



Oklahoma State Department of Health
Creating a State of Health

December 3, 2019

License Number: AL2002

Ms. Michelle Carter, Administrator
Angelwood Assisted Living And Memory Care
3200 West Hayes
Clinton, OK 73601

RE: Survey Event ID: PQ2011

Dear Ms. Carter:

On **October 22, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on October 22, 2019.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;

Board of Health

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(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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,



 Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lc
Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANGELWOOD ASSISTED LIVING AND MEMOR

**3200 WEST HAYES
CLINTON, OK 73601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A re-licensure survey was conducted on 10/21/19 and 10/22/19. Census was 24. Deficient practice was cited as follows.	N 000		
N1105 SS=F	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure annual performance reviews had been completed for 6 (#2, 4, 7, 8, 9, and #10) of 7 CNA's (certified nursing assistants) who had been employed by the center for at least one year. This deficient practice had the widespread potential for more than minimal harm. Findings: On 10/21/19 at 12:45 p.m., the administrator was asked to provide verification for annual skills	N1105		

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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NAME OF PROVIDER OR SUPPLIER ANGELWOOD ASSISTED LIVING AND MEMOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WEST HAYES CLINTON, OK 73601		
(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
N1105	Continued From page 1 checks completed for the CNA's. The administrator stated, "we don't have them, the last ones I have are dated 2018." At 1:15 p.m., the employee files were reviewed. CNA's #2, 4, 7, 8, 9, and #10 did not have any annual nurse aide skill performance checklists completed for 2019.	N1105		
N1442 SS=F	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to perform annual competency skills evaluation for 2 (#2 and #4) of 4 sampled CMA's (certified medication aides) who had been employed by the center for at least one year. This deficient practice had the widespread potential for more than minimal harm. Findings: On 10/21/19 at 12:45 p.m., the administrator was asked to provide verification that the medication skills checklist had been completed. She stated the annual medication skills checks for CMAs #2 and #4 had not been done.	N1442		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

**ANGELWOOD ASSISTED LIVING AND MEMOR 3200 WEST HAYES
CLINTON, OK 73601**

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N1442	Continued From page 2 At 1:15 p.m., the employee records were reviewed. CMA #2's last annual medication competency checklist was completed on 08/17/18 and #4's last annual medication competency checklist was completed on 07/24/18.	N1442		
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 10/21/19 and 10/22/19. Census was 24. Deficient practice was cited as follows.	C 000		
C 103 SS=E	310:663-1-3(c) SMOKING PROHIBITED (c) Smoking or possessing a lighted tobacco product is prohibited in a continuum of care or assisted living facility and within fifteen (15) feet of each entrance to a facility and of any air intakes; provided however, the facility may provide a smoking room not available to the public for use by residents. This Rule is not met as evidenced by: Based on observation and interview it was determined the center failed to ensure smoking was prohibited within 15 feet of an entrance to the center. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 10/22/19 at 09:56 a.m., resident #8 was observed smoking outside approximately 3 feet from the entrance door to the dining room. Employee #6 was asked what the sign stated above resident #8's wheelchair. Employee #6 stated, "No Smoking." Employee #6 was asked where the ashtray was located and she stated, right next to the entrance door to the dining room.	C 103		

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C 103	Continued From page 3 At 10:05 a.m., licensed practical nurse/director of nurses (LPN/DON) was asked where resident #8 smoked. LPN/DON stated resident #8 smoked outside the dining area. LPN/DON was asked where the ashtray was located. She stated right there (next to the door to the dining room entrance). She was asked if the ashtray was 15 feet from the dining room entrance. She stated no. Maintenance moved the ashtray 15 feet away from the door to the dining room entrance.	C 103		
C 913 SS=D	310:663-9-1(3) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (3) documenting the resident's living will or "Do Not Resuscitate Order." This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to accurately document the DNR (Do Not Resuscitate) status for 1 (#3) of 1 sampled resident without documentation of the DNR consent form. This deficient practice resulted in the isolated potential for more than minimal harm. Findings:	C 913		

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C 913	Continued From page 4 Resident #3 was admitted to hospice services on 07/07/19. Resident #3's clinical record contained no DNR (Do Not Resuscitate) consent form. There was no DNR sticker located on the outside of the clinical record. On 10/21/19 at 5:30 p.m., the hospice agency faxed a copy of resident #3's DNR consent form dated on 07/03/19 to be placed in resident #3's clinical record.	C 913		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to follow the physician's order to administer medication with specific instructions for 1 (#1) of 1 sampled resident with Carafate to be administered on an empty stomach before meals. This deficient practice resulted in the isolated potential for more than minimal harm. Findings: The center's physician order for resident #1, dated 07/02/19, documented to start Carafate 1 gram tablet on an empty stomach before meals and at bedtime. On 10/21/19 at 12:15 p.m., a medication pass was started with advanced certified medication aide (ACMA) #2 and resident #1. ACMA #2 administered a one gram tablet of Carafate to resident #1. At 12:28 p.m., ACMA #2 was asked if resident #1 was eating her lunch. She stated she was done, she eats pretty quickly. She was asked why she did not administer the medication before lunch as prescribed. She stated she usually did. The policy titled, 'Medication Administration, Assistance or Observation Times' not dated, documented the Community should assist with administration or observation of medications ordered before meals approximately thirty (30) minutes before meal time.	C1505		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate,	C1951		

