/21/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921

Based on: record review and interview, the center failed to ensure monthly medication reviews were completed by the RN or pharmacy consultant at least monthly.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Regional Care Specialist RN and/or RN designee completed November's monthly medication review for current residents on 11/17/22.

Regional Care Specialist RN and/or designee co Regional Care Specialist RN completed December's monthly medication review for current residents on 12/16/22. PCP's to be notified as necessary.

Regional Care Specialist RN educated CSM on monthly medication review process on 12/16/22. CSM and/or RN designee to complete medication reviews on the first Monday of every month. Results from medication reviews to be shared with ED via weekly ED/CSM 1:1 meetings.

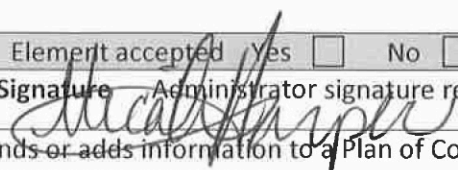
ED and /or designee to monitor progress of monthly medication reviews via QA meetings weekly x 4 weeks, biweekly for 1 month and monthly thereafter until compliance is met.

Enter methods to evaluate for effectiveness:

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

Enter methods to keep monitoring records: monthly medication reviews will be maintained in the resident file.

2/3/2023

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. 		Date Enter a date of signature. 12-19-2022	
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/19/2022

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: GWL811

Date Survey Completed: 11/21/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C922

Based on: interview and record review, the center failed to provide evidence of a completed training program for one advanced certified medication aide (#8) of five advanced certified medication aides who administered medications at the center.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

ACMA #8 was removed from the med cart until training completed. ACMA #8 completed certification on 12/2/2022.

ED and/or designee audited current ACMA files and Nurse Aide Registry to ensure no others were expired on 12/16/2022. Employee certifications to be stored and maintained in employee files.

RED educated Administrative Specialist on tracking certification expiration dates and providing monthly updates for staff on 12/8/2022.

ED and/or designee will audit 5 ACMA files to ensure ACMA certification is current weekly for 4 weeks, biweekly for one month, and monthly for 1 month.

Enter methods to evaluate for effectiveness:

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

Enter methods to keep monitoring records: records will be maintained in the employee files and updated monthly by the administrative specialist.

2/3/2023

Administrator's Signature Administrator signature required.

OAC 310:663-25-4(F)

Date Enter a date of signature.

12-19-2022

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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OPTIONAL PLAN OF CORRECTI/ON TEMPLATE

Current Date: 12/19/2022

Facility Name: Ten Oaks Place/

License Number: AL1602

Survey Event ID: GWL811

Date Survey Completed: 11/21/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954

Based on: record review and interview, the center failed to provide evidence of CPR and first aid training for 11 employees and failed to submit first aid training for one transport driver.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

CSM and/or designee assigned CPR and first aid training to CNA #1, #2, #3, #8, #9, #10, #11, CMA #1, #2, #3, ACMA #9 and transport driver on 11/21/22. All have completed except for CNA #2. CNA #2, prn employee, will not be placed on schedule until training is completed.

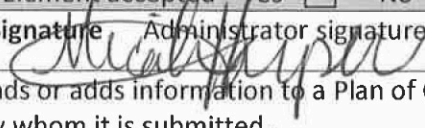
CSM and/or designee to complete CPR and first aid training with current staff. CSM and/or designee will train new hires within first 5 days of employment and annually thereafter in CPR and first aid.

Regional ED to provide education to ED on staff training guidelines for CPR and first aid. ED and/or designee to ensure annual CPR and first aid training is conducted with staff, tracking will be maintained via employee roster and stored within in-service binder.

ED and/or designee to audit 5 personnel files to monitor progress of upon hire/annual CPR and first aid training via QA meetings weekly x 4 weeks biweekly for 1 month and monthly thereafter until compliance is met.

Enter methods to evaluate for effectiveness:

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

		Enter methods to keep monitoring records: records of CPR and First Aid training will be maintained in the employee file.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/3/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 		Date Enter a date of signature. 12-19-2022	
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/19/2022

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: GWL811

Date Survey Completed: 11/21/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1330

Based on: record review and interview, the center failed to include a provision in the contracts in the event that a resident's condition merits transfer the transfer shall be initiated within five (5) working days for ten (#1- #10) of ten sampled resident contracts.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

A revision was made to the residency agreement on 12/16/22 to include that if a residents' condition merits transfer, the transfer shall be initiated within five (5) working days. (An addendum has been created and will be delivered by 12/20/22 for resident # 1,2,3,4,5,6,7,8,9 and 10 to include if a residents' condition merits transfer, the transfer shall be initiated within 5 working days)

ED and/or designee will complete addendum with current residents. The new residency agreement will be used for new admissions by 2/3/2023.

RED and/or designee educated the ED and the community relations specialist on 12/8/2022 on the use of the updated residency agreement and the addendum for current residents.

ED and/or designee will review new resident files to ensure the addendum has been completed on current residents and revised contract utilized on new residents weekly for 4 weeks, bi-weekly for a month, and monthly for 3 months.

Enter methods to evaluate for effectiveness:

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