OKLAHOMA
State Department
of Health

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

Survey Event ID: 4BB111

Dear Ms. Harper:

On **March 15, 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

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Ten Oaks Place**
Address: **3610 Southeast Huntington Circle**
City, State, Zip: **Lawton, OK 73501**
Provider #: **AL1602**
Complaint #: **OK00060158**
Investigation Date(s): **03/15/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure they did not admit residents who were a higher level of care than the center could provide.	**US**
2. The center failed to provide a safe, clean and homelike environment.	**S**
3. The center failed to ensure adequate staff to provide care for dependent residents.	**S**

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

An unannounced on-site investigation was initiated on 03/15/2023 at 08:30 a.m.

A sample of four 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 admissions to the center who required a higher level of care was conducted.

Contracts, assessments, and care plans were requested and reviewed upon entrance to the center. The incident reports related to falls were reviewed for notifications made to the family's representatives. The 30-day notices provided to the center were reviewed. The progress notes related to falls without injury were reviewed.

Notifications were made to the family's representatives and the hospice agency. Two sampled closed records were reviewed for assessments, care plans, and incidents.

Upon entrance to the center a tour was conducted and there were several areas of stained carpeting noted throughout the center with substances observed on the baseboards. Staff were observed administering medications.

A resident who was recently admitted to the center was interviewed and had no complaints at this time related to care. Residents interviewed voiced no care related issues and were well groomed. Residents interviewed reported the staff notified their family members with a change of condition and/or fall.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C0962 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2 and #3. 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 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: 2023.03.17 21:37:41 -05'00'

Julie Edmiaston RN, BSN

Date report completed: 03/16/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	03/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A complaint investigation (#OK00060158) was conducted on 03/15/23. Listed below are abbreviations which may be used throughout this document: CMA - Certified Medication Aide Department- Oklahoma State Department of Health RN - Registered Nurse	C 000		
C 962 SS=F	310:663-9-6(b) MINIMUM STAFF FOR SERVICES (b) A continuum of care facility or assisted living center that has only one direct care staff member on duty shall: (1) Disclose the one-person staffing and the plan for dealing with urgent and emergent situations to residents and their representatives before admission or prior to one-person staffing if such staffing was not previously practiced by the assisted living center; and, (2) Have in place a plan, approved by the Department, for dealing with urgent or emergent situations, including resident falls, during periods when the assisted living center has only one direct-care staff member on duty.	C 962		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	03/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 962	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the Center failed to ensure one-person staffing, and a plan to deal with emergent situations was disclosed to the residents and their representatives, and such plan was approved by the Department, for 23 of 23 memory care residents who resided at the Center. The "Resident Roster" identified a total of 70 residents, with 47 residents who resided in the assisted living and 23 residents who resided in the locked memory care unit. The daily staffing schedule, dated 03/11/23, documented one staff member (CMA #1) on the assisted living side, with two staff members scheduled for a locked memory care unit separated from the assisted living center by locked doors for the night shift. The daily staffing schedule, dated 03/12/23, documented one staff member (CMA #1) on the assisted living side, with two staff members scheduled for a locked memory care unit separated from the assisted living center by locked doors for the night shift. On 03/15/23 at 2:47 p.m., the staff schedule was reviewed for the weekend of 03/11/23 with CMA #1. The CMA was asked if they had worked that weekend and they reported, yes, they had worked. The CMA was asked to review the written schedule. The CMA stated the past couple of weeks they had worked by themselves on the assisted living side for the 10:00 p.m. to 6:00 a.m. shift. The CMA was asked what they did in an emergency situation or when two-person assist was required, and they reported they borrowed a staff member from the memory care	C 962		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	03/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 962	Continued From page 2 unit. The CMA identified a two-person assist resident who resided on the assisted living side and required a mechanical lift. On 03/15/23 at 3:00 p.m., the Administrator was asked if the center disclosed one-person staffing, had a plan for emergent situations, and if they had received approval from the Department. The Administrator reported, no, because the center had three people on staff on the overnight shift. On 03/15/23 at 4:10 p.m., the regional RN was asked to submit an assessment for Resident #1. The RN stated the resident was a two-person assist and required a mechanical lift.	C 962		

OKLAHOMA
State Department
of Health

Delivery via email to: mharper@enlivant.com

April 7, 2023

License Number: AL1602

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

Survey Event ID: 4BB111

Dear Ms. Harper:

On **March 15, 2023**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **Tag C0962** - The Plan of Correction is not accepted. The proposed action did not describe what corrective action would be implemented for those residents found to be affected by one staff member to provide care for 23 memory care residents. The proposed action did not describe how other residents having the potential to be affected by the practice. Additionally, the center did not describe what measures would be put in place or what systemic changes would be made to ensure the deficient practice would not recur. The effective date of **April 6, 2023** to begin audits, cannot be the same date the corrective action will be completed.

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/6/2023** **Facility Name:** Ten Oaks Place **License Number:** AL1602 **Survey Event ID:** 4BB111 **Date Survey Completed: 3/15/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: 962	Based on: Based on record review and interview, the Center failed to ensure one-person staffing, and a plan to deal with emergent situations was disclosed to the residents and their representatives, and such plan was approved by the Department, for 23 of 23 memory care residents who resided at the Center.

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	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	On 03/16/23, Executive Director (ED) verified Ten Oaks Place staffing schedule was compliant with community policy and regulatory requirement for minimum staff for services; Ten oaks has adequate trained staff on duty, awake, and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	On 03/16/23 ED audited staffing schedule to ensure adequate staffing was in place to meet the needs of resdeints through the end of the month with no concerns in staffing 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?	On 04/06/23 Regional Director of Operations (RDO) reviewed with ED requirement for community to disclose one-person staffing and the plan for dealing with urgent and emergent situations to residents and their representatives prior to one-person staffing being initiated.
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.	Effective 04/06/23 ED and/or designee will audit staffing schedule weekly for 4 weeks, bi-weekly for a month, and monthly for 3 months to ensure adequate staffing is maintained for minimum staffing for services and a plan is implemented to disclose one-person staffing and the plan for dealing with urgent and emergent situations to residents and their representatives prior to one-person staffing being initiated if applicable. 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 ongoing. Monitoring records will be maintained within the community for review upon the departments request. 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?	4/6/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 4/6/2023**

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

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

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department
of Health

Delivery via email to: mharper@enlivant.com

April 21, 2023

License Number: AL1602

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

Survey Event ID: 4BB111

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 22, 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: 2023.04.21 15:29:43 -05'00'

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: 4/12/2023** **Facility Name:** Ten Oaks Place **License Number:** AL1602 **Survey Event ID:** 4BB111 **Date Survey Completed: 3/15/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: 962	Based on: Based on record review and interview, the Center failed to ensure one-person staffing, and a plan to deal with emergent situations was disclosed to the residents and their representatives, and such plan was approved by the Department, for 23 of 23 memory care residents who resided at the Center.

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	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	On 4/11/23, ED met the rule for "Minimum Staff Limitations" by ensuring that at least 1 staff member and 1 direct care staff member are scheduled for the Memory Care Unit and at least 2 direct care staff members are scheduled for the Assisted Living side of the community.
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 5/22/23 ED and/or designee will present and review department approved one-person staffing disclosure with current residents and/or their representatives.
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 5/22/23 ED and/or designee to add addendum to residency agreement to include communities one-person staffing disclosure for current residents and new residents moving into the community, disclosure to include plan for dealing with urgent or emergent situations, including resident falls.
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 5/22/23 ED and/or designee will review 5 random resident files to ensure the addendum has been completed weekly for 4 weeks, bi-weekly for a month, and monthly for 3 months. 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 ongoing. Monitoring records will be maintained within the community for review upon the departments request.. 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?	5/22/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 4/12/2023**

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

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

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	03/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A complaint investigation (#OK00060158) was conducted on 03/15/23. No deficiencies were cited.	C 000		

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

04/12/23

OKLAHOMA
State Department
of Health

Oklahoma State Department of Health
Long Term Care
123 Robert S Kerr Ave, Suite 1702
Oklahoma City, OK 73012-6406
p. (405) 426-8200
f. (405) 900-7594

Assisted Living Informal Dispute Resolution Request Form

In Accordance with the Continuum of Care and Assisted Living Act

To access this form and the IDR process online at the Health Department web site click here.

Assisted Living Centers must complete this form to dispute cited deficiencies. If you have any questions, contact the IDR Coordinator by telephone at (405) 426-8200 or via e-mail at IDRCoordinator@health.ok.gov.

Submission

Complete this form, attach all documentary evidence relevant to each disputed deficiency and submit within **ten (10) calendar days** of receiving the official Statement of Deficiencies. Submit this form to Oklahoma State Department of Health, Long Term Care, Attention: IDR Coordinator, 123 Robert S Kerr Ave, Suite 1702, Oklahoma City, OK 73102-6406. **An IDR will not be granted when a request form is incomplete or inaccurate. Documentary evidence submitted past the required timeframe will not be considered.**

IDR Type: (Check One) Face-to-Face Meeting ☐ Record Review ☑ Telephone/Virtual Conference ☐

Facility Name: Ten Oaks Place Assisted Living

Facility Administrator: Micah Harper

Mailing Address: 3610 SE Huntington Circle Telephone Number: ( ) (580) 353-1190

City: Lawton Zip Code: 73501 Facsimile Number: ( ) (580) 357-0813

Date Statement of Deficiencies Received: 03 / 23 / 2023 Survey Exit Date: 03 / 15 / 2023

Dispute Description

Tag Number **Explanation of Dispute** (Why is facility disputing the deficiency? List reason for each.)
A separate sheet may be attached, but must clearly identify the following: facility name, ID, survey exit date, tag number, and the explanation of the dispute. All documentary evidence submitted must also identify these items.

1. C962 Please see "Exhibit A" attached.
2.
3.
4.

Submitted by: Micah Harper Date: 3 / 30 / 2023

OKLAHOMA
State Department
of Health

April 7, 2023

VIA EMAIL

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

Re: Informal Dispute Resolution Notification
License Number: AL1602

Dear Ms. Harper:

We have received your request for an Informal Dispute Resolution (IDR) Record Review concerning the deficiencies cited at your facility during the complaint investigation of March 15, 2023. The meeting has been scheduled for **Monday, April 25, 2023 at 10:00am** via Microsoft TEAMS. The IDR panel will convene on that date a make a determination regarding the disputed tag. You will be notified of the determination at a later date.

If you wish to withdraw your IDR request, we must receive written notification at least seventy-two (72) hours prior to the meeting date. If you have any questions or need additional information, please contact me at (405) 426-8200 or email idrcoordinator@health.ok.gov.

Sincerely,

Clorissa Nubine

Clorissa Nubine
IDR Coordinator
Long Term Care
Protective Health Services

c: William Whited, Ombudsman
Facility File
Janene Stewart
Shayla Spriggs
Survey Team

OKLAHOMA
State Department
of Health

April 25, 2023

VIA EMAIL

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

Re: Ten Oaks Place - Informal Dispute Resolution Determination Report
License Number: AL1602

Dear Ms. Harper:

Thank you for participating in the Informal Dispute Resolution (IDR) panel process of the Oklahoma State Department of Health concerning the survey conducted at your facility on March 15, 2023. The IDR Panel was present at the meeting. The disputed deficiencies are discussed in the attached determination report.

A copy of this determination has been forwarded to the State Survey Agency for review.

Sincerely,

K Hamilton

Kourtney Hamilton
Chairperson
IDR Decision Making Panel
Protective Health Services

cn

Enclosure

c: Janene Stewart
IDR Panel
Survey Team
Facility File

IDR
Informal Dispute Resolution
Impartial Decision Making Panel
Determination Report
Today's Date: 04-25-23

Facility Name:
Ten Oaks Place

Facility ID:
AL1602

Survey Date:
03-15-23

IDR Date:
04-25-23

Tags Disputed:
1. C962 s/s=F

Status Change*
*Removed Tag

Panel Members:
Kourtney Hamilton, Chairperson
Emilie Creswell
Kara Bolino
Merrideth Harper
Sheila McLeod, OSDH

Determination Report:
The panel determined that with three staff members present in the building, the regulation does not specify staffing requirements per area. Therefore, a disclosure was not required.
(1) Disclose the one-person staffing and the plan for dealing with urgent and emergent situations to residents and their representatives before admission or prior to one-person staffing if such staffing was not previously practiced by the assisted living center; and, (2) Have in place a plan, approved by the Department, for dealing with urgent or emergent situations, including resident falls, during periods when the assisted living center has only one direct-care staff member on duty

Signature K Hamilton

Chairperson, Impartial Decision Making Panel

OKLAHOMA
State Department
of Health

April 25, 2023

VIA EMAIL

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

Subject: State Survey Agency Informal Dispute Resolution Determination
Re: AL1602, Ten Oaks Place April 25, 2023 Informal Dispute Resolution

Dear Ms. Harper:

The Department of Health has received the determination of the Informal Dispute Resolution (IDR) Decision Making Panel concerning the March 15, 2023 complaint investigation conducted at Ten Oaks Place. The findings of the IDR Decision Making Panel have been reviewed. It is the determination of the State Survey Agency to uphold the Decision Making Panel's determination. The amended State Statement of Deficiencies (Form CMS-2567) is enclosed. If applicable, further instructions regarding the impact of these changes on any previous enforcement action will be forthcoming from the Long Term Care Enforcement office.

Sincerely,

Janene Stewart

Janene Stewart
Director, Long Term Care Services
Protective Health Services

cn

c: William Whited, Ombudsman
Espaniola Bowen, Nurse Aide Registry
IDR Decision Making Panel
Shayla Spriggs
Survey Team
Facility File

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1602	A. BUILDING: _____ B. WING _____	03/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS On 04/25/23, the 2567 was amended as a result of an IDR. A complaint investigation (#OK00060158) was conducted on 03/15/23.	C 000		

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

04/12/23

IDR Meeting Attendees Sign-In Sheet

04-25-23

Microsoft Teams Meeting

Ten Oaks Place

Survey Date: 03-15-23

Name	Organization	Title
Sheila McLeod	Panel – OSDH	CHF Surveyor
Kourtney Hamilton	Panel – Chairperson	Regional Nurse Consultant
Merrideth Harper	Panel	Administrator
Emilie Creswell	Panel	Administrator
Kara Bolino	Panel	Executive Director