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C1951	Continued From page 6 clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to maintain accurate clinical records for 2 (#2 and #3) of 8 sampled clinical records. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #2 Resident #2 was admitted to the center on 09/30/19. Resident #2's clinical record had no name on the outside of the chart. The LPN/DON was asked if resident #2 had a DNR consent form. She stated he had a DNR and an advance directive. The LPN/DON was asked if resident #2 had a DNR sticker on the outside of his chart. She stated no it was not on the chart, because they were waiting on the order for the DNR stickers. The physician's order indicated resident #2 had a mechanical soft diet ordered. The licensed practical nurse/director of nurses (LPN/DON) was asked if resident #2 had a change in his diet order. She stated he had a regular diet and reduced concentrated sweets. She stated she was not aware of the physician's order for a mechanical soft diet and would need to obtain clarification from the physician. Resident #2 was	C1951		

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C1951	Continued From page 7 asked if the center served sugar free snacks and desserts. He stated no, they were supposed to. A clarification order was sent to resident #2's physician on 10/22/19 to clarify the diet. The physician's order indicated resident #2 had Toujeo (diabetic medication) 60 units SQ (subcutaneous) every day. The LPN/DON was asked if she was aware the home health agency documented a dose of Toujeo was administered at 8:07 p.m., on October 14, 2019. She stated yes, and home health informed her the medication was ordered to be administered daily. On October 15, 2019 at 7:34 a.m., eleven hours later resident #2 received another dose of Toujeo. The LPN/DON was asked about administering the Toujeo at approximately the same time each day. The LPN/DON stated the medication should be administered at least 18 hours apart. The LPN/DON notified the home health agency and provided additional documentation the nurse had administered the Toujeo to resident #2 on the morning of October 14, 2019; however, the home health nurse did not document she administered the Toujeo until she arrived home that night at 8:07 p.m. The center's policy, Medication Administration, Assistance or Observation Times, not dated, documented, "The Community should ensure that authorized personnel, as determined by Applicable Law, assist with administration or observation of medications according to times of administration determined by the Community." Resident #3 Resident #3 was admitted to hospice services on 07/07/19. The resident chart contained no DNR	C1951		

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C1951	Continued From page 8 (Do Not Resuscitate) consent form. There was no DNR sticker located on the outside of the clinical record. On 10/21/19 at 5:30 p.m., the hospice agency faxed over a copy of resident #3's DNR consent form signed on 07/03/19 to be placed in resident #3's clinical record.	C1951			
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010			

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**3200 WEST HAYES
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C5010	Continued From page 9 This Rule is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to: a) Coordinate end of life decisions for 1 (#3) of 2 sampled residents with hospice services. b) Coordinate a medication change for Furosemide (Lasix) for 1 (#13) of 6 sampled residents with home health services. These deficient practices resulted in the potential for more than minimal harm at a pattern. Findings: Resident #3 Resident #3 was admitted to hospice services on 07/07/19. Resident #3's clinical record contained no DNR (Do Not Resuscitate) consent form. There was no DNR sticker located on the outside of the clinical record. At 4:50 p.m., licensed practical nurse (LPN/DON) was asked if resident #3 had a signed DNR consent form in the clinical record. She stated she did not have one in the chart. At 5:30 p.m., the hospice agency faxed a copy of resident #3's signed DNR consent form to the center to be	C5010		

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C5010	Continued From page 10 placed into the clinical record. LPN/DON was asked where in resident #3's clinical record indicated she was on hospice services. She stated she just knew she was on hospice. She stated they did not have the paperwork from hospice yet. Policy The center's policy titled, 'Emergency Procedures' dated 02/03/12, documented, for residents under the care of a Licensed Hospice Agency, staff shall contact the responsible Hospice Agency to request a Registered Nurse to assess the resident's condition on-site within 2 hours. Resident #13 On 10/21/19 at 12:15 p.m., a medication pass was started with advanced certified medication aide (ACMA) #2 and resident #13. ACMA #2 administered one tablet of Furosemide (Lasix) 40 mg to resident #13. The medication card read Furosemide 40 mg (milligrams) at noon X (times) three days then as needed for weight gain above 3 lbs. ACMA #2 was asked if she weighed resident #13. She stated yes she weighed 193.8 lbs (pounds) minus 49.0 lbs. for the wheelchair. The center's physician's order for resident #13, dated 10/14/19, documented, Furosemide tablet 40 mg, one tablet twice a day, morning and noon. The home health document faxed to the center on 10/22/19, documented to discontinue the Lasix 40 mg for a weight gain of 3 lbs. or more in a 24-hour period dated on 10/15/19 and to add Lasix 40 mg tablet two times daily. The assisted living center medication	C5010		

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NAME OF PROVIDER OR SUPPLIER ANGELWOOD ASSISTED LIVING AND MEMOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WEST HAYES CLINTON, OK 73601		
(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
C5010	Continued From page 11 administration record (MAR) for resident #13, documented to continue with the Lasix PRN (as needed) for a weight gain of 3 lbs. The as needed Lasix had not been administered and had no weight gain of 3 lbs. was documented for resident #13 in October 2019. On 10/22/19 at 12:54 p.m., LPN/DON was asked about the physician's order home health had to discontinue the as needed Lasix. She stated she had only received the physician's order to increase Lasix for 30 days. At 1:10 p.m., ACMA #2 was asked when she administered resident #13's Lasix. She stated she administered it in the morning and at noon. She was asked if she weighed resident #13 daily. She stated yes and she would report it to the nurse. She was asked if she had administered Lasix PRN to resident #13 for a weight gain. She stated no. At 1:37 p.m., LPN/DON was asked if home health had discontinued the PRN Lasix. She stated yes they did. She was asked if the center had discontinued resident #13's PRN Lasix. She stated no she did not. She stated she would need to send a clarification order to the physician.	C5010		

STATE WORKLOAD REPORT

Provider/Supplier Number
AL2002

Provider/Supplier Name
ANGELWOOD ASSISTED LIVING AND MEMORY CARE

Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
---	--	--	--	--

- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30875	10/21/2019	10/22/2019	1.00	0.00	16.00	0.00	2.50	6.00
2. 41872	10/21/2019	10/22/2019	0.25	0.00	16.00	0.00	4.00	6.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours.....

0.00

Total SA Clerical/Data Entry Hours.....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

DEC 04 2019

jm



Oklahoma State Department of Health
Creating a State of Health

December 20, 2019

License Number: AL2002

Mr. George Barton, Administrator
Angelwood Assisted Living and Memory Care
3200 West Hayes
Clinton, OK 73601

RE: Survey Event PQ2011

Dear Mr. Barton:

On October 22, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **February 3, 2020**.

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) 271-6868.

Sincerely,

Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

Board of Health

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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/16/2019

Facility Name: Angelwood Assisted Living

License Number: AL2002

Survey Event ID: PQ2011

Date Survey Completed: 10/22/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1105

Based on: Interview and record review it was determined the center failed to ensure annual performance reviews had been completed for 6 (#2, 4, 7, 8, 9, and #10) of 7 CNA's (Certified Nursing assistants) who had been employed by the center for at least one year. This deficient practice had the widespread potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state law.

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

*All currently employed CNA (Certified nursing assistant) files, who have been employed by the center for at least one year have been audited by Community Executive Director, and all have completed nurse aide skill performance checklists by 11-04-2019.

OSDH Response: Element accepted Yes ☒ No ☐

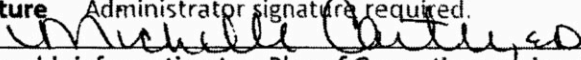
2. How will other residents having the potential to be affected by the same deficient practice be identified?

*Community Director of Health and Wellness/LPN to review company policy 'Caregiver Skills Check Guide' by 12-18-2019.
*Community Director of Health and Wellness/LPN to review 310:677-11-1(a)(1)(2)(3) by 12-18-2019.
*Community Director of Health and Wellness/LPN to conduct weekly audit of all CNA (Certified Nursing Assistant) files for review of nurse aide skills performance checklists. Any employee found to be out of compliance will be reported to the community Executive Director immediately and be removed from the schedule until nurse aide skills performance checklist is complete. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.

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?

*Community Executive Director to review company policy 'Caregiver Skills Check Guide' by 12-18-2019.
*Community Executive Director to review 310:677-11-1(a)(1)(2)(3) 'General Requirements-LTC by 12-18-2019.
*Executive Director to complete monthly audit of all CNA (Certified nursing assistants) files for review of nurse aide skills performance checklists. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.

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.	Enter methods to ensure corrections are sustained: By 12-18-2019 the Quality Assurance Committee will meet and address the deficiencies discussed in the survey exit conference as well as corrective measures. The Quality Assurance Committee will address and review further auditing procedures to ensure corrective measures are enforced. Each Quality Assurance meeting will include discussion and review of nurse aide skills and functions at least quarterly until 100 percent compliance is maintained for 2 consecutive months. Each Quality Assurance meeting will include any regulatory issues and survey readiness. The Executive Director and the Director of Health and Wellness will be responsible for monitoring.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/3/2020
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 	Date 12/16/2019
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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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/16/2019

Facility Name: Angelwood Assisted Living

License Number: AL2002

Survey Event ID: PQ2011

Date Survey Completed: 10/22/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1442

Based on: Interview and record review it was determined the center failed to perform annual competency skills evaluation for 2 (#2 and #4) of 4 sampled CMA's (Certified medication aides) who had been employed by the center for at least one year. This deficient practice had the widespread potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state law.

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:

ASSISTED LIVING CENTER'S PLAN ELEMENTS

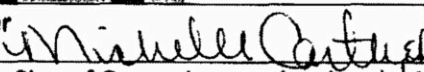
*All currently employed CMA (Certified Medication Aide) files, who have been employed by the center for at least one year have been audited by community Executive Director, and all have completed medication skills checks by 11-04-2019.

*Community Director of Health and Wellness/LPN to conduct biweekly (every 2 weeks) audits of all CMA (Certified Medication Aide) files for review of Medication Skills Checks. Any employee found to be out of compliance will be reported to the community Executive Director immediately and be removed from the schedule until medication skills check is complete. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.

*Community Executive Director and Health and wellness Director to review company policy 'Licensed Staff Skills Check Off' by 12-18-2019.
*Community Executive Director and Health and Wellness Director to review 310:677-13-7 (c) 'Skills and Functions' by 12-18-2019.
*Community Executive Director to conduct monthly audits of all CMA (Certified Medication Aide) files for review of Medication Skills Check compliance. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.

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.	By 12-18-2019 the Quality Assurance Committee will meet and address the deficiencies discussed in the survey exit conference as well as corrective measures. The Quality Assurance Committee will address and review further auditing procedures to ensure corrective measures are enforced. Each Quality Assurance meeting will include discussion and review of certified medication aide skills and functions at least quarterly until 100 percent compliance is maintained for 2 consecutive months. Each Quality Assurance meeting will include any regulatory issues and survey readiness. The Executive Director and the Director of Health and Wellness will be responsible for monitoring.		
OSDH Response: Element accepted: Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/3/2020	
OSDH Response: Element accepted: Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date 12/16/2019	
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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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 12/16/2019	
	Facility Name: Angelwood Assisted Living	
	License Number: AL2002	
	Survey Event ID: PQ2011	
		Date Survey Completed: 10/22/2019
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C103	Based on: observation and interview it was determined the center failed to ensure smoking was prohibited within 15 feet of an entrance to the center. This failed practice had the potential for more than minimal harm at a pattern.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state law.		
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 10-22-2019, the center's designated smoking area's ashtray was immediately moved by community Maintenance Director at least 15 feet away from the entrance. * On 10-22-2019 resident #8 was educated by community Executive Director on the community policy 'Smoking (Resident Smoking)'. * On 10-22-2019 resident #8 was educated by community Executive Director on the Resident Handbook policy 'Smoking'.
OSDH Response: Element accepted Yes ☐ No ☒		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		* Community Director of Health and Wellness to review 310:663-1-3(c) by 12-18-2019. * Community Director of Health and Wellness to review Company Policy 'Smoking (Resident Smoking)' by 12-18-2019. * On 10-22-2019 all current residents that smoke were educated by community Executive Director on the company policy titled 'Smoking (Resident Smoking)'. * On 10-22-2019 all current residents that smoke were educated by community Executive Director on the Resident Handbook policy 'Smoking'. * All current staff to be educated by Community Executive Director and/or community Director of Health and Wellness/LPN on 310:663-1-3 (c) by 12-31-2019. * All current staff to be educated by community Executive Director and/or community Director of Health and Wellness/LPN on Company Policy 'Smoking (Resident Smoking)' by 12-31-2019. * Director of Plant Operations to audit building grounds for ashtray(s) being at least 15 feet of each applicable entrance at least twice per week. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.

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?	* Community Executive Director to review 310:663-1-3 (c) by 12-18-2019. *Community Executive Director to review Company Policy 'Smoking (Resident Smoking)' by 12-18-2019. * Community Executive Director to audit current resident files monthly for any resident(s) newly admitted for review of Company Policy 'Smoking (Resident Smoking)' and Resident Handbook Policy 'Smoking'. Audit to continue until 100 percent compliance is maintained for 2 consecutive months. *Community Executive Director to audit building grounds for ashtray(s) being at least 15 feet of each applicable entrance at least monthly. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.
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.	By 12-18-2019, the Quality Assurance Committee will meet and addressed the deficiencies discussed in the statement of deficiencies as well as corrective measures. The Quality Assurance Committee will address and review further auditing procedures to ensure corrective measures are enforced. Each Quality Assurance will include discussion and review of Smoking Prohibited-resident smoking at least quarterly until 100 percent compliance is maintained for 2 consecutive months. Each Quality Assurance meeting will include any regulatory issues and survey readiness. The Executive Director and Health and Wellness Director will be responsible for monitoring.
OSDH Response: Element accepted: Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/3/2020
OSDH Response: Element accepted: Yes ☐ No ☐	
Administrator's Signature Michelle Carter  Date 12/16/2019 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
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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: 12/16/2019

Facility Name: Angelwood Assisted Living

License Number: AL2002

Survey Event ID: PQ2011

Date Survey Completed: 10/22/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C913

Based on: Interview and record review it was determined the center failed to accurately document the DNR (Do Not Resuscitate) status for 1 (#3) of 1 sampled resident without documentation of the DNR consent form. This deficient practice resulted in the isolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state law.

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 10-22-2019 current resident charts for residents receiving Hospice services were audited by community Executive Director and updated to accurately reflect DNR stickers on the outside of clinical record and consent form in clinical record.

OSDH Response: Element accepted Yes ☒ No ☐

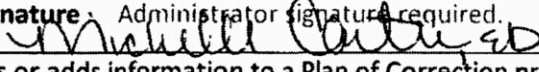
2. How will other residents having the potential to be affected by the same deficient practice be identified?

*Community Director of Health and Wellness/LPN to review 310:663-9-1(3) NURSE by 12-18-2019.
*Community Director of Health and Wellness/LPN to perform initial chart audit on all current resident charts for accurately filed DNR (Do Not Resuscitate) consent forms, Living Will document, and/or Advanced Directive where applicable and proper labeling of DNR (Do Not Resuscitate) on all applicable resident charts by 12-20-2019.
*Community Director of Health and Wellness/LPN to perform chart audit of all current resident charts biweekly (every 2 weeks) for compliance of DNR (Do No Resuscitate) consent forms, Living Will form, and/or DNR sticker located on outside of any resident chart where applicable. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.

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?

*Community Executive Director to review 310:663-9-1(3) NURSE by 12-18-2019.
*Community Executive Director to complete monthly audit on all current resident charts for accurately filed DNR (Do Not Resuscitate) consent forms, Living Will document, and/or Advanced Directive where applicable and proper labeling of DNR (Do Not Resuscitate) on all applicable resident charts. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.

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.	Enter methods to ensure corrections are sustained. By 12-18-2019 the Quality Assurance Committee will meet and address the deficiencies discussed in the survey exit conference as well as corrective measures. The Quality Assurance Committee will address and review further auditing procedures to ensure corrective measures are enforced. Each Quality Assurance meeting will include discussion and review of DNR status and documentation at least quarterly until 100 percent compliance is maintained for 2 consecutive months. Each Quality Assurance meeting will include any regulatory issues and survey readiness. The Executive Director and the Director of Health and Wellness will be responsible for monitoring.
OSDH Response: Element accepted: Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/3/2020
OSDH Response: Element accepted: Yes ☐ No ☐	
Administrator's Signature : Administrator signature required. OAC 310:663-25-4(F) 	Date 12/16/2019
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.	
Addendum Date	Enter a date of addendum.
Submitted by	Enter name of person submitting addendum.
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/16/2019

Facility Name: Angelwood Assisted Living

License Number: AL2002

Survey Event ID: PQ2011

Date Survey Completed: 10/22/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: Observation, interview, and record review it was determined the center failed to follow the physician's order to administer medication with specific instructions for 1 (#1) of 1 sampled resident with Carafate to be administered on an empty stomach before meals. This deficient practice resulted in the isolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state law.

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 10-22-2019 ACMA #2 was re-educated by community Director of Health and Wellness on Company Policy 'Medication-Medication Policy'.
*On 10-22-2019 ACMA #2 was re-educated by community Director of Health and Wellness on Company Policy 'Medication: Medication Administration Records (MAR)/ Medication Observation Record/MOR Policy'.
* On 10-22-2019 ACMA #2 was re-educated by community Director of Health and Wellness on Pharmacy Policy 'Administration, Assistance and Observation of Medication'.
*On 10-22-2019 Community Director of Wellness/LPN reviewed resident #1 MAR (Medication Administration Record) to ensure proper time frame of administering medication(s) before and/or after meals as ordered by physician, was notated on each applicable medication.
*On 10-22-2019 Community Director of Health and Wellness/LPN reviewed Pharmacy Policy 'Administration, Assistance and Observation of Medication'.

OSDH Response: Element accepted Yes ☐ No ☐

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

*Community Director of Health and Wellness/LPN to review 310:663-15-1 by 12-18-2019.
*Community Director of Health and Wellness/LPN to review 63 O.S. 1-1918.(B)(5) by 12-18-2019.
*Community Director of Health and Wellness/LPN to review Company Policy 'Medication-Medication Policy' by 12-18-2019.
*Community Director of Health and Wellness/LPN to review Company Policy 'Medication: Medication Administration Records (MAR)/ Medication Observation Record/MOR Policy' by 12-18-2019.

	* Community Director of Health and Wellness/LPN to re-educate all current medication aides on 310:663-15-1 and 63 O.S.1-1918.(B)(5) by 12-31-2019. * Community Director of Health and Wellness/LPN to re-educate all medication aides on Company Policy 'Medication-Medication Policy' by 12-31-2019. * Community Director of Health and Wellness to re-educate all medication aides on company Policy 'Medication: Medication Administration Records (MAR)/Medication Observation Record/MOR Policy' by 12-31-2019. * Community Director of Health and Wellness to re-educate all medication aides on Pharmacy Policy 'Administration, Assistance and Observation of Medications' by 12-31-2019. *Community Director of Health and Wellness/LPN to perform audit on all current resident MAR's (Medication Administration Record) to ensure proper time frame of administering medication before and/or after meals as ordered by the physician is notated on the MAR's as applicable. Audit to be conducted by 12-20-2019. *Community Director of Health and Wellness/LPN to conduct biweekly (every 2 weeks) audit on all current resident MAR's (Medication Administration Record) to ensure proper time frame of administering medication before and/or after meals as ordered by the physician is notated on the MAR's as applicable. Audit to continue until 100 percent compliance is maintained for 2 consecutive months. * Community Director of Health and Wellness/LPN to conduct biweekly (every 2 weeks) audit on all current employee files to ensure all recently-hired medication aides and/or current staff receiving certification for medication administration are educated on Pharmacy Policy 'Administration, Assistance and Observation of Medications', Company Policy 'Medication-Medication Policy', and Company Policy 'Medication:Medication Administration Records (MAR)/Medication Observation Record/MOR Policy'. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.
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?	*Community Executive Director to review 310:663-15-1 by 12-18-2019. * Community Executive Director to review 63 O.S. 1-1918.(B)(5) by 12-18-2019. *Community Executive Director to review company policy 'Medication-Medication Policy' by 12-18-2019. *Community Executive Director to review Company Policy 'Medication:Medication Administration Records

	(MAR)/Medication Observation Record/MOR Policy' by 12-18-2019. *Community Executive Director to review Pharmacy Policy 'Administration, Assistance and Observation of Medications' by 12-18-2019. *Community Executive Director to conduct monthly audit of all current resident MAR's (Medication Administration Record) to review for proper time frame of administering medication before and/or after meals as ordered by the physician, is notated on MAR's as applicable. Audit to continue until 100 percent compliance is maintained for 2 consecutive months. *Community Executive Director to audit current employee files monthly to ensure all medication aide's hired and/or current staff receiving certification for medication administration are educated on Pharmacy Policy 'Administration, Assistance and Observation of Medications', Company Policy 'Medication-Medication Policy', and Company Policy 'Medication:Medication Administration Records (MAR)/Medication Observation Record/MOR Policy'.	
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.		
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		2/3/2020
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature <i>[Signature]</i> OAC 310:663-25-4(F)		Date 12/16/2019
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	Submitted by	
Items Below Are For OSDH Use Only		
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: _____ Surveyor: _____		
If Plan of Correction is unacceptable, the reasons are as follows: _____		
Facility in Compliance by: _____		



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Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/16/2019

Facility Name: Angelwood Assisted Living

License Number: AL2002

Survey Event ID: PQ2011

Date Survey Completed: 10/22/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1951

Based on: Interview and record review it was determined the center failed to maintain accurate clinical records for 2 (#2 and #3) of 8 sampled clinical records. This deficient practice resulted in the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state law.

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 10-22-2019 All current resident charts audited by community Executive Director and updated to accurately reflect proper labeling on the outside of charts to include but not limited to DNR stickers and resident name.
*On 10-24-2019 Community Director of Health and Wellness/LPN received clarification from resident #2's physician for resident #2's diet.
*On 10-29-2019 Community Director of Health and Wellness/LPN educated noted Home Health nurse on State Regulation 310:663-19-2(A)(1)(2)(3) Medication Administration.
*On 10-29-2019 Community Director of Health and Wellness/LPN educated noted Home Health nurse on Pharmacy Policy 'Administration, Assistance and Observation of Medications'.
*On 10-22-2019 all current charts for residents receiving Hospice services were audited by community Executive Director and updated to accurately reflect DNR (Do Not Resuscitate) stickers on the outside of the clinical records and consent forms in clinical records as applicable.

OSDH Response: Element accepted: Yes ☒ No ☐

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

*Community Director of Health and Wellness/LPN to review 310:663-19-3(a) Maintenance of Records by 12-18-2019.
*Community Director of Health and Wellness/LPN to perform chart audit of all current resident charts biweekly (every 2 weeks) for compliance of DNR (Do No Resuscitate) consent forms, Living Will form, DNR sticker located on outside of any current resident chart, and resident name where applicable. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.
*Community Director of Health and Wellness to perform initial audit of all physician prescribed diets and ensure resident care plans reflect accordingly 12-20-2019.

	*Community Health and Wellness Director/LPN to update Community Prescribed Diet List and be made available to all dining staff by 12-20-2019. *Community Director of Health and Wellness/LPN to audit community Prescribed Diet List at least biweekly (every 2 weeks) for accuracy and update as necessary. Audit to continue until 100 percent compliance is maintained for 2 consecutive months. *Community Director of Health and Wellness to educate all Home Health and Hospice provider companies providing care to community residents on Pharmacy Policy 'Administration, Assistance and Observation of Medications' by 12-20-2019. Community Director of Health and Wellness to educate all Home Health and Hospice provider companies providing care to community residents on 310:663-19-2(a)(1)(2)(3) Medication Administration by 12-20-2019.
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?	*Community Executive Director to review 310:663-19-3(a) Maintenance of Records by 12-18-2019. *Community Executive Director to perform chart audit of all current resident charts monthly for compliance of DNR (Do No Resuscitate) consent forms, Living Will form, DNR sticker located on outside of any resident chart, and resident name where applicable. Audit to continue until 100 percent compliance is maintained for 2 consecutive months. *Community Executive Director to perform monthly audit of all physician prescribed diets and ensure current resident care plans and community Prescribed Diet List reflect accordingly. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.
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.	Enter methods to ensure corrections are sustained: By 12-18-2019 the Quality Assurance Committee will meet and address the deficiencies discussed in the statement of deficiencies as well as corrective measures. The Quality Assurance Committee will address and review further auditing procedures to ensure corrective measures are enforced. Each Quality Assurance meeting will include discussion and review of maintenance of resident records at least quarterly, until 100 percent compliance is maintained for 2 consecutive months. Each Quality Assurance meeting will include any regulatory issues and survey readiness.

		The Executive Director and the Director of Health and Wellness will be responsible for monitoring.	
OSDH Response: Element accepted. Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/3/2020	
OSDH Response: Element accepted. Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date 12/16/2019	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/16/2019

Facility Name: Angelwood Assisted Living

License Number: AL2002

Survey Event ID: PQ2011

Date Survey Completed: 10/22/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C5010

Based on: Observation, interview, and record review it was determined the center failed to a)Coordinate end of life decisions for 1 (#3) of 2 sampled residents with hospice services, b)Coordinate a medication change for Furosemide (Lasix) for 1 (#13) of 6 sampled residents with home health services. This deficient practice resulted in the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state law.

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

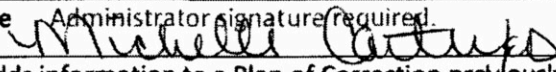
*On 10-22-2019 All charts for current residents receiving Hospice services were audited by community Executive Director and updated to accurately reflect DNR stickers on the outside of clinical record and DNR consent form in clinical record.
*On 10-22-2019 DNR consent form was placed in resident #3's clinical record by community Director of Health and Wellness/LPN and DNR sticker placed on the outside of resident #3's clinical chart.
*Community Health and Wellness Director received requested clarification of resident #13's Lasix (Furosemide) order on 10-24-2019.

OSDH Response: Element accepted Yes ☒ No ☐

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

*Community Director of Health and Wellness/LPN to review 63 O.S. 1-890.8(A-D) by 12-18-2019.
*Community Director of Health and Wellness/LPN to perform initial chart audit on all current resident charts for accurately filed DNR (Do Not Resuscitate) consent forms, Living Will document, and/or Advanced Directive where applicable and proper labeling of DNR (Do Not Resuscitate) on all applicable current resident charts by 12-20-2019.
*Community Director of Health and Wellness/LPN to perform chart audit of all current resident charts biweekly (every 2 weeks) for compliance of DNR (Do No Resuscitate) consent forms, Living Will form, and/or DNR sticker located on outside of any resident chart where applicable. Audit to continue until 100 percent compliance is maintained for 2 consecutive months.
*Community Director of Health and Wellness to review company policy 'Community Emergency Procedures Standard' by 12-18-2019.

	*All staff to be re-educated by community Director of Health and Wellness/LPN on company policy 'Community Emergency Procedures Standard' by 12-31-2019. *Community Director of Health and Wellness to perform initial audit of MAR (Medication Administration Record) to Medication cart to identify any medications requiring a change in direction to be notated on medication label and/or any clarification needed by 12-20-2019. *Community Director of Health and Wellness/LPN to perform a MAR to Medication Cart review/audit at least monthly to identify any medications requiring a change in direction to be notated on medication label and/or any clarification needed. Audit to continue until 100 percent compliance is maintained for 2 consecutive months. *Community Director of health and Wellness/LPN to review company policy 'Medication Change Direction Labels Standard' by 12-18-2019. *Community Director of Health and Wellness/LPN to re-educate all medication aides on company policy 'Medication Change Direction Labels Standard' by 12-31-2019.
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?	*Community Executive Director to review 63 O.S. 1-890.8(A-D) by 12-18-2019. *Community Executive Director to review company policy 'Community Emergency Procedures Standard' by 12-18-2019. *Community Executive Director to complete monthly audit on all current resident charts for accurately filed DNR (Do Not Resuscitate) consent forms, Living Will document, and/or Advanced Directive where applicable and proper labeling of DNR (Do Not Resuscitate) on all applicable current resident charts. Audit to continue until 100 percent compliance is maintained for 2 consecutive months. *Community Executive Director to review company policy 'Medication Change Direction Labels Standard' by 12-18-2019.
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.	Enter methods to ensure corrections are sustained: By 12-18-2019 the Quality Assurance Committee will meet and address the deficiencies discussed in the statement of deficiencies as well as corrective measures The Quality Assurance Committee will address and review further auditing procedures to ensure corrective measures are enforced. Each Quality Assurance meeting will include discussion and review of care and services-coordination of

		care at least quarterly until 100 percent compliance is maintained for 2 consecutive months. Each Quality Assurance meeting will include any regulatory issues and survey readiness.
		The Executive Director and the Director of Health and Wellness will be responsible for monitoring
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		2/3/2020
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 		Date 12/16/2019
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: mcarter@seniorlifestyle.com

August 13, 2020

License Number: AL2002

Mr. George Barton, Administrator
Angelwood Assisted Living and Memory Care
3200 West Hayes
Clinton, OK 73601

RE: Survey Event ID: PQ2012

Dear Mr. Barton:

Enclosed is the summary of deficiencies following the revisit of a State Licensure survey conducted at your Assisted Living Center on **February 12, 2020**. These deficiencies remain uncorrected from our original investigation conducted **October 22, 2019**.

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

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance.

However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies. If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

**Katie
Stagner**

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma
State Department of Health,
ou=Long Term Care,
email=katies@health.ok.gov, c=US
Date: 2020.08.13 10:01:59 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/12/2020
NAME OF PROVIDER OR SUPPLIER ANGELWOOD ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WEST HAYES CLINTON, OK 73601		
(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 follow up survey was completed 02/11/2020 to 02/12/2020. Census was 24. Deficient practice was cited as follows.	{C 000}		
{C1951} SS=D	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: Surveyor: Cooper, Mary Based on interview and record review, it was determined the center failed to maintain an accurate clinical record for 1(#1) of 4 sampled residents' current physician orders. This deficient practice had the isolated potential for more than minimal harm. Findings: On 02/11/2020 at 11:20 a.m., resident #1's physician orders for February 2020 were reviewed with licensed practical nurse (LPN) #1 . Order #1 "Furosemide 20 milligrams give one tab by mouth at noon as needed for 2 pound weight gain in 24 hours or 5 pounds in 1 week time, edema, or can't lay flat." Order #2 "Weigh daily give one additional furosemide for weight gain of 3 pounds, edema or can't lay flat." LPN #1 was asked why there was a discrepancy on the weight gain to administer the extra	{C1951}		

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: AL2002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/12/2020
NAME OF PROVIDER OR SUPPLIER ANGELWOOD ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WEST HAYES CLINTON, OK 73601		
(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 1 furosemide. She stated she did not know why and had sent an order to clarify the weight discrepancy to the physician on 02/10/2020. No physician clarification was given to this surveyor prior to exit.	{C1951}		
{C5010} SS=D	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	{C5010}		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/12/2020
NAME OF PROVIDER OR SUPPLIER ANGELWOOD ASSISTED LIVING AND MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WEST HAYES CLINTON, