

Delivery via email to: mharper@enlivant.com

February 16, 2023

License Number: AL1602

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

Survey Event ID: BFOD11

Dear Ms. Harper:

On **February 8, 2023**, 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

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure



**INVESTIGATIVE REPORT
LICENSURE**

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK, 73501
Provider #: AL1602
Complaint #: OK00060044
Investigation Dates: 02/06/23, 2/07/23, and 02/08/23

ALLEGATION	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The facility failed to protect residents' right to privacy.	US
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☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 02/06/2023 at 08:30 p.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility protecting residents' right to privacy was conducted.

Sampled clinical records were reviewed for nurse notes, incident reports, behavior monitoring notes, physician orders, and care plans. The facility's abuse policy and cell phone policy were reviewed. An incident report related to residents being photographed by a staff member documented the incident had been thoroughly investigated and reported following the facility's abuse policy. In-services documented all staff had been re-educated on the facility's abuse and cell phone policies.

A tour of the facility was conducted upon entrance and throughout the survey. The facility was observed to be free of lingering odors. Residents were observed to be clean and well-groomed. Residents were observed during mealtimes, during group activities, and in their room. Residents were observed to be monitored by staff for wandering behaviors on the memory care unit. No residents were observed to wander into other resident rooms throughout the survey. Staff was observed providing care and assistance for residents, while ensuring their privacy was maintained. Staff was observed monitoring the location of residents with wandering behaviors and redirecting when needed. No staff had been observed using their personal cell phones.

Residents were interviewed and reported no concerns related to having their photo taken by staff and no concerns related to their privacy. Staff was interviewed and reported they were not allowed to have their personal cell phones while working and not allowed to take photos of residents. Staff reported they had received abuse training and cell phone use training. Staff were knowledgeable about the different types of abuse and what to do if abuse was witnessed. The manager of the memory care unit reported an incident had occurred related to residents being photographed by a staff member, the incident had been thoroughly investigated following the facility's abuse policy, and the staff member was terminated. The memory care manager reported the involved residents had been started on behavior monitoring and were not aware the photos had been taken.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.



Leah Mays, Clinical Health Facility Surveyor

Date report completed: 02/08/2023

INVESTIGATIVE REPORT LICENSURE

Facility: Ten Oaks Place
Address: 3610 Southeast Huntington Circle
City, State, Zip: Lawton, OK 73501
Provider #: AL1602
Complaint #: OK00060024
Investigation Date(s): 02/06/23-02/08/23

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents did not have significant weight loss.	US
2. The facility failed to ensure medications were administered according to physician's orders.	S
3. The center failed to ensure residents received timely incontinent care.	S
4. The center failed to have and/or implement an effective infection control program.	S

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

An unannounced on-site investigation was initiated on 02/06/2023 at 8:30 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to weight loss was investigated.

The assessment, care plans, and weight records were reviewed. The sampled resident's medication administration records were reviewed and contained nutritional supplements and medications to improve

appetite. The sampled resident's weight records revealed a weight loss one month following admission to the center and nutritional supplements were added and weights remained stable for the past seven months. Current weight was obtained on the day of survey. Meal percentages reports were being recorded at the time of survey and were reviewed.

A tour of the center was conducted to include inspection of the physical environment which included resident apartments, dining room, and the noon meal service preparation. Residents were observed eating lunch. Staff were observed serving lunch, providing assistance with eating, and cueing. Music was provided during meal service. The last bowl of soup left on the cart at lunch service was warm to the touch. A glass of water with a straw was within reach of the sampled resident when initial contact was made. Staff interacted with residents with dignity and respect when assisting residents with meal service allowing them ample time to eat, refills for drinks, assistance with eating, and cueing.

Residents interviewed following meal service reported the food was good. Staff received a special request from a resident for a piece of cheese and it was provided. A full glass of ice water was prepared for sampled resident to take back to her apartment after lunch service.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1923 for details.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1951 for details.

Allegation #4: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2, 3, and #4. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

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

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

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

Thank you for bringing these concerns to our attention.

Julie Edmiaston Digitally signed by Julie Edmiaston
Date: 2023.02.13 09:02:30 -06'00'

Julie Edmiaston RN, BSN

Date report completed: 02/13/2023

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 02/08/2023
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 Complaint investigations (#OK00060044 and #OK00060024) were conducted on 02/06/23 through 02/08/23. Listed below are abbreviations that may be used throughout this document: CMA - Certified Medication Aide Department/OSDH - Oklahoma State Department of Health EMR - Electronic Medical Record MAR- Medication Assistance Record MC- Memory Care RN- Registered Nurse	C 000		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to provide routine maintenance and housekeeping for one (#6) of	C1304		

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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C1304	Continued From page 1 one sampled resident who contracted for services. A "State of Oklahoma Memory Care Residency Agreement," dated 07/15/22, for resident #6, read in parts, "...Housekeeping, Laundry, and Maintenance. The Residence launders bed and bath linens weekly and provides weekly housekeeping as well as regular routine maintenance..." On 02/07/23 at 11:50 a.m., a large section of carpet was observed to be loose and unsecured from the floor at the front entrance door to the memory care unit. Observations were made in resident #6's apartment. Numerous soiled spots were observed on the carpet next to the resident's bed and the closet doors were propped up against the wall (not attached) to the closet door. On 02/08/23 at 09:00 a.m., the Administrator was asked if the center was responsible for routine maintenance. He stated, "Yes, it states in the contract housekeeping, laundry, and maintenance." The Administrator was asked if he was aware of what appeared to be fecal stains on the carpet in resident #6's apartment. He stated he was not aware of any reports related to carpet stains but he could look at the work order book. He was asked if he was aware of the closet doors not being attached to the closet in resident #6's apartment, and he reported he was not aware. The Administrator was asked about a tear in the carpet at the front entrance to the memory care unit. He stated he had spoken with the regional office about taking out that section of carpet. The Administrator was asked how long the carpet had been in need of repair and he stated, "for a while," but did not know a specific time frame.	C1304		

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C1304	Continued From page 2 The work order book at the nurse's station on the memory care unit was reviewed. Resident #6's name was not listed in the work order book for carpet cleaning or for the unsecured closet doors. On 02/08/22 at 09:15 a.m., maintenance staff was asked how long he had known about the tear in the carpet at the front entrance to the memory care unit. He stated, "I have known about it for 6 months."	C1304		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		

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C1911	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the center failed to report the completed incident investigation to the Department, not to exceed ten Department business days after the incident, for one (#6) of two sampled for incident investigations. The Administrator reported 24 residents resided in the memory care unit. Findings: The "Incident Reporting Guidelines" policy, dated 11/2022, read in parts, "...The resident's family/responsible party and Physician should be promptly informed of all incidents and accidents. The Executive Director or designee will notify the state licensing agency as required by state specific regulations..." A final "Incident Report Form," for resident #6, read in parts, "...Description of incident...On 01/07/23, family sent email claiming resident abuse in the areas of assistance with toileting, medication administration and showers...For 5 days and final reports, please include a summary of the investigation (include investigative actions, findings and causative factors) and corrective measures implemented to prevent recurrence...Residence investigated claims by interviewing staff and reviewing records and could not fully substantiate claims...Conducted abuse/neglect in-service for staff on 01/13/2023.	C1911		

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C1911	Continued From page 4 Held care conference with family on 01/23/2023...Educated family regarding refusals and resident rights...Also implemented behavioral monitoring and short-term monitoring on meal percentages. Memory Care Manager and Care Services Manager to update family on refusals and updates during business hours..." On 02/08/23 at 9:50 a.m., the Administrator was asked to review the final incident report dated 01/07/23. He was asked if the final incident report was sent to the Department within 10 department business days as required. He stated he was out of the community and ended up submitting it when he returned to the community. The Administrator was asked if the fax date of 01/25/23 was outside of the 10 Department business days and he stated the final incident report was submitted late.	C1911		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident.	C1923		

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C1923	Continued From page 5 (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to maintain an accurate written record of medications administered for one (#6) of one sampled resident with medication assistance. The Administrator reported 24 residents resided in the memory care unit. Findings: A "Documentation" policy, dated 09/01/16, read in parts, "...The Resident Record is a legal document and the primary site for documentation regarding resident health, care and services. Resident health and resident care services documentation occurs primarily in two places: Resident Service Notes (RSN), Medication Assistance Record (MAR)..." Resident #6's "MAR," dated February 2023, documented codes at the top of the MAR to be used on the medication record. A "check mark" indicates administer. An "M" code indicates missed. An "A" code indicates away. An "S" indicates suspended. An "N/A" was listed as a code. An "R" indicates refused. An "O" indicates others. Resident #6's "MAR," dated February 2023, documented Zyrtec, Ensure, metoprolol, Protonix, Zoloft, and metformin with the code "N/A" along with the staff initials. These medications did not	C1923		

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C1923	Continued From page 6 contain a check mark with the staff initials and it could not be determined they were administered because of the code "N/A" [not available] was added to the staff initials on the medication record. The remainder of resident #6's medications on the February 2023 MAR contained a check mark with the staff initials to indicate the medications were administered. 02/07/23 at 4:25 p.m., CMA#2 reported that "N/A" marked on a resident's MAR indicated the medication was not available to be given. 02/08/23 at 9:10 a.m., CMA #2 conducted an audit of the medication cart for resident #6's medications. The CMA reported all of resident #6's physician ordered medications were available. The CMA reported no medication should be marked as "N/A" for this resident in the EMR and was not aware of any time that the resident's medication had been unavailable to be administered. On 02/08/23 at 10:10 a.m., the Administrator was asked why the "N/A" was listed on resident #6's MAR. He stated the pharmacy would drop the orders into the system and things were flagged as "N/A". The Administrator stated the medications were given and they were trying to fix that. The Administrator was asked if these discrepancies should have been caught by the center's staff when they reviewed the resident's medication records. He stated they were still learning the medication delivery system. The Administrator was asked when the medication delivery system had been launched at the center, and he reported May 2022. The Administrator was asked if he was able to give full access to the surveyors to review the system and he stated, "No."	C1923		

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C1923	Continued From page 7 On 02/08/23 at 2:30 p.m., the regional RN was asked why the medications on resident #6's MAR were initialed by staff and contained a "N/A" [not available] code. She stated the prescription had to be sent to the center's pharmacy and they uploaded each order. She stated she would need to check every resident's MAR to make sure they were not marked "N/A." The RN was asked if the MARs showed the codes, as well as staff initials, and would that be an accurate clinical medication record. She reported, "no," because the CMAs could not document appropriately. The RN reported the CMAs could click on the medication, but it would not push it over to show the medication was administered with a check mark.	C1923		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on record review and interview, the center failed to maintain an organized, accurate, clinical record to reflect two-hour room checks consistent with professional standards of practice for one (#6) of one sampled resident contracted for nursing care services. The Administrator reported 24 residents resided in the memory care unit. Findings.	C1951		

Oklahoma State Department of Health

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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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C1951	Continued From page 8 A "Documentation" policy, dated 09/01/16, read in parts, "...The Resident Record is a legal document and the primary site for documentation regarding resident health, care and services. Resident health and resident care services documentation occurs primarily in two places: Resident Service Notes (RSN), Medication Assistance Record (MAR)..." A "State of Oklahoma Memory Care Residency Agreement," dated 07/15/22, for resident #6, read in parts, "...Levels of Service. The Residence evaluates Your needs using the attached Appendix B, Assessment/Service Level Determinations, which attached hereto and incorporated herein. These services offer a variety of personal care and nursing care assistance and/or behavioral interventions based upon Your personal preferences and needs. The costs for Your care is [sic] included in your Basic Service Fees..." Resident #6's "Resident/Family Concern Form," dated 09/12/22, read in parts, "...On 09/12/22, I had a zoom with family. Family was upset that night time checks were not be being conducted...Documentation of Community Follow-up: Results of action taken: rounding logs...Resolution of Concern: Rounding logs were put in place. Also, added two-hour checks to [computer system] ..." A final "Incident Report Form," for resident #6, read in parts, "...Description of incident...On 01/07/23, family sent email claiming resident abuse in the areas of assistance with toileting, medication administration and showers...For 5 days and final reports, please include a summary of the investigation (include investigative actions,	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/08/2023
NAME OF PROVIDER OR SUPPLIER TEN OAKS PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1951	Continued From page 9 findings and causative factors) and corrective measures implemented to prevent recurrence...Residence investigated claims by interviewing staff and reviewing records and could not fully substantiate claims. Conducted abuse/neglect in-service for staff on 01/13/2023. Held care conference with family on 01/23/2023. Educated family regarding refusals and resident rights. Also implemented behavioral monitoring and short-term monitoring on meal percentages. Memory Care Manager and Care Services Manager to update family on refusals and updates during business hours..." Resident #6's "Communication Log," dated 01/23/23 through 02/06/23, was not consistent with two-hour charting. There was no charting for the weekend for 01/28/23 through 01/30/23. There was only one entry for 01/31/23. The communication logs were submitted as documentation for charting. On 02/05/23 there was only one entry made for charting. Resident #6's "Tasks," dated 02/01/23-02/28/23, was submitted for documentation for the two-hour room checks. These task sheets documented duplicate time slots for 12:00 a.m., to 2:00 a.m., and 2:00 a.m., to 4:00 a.m., and 4:00 a.m., to 6:00 a.m. The task sheets contained inconsistent initials for the duplicated time slots. The task sheets also contained blanks from 02/01/23 through 02/05/23 for the two- hour room checks. The notes recorded under the tasks were documented with the day the entry was made, without any corresponding times when the entry was made and without corresponding staff initials. There were 29 blanks outside of the above duplicated time slots for the two-hour room checks.	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/08/2023
NAME OF PROVIDER OR SUPPLIER TEN OAKS PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1951	Continued From page 10 On 02/06/23 at 12:06 p.m., resident #6's apartment was observed and a camera observed on the edge of the dresser. CMA #2 was observed to provide care for the resident prior to lunch. On 02/08/23 at 12:23 p.m., the memory care manager was asked if she conducted tasks audits for February 2023. She reported there were numerous blanks on the task sheets for various residents. She stated she was still finding blanks in the documentation for the tasks and felt it was related, in part, to staff turnover. On 02/08/23 at 2:30 p.m., the RN was asked about the training for documentation in the care delivery computer system. The RN reported as issues came up, they realized they did not have some of the documentation capabilities. On 02/08/23 at 2:36 p.m., the RN was asked about the center's policy for wellness checks. She stated, "It is our standard to provide two-hour checks, I cannot find a policy on that."	C1951		

Delivery via email to: mharper@enlivant.com

March 14, 2023

License Number: AL1602

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

Survey Event ID: BFOD11

Dear Ms. Harper:

On **February 8, 2023**, 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 **March 15, 2023**.

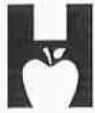
We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman Digitally signed by Tempal Killman
Date: 2023.03.14 13:24:14 -05'00'

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

enc



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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/2/2023

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: BFOD11

Date Survey Completed: 2/8/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: 1304

Based on: Based on record review, observation, and interview, the center failed to provide routine maintenance and housekeeping for one (#6) of one sampled resident who contracted for services.

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 2/21/23, Maintenance Technician (MT) removed the large section of loose and unsecured carpet at front entrance door to Memory Care Unit and removed unattached closet doors from Resident #6's apartment. On 2/22/23 the MT deep cleaned the carpeting in Resident #6's apartment.

OSDH Response: Element accepted Yes ☐ No ☐

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

By 3/1/23, the Executive Director (ED) will assess the community for other heavily soiled stains and carpet in need of repairs; stains will be cleaned, and repairs will be made as necessary.

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?

On 2/24/23 MT educated current staff on process for placing work orders.

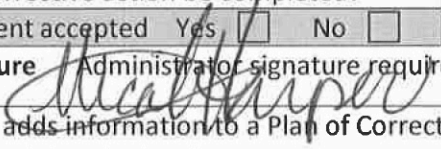
On 2/28/23 the Regional Director of Facilities Management (RDFM) educated the MT on timely processing of documented work orders.

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

Beginning 3/1/23, ED and/or designee shall conduct an audit of common areas and 5 random resident rooms weekly x4 weeks, biweekly x4 weeks, then monthly x1 month to assess for unsecured or stained carpets and unattached closet doors and will document findings in the work order log as required. Results of the audit will be

center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		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. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/15/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 		Date Enter a date of signature. 3-2-23	
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.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/2/2023

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: BFOD11

Date Survey Completed: 2/8/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: 1911

Based on: Based on record review and interview, the center failed to report the completed incident investigation to the Department, not to exceed ten Department business days after the incident, for one (#6) of two sampled for incident investigations.

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 1/25/23, the Executive Director (ED) submitted final state report to state for Resident #6.

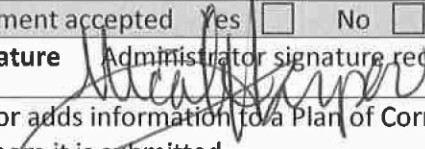
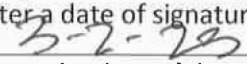
On 2/28/23, the Regional Care Specialist (RCS) audited the last 90 days of incident reports to ensure timely reporting to OSDH. Findings will be addressed and corrected ad hoc.

On 2/22/23, the Regional Director of Care Services (RDCS) educated the ED, Care Services Manager (CSM), and RCS on OSDH incident reporting timelines, not to exceed 10 business days.

Beginning 3/1/23 ED and/or designee will audit current months incident reports and ensure timely reporting to OSDH weekly x 4 weeks, biweekly x 4 weeks, and monthly x 1 month to ensure 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.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

OSDH Response: Element accepted Yes ☐ No ☐		Enter methods to keep monitoring records:	
5. On what date will corrective action be completed?		3/15/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 		Date Enter a date of signature. 	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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Facility in Compliance by: Click here to enter a date.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/2/2023

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: BFOD11

Date Survey Completed: 2/8/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: 1923

Based on: Based on record review, observation, and interview, the center failed to maintain an accurate written record of medications administered for one (#6) of one sampled resident with medication assistance.

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 2/8/23 Regional Care Specialist (RCS) audited Resident #6's current prescribed medications available for administration, with no missing medications identified. Review of current Medication Administration Record (MAR) from RCS on 2/8/23 reflected appropriate documentation of medications administered. Findings reviewed with Resident #6 physician on 3/01/23.

OSDH Response: Element accepted Yes ☐ No ☐

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

By 3/01/23, RCS to conduct an audit of current residents' MAR's to ensure medications are available for administration and documented appropriately. Findings of audit will be addressed and corrected ad hoc.

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?

On 2/24/23, RCS educated current medication passers on documentation requirements and how to address medications not 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:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the

Beginning 3/1/23, Care Service Manager and/or designee will conduct medication cart audit to ensure availability of medications for administration, and MAR audit to ensure medication administration documentation is correct weekly x 4 weeks, biweekly x 4 weeks and monthly x 1 month to ensure compliance. Results of the audit will be

center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/15/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature. 3-1-23	
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.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/2/2023

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: BFOD11

Date Survey Completed: 2/8/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: 1951

Based on: Based on record review and interview, the center failed to maintain an organized, accurate, clinical record to reflect two-hour room checks consistent with professional standards of practice for one(#6) of one sampled resident contracted for nursing care services.

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

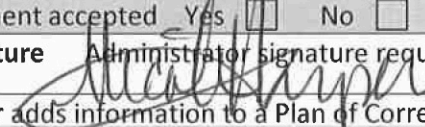
ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 2/21/23, the Care Service Manager (CSM) assessed electronic health record and confirmed 2hr rounding documentation compliance for resident #6.

By 3/1/23, CSM and/or designee will conduct an audit of memory care residents and determine which residents require 2hr room checks, care plans to be updated as necessary and ensure 2hr checks are documented accordingly.

By 3/1/23, Regional Care Specialist (RCS) and/or designee will reeducate current care staff on documentation of 2hr room checks in electronic health care record, according to resident care plan.

Beginning 3/1/23, CSM and/or designee will audit 5 memory care resident records requiring 2hr room checks weekly x 4 weeks biweekly x 4 weeks and monthly x 1 month to ensure 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.

correction.		Enter methods to evaluate for effectiveness:	
		Enter methods to incorporate into QA system:	
		Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/15/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)		Administrator signature required.	Date Enter a date of signature.
			3-2-23
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.			

Delivery via email to: mharper@enlivant.com

March 23, 2023

License Number: AL1602

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

RE: Survey Event BFOD12

Dear Ms. Harper:

Enclosed is the Assisted Living Center Licensure inspection deficiency report form, showing the summary of deficiencies noted during the revisit at your facility on **March 15, 2023**. These deficiencies remain uncorrected since your survey of **February 8, 2023**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TEN OAKS PLACE

3610 SOUTHEAST HUNTINGTON CIRCLE
LAWTON, OK 73501

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/15/2023
NAME OF PROVIDER OR SUPPLIER TEN OAKS PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3610 SOUTHEAST HUNTINGTON CIRCLE LAWTON, OK 73501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C1304}	Continued From page 1 launders bed and bath linens weekly and provides weekly housekeeping as well as regular routine maintenance..." On 03/15/23 at 9:30 a.m., observations were made in Resident #1's apartment. Upon entrance to the apartment in the hallway were twelve areas patched up with a white spackling material but had not been painted over. On 03/15/23 at 10:20 a.m., the entrance hallway to Resident #1's apartment had chipped/cracked sheetrock pieces on the floor with white patches observed on the wall without paint. Resident #1 reported some of it was caused by the wheelchair and some of it was caused by the mechanical lift. 2. A "State of Oklahoma Memory Care Residency Agreement," dated 12/31/19, for resident #2, read in parts, "...Housekeeping, Laundry, and Maintenance. The Residence launders bed and bath linens weekly and provides weekly housekeeping as well as regular routine maintenance..." A "State of Oklahoma Memory Care Residency Agreement," dated 12/31/19, for resident #3, read in parts, "...Housekeeping, Laundry, and Maintenance. The Residence launders bed and bath linens weekly and provides weekly housekeeping as well as regular routine maintenance..." On 03/15/23 at 11:00 a.m., a large section of carpet was removed with the exposed concrete at the front entrance door to the memory care unit. Observations were made throughout the facility and a dark stain on the carpet and something splattered on the wall/base board outside of room 327. There was a brown splashed substance on	{C1304}		

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 R 03/15/2023
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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{C1304}	Continued From page 2 the base board outside the dining room doors. A brown stain on the floor in the activity common area was observed. A reddish-brown stain on the green colored couch in the foyer area. On 03/15/23 at 11:30 a.m., observations were made in Resident #2 and Resident #3's apartment. Upon entrance to the apartment the wall had a long-exposed metal strip on the edge of sheetrock with sharp edges. The door between the two adjoining apartments had a large hole in the bottom left corner of the door. On 03/15/23 at 1:15 p.m., the Administrator was asked to inspect Resident #2 and Resident #3's apartment. The Administrator reported the metal exposed was a hazard and someone could get hurt. They stated they had not made it to this apartment yet and he would get it repaired and educate the staff on reporting hazards like this.	{C1304}		

Delivery via email to: mharper@enlivant.com

April 5, 2023

License Number: AL1602

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

Survey Event ID: BFOD12

Dear Mr. Harper:

On **March 15, 2023**, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **May 4, 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: 2023.04.05
08:27:05 -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: 4/4/2023

Facility Name: Ten Oaks Place

License Number: AL1602

Survey Event ID: BFOD12

Date Survey Completed: 3/15/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: 1304

Based on: Based on record review, observation, and interview, the center failed to provide routine maintenance for three (#1, 2, and #3) of five sampled residents who contracted for services and failed to provide maintenance and housekeeping in common areas around the facility.

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 3/16/23 Maintenance Technician (MT) repaired Resident #2 and Resident #3's apartment, repairs were made to a long exposed metal strip on the edge of the sheetrock (wall corner).

On 3/22/23, a dark stain on the carpet was shampooed and removed, wall/baseboard outside of the room 327 spot cleaned by Maintenance Technician. Brown splashed substance on the baseboard outside the dining room doors was cleaned by Maintenance Technician (MT).

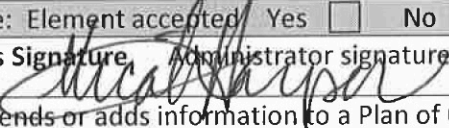
On 3/22/23 Maintenance Technician (MT) submitted work order for carpet repairs to area in front of memory care doors, assisted living side. Carpet repairs expected to be finalized by 5/22/23.

On 3/23/23, a reddish-brown stain on the green couch in foyer area was deep cleaned and removed by Maintenance Technician (MT).

On 3/31/23, Maintenance technician shampooed and removed a brown stain noted on the floor in the activity common area.

On 3/31/23, in Resident #2 and Resident #3's apartment, a door between the two adjoining apartments with a large hole in the bottom left corner of the door was removed permanently, per resident request, from the apartment by Maintenance Technician (MT).

On 4/03/23, Resident #1 apartment repairs were made, chipped drywall debris found on floor vacuumed, damaged

	drywall in entrance hallway spackled, hallway walls sanded and painted by Maintenance Technician (MT).		
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		By 4/06/23, the Executive Director (ED) and/or designee will assess common areas for carpet/furniture stains and occupied units for general repairs and cleanliness, findings will be addressed as necessary.	
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?		By 4/06/23, the Executive Director (ED) and/or designee will round with Maintenance Technician (MT) at least weekly to identify need for new repairs and ensure any previously identified repairs have been or are in the process of being completed.	
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.		Beginning 4/06/23, ED and/or designee shall conduct an audit of common areas and 5 random resident rooms weekly x4 weeks, biweekly x4 weeks, then monthly x1 month to assess for damaged or stained carpets, stained common area furniture, damaged drywall and overall cleanliness in resident apartments. ED and designee will document findings in the work order log as required. 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. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/4/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature 		Administrator signature required. Date 4/4/2023	
OAC 310:663-25-4(F)			
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.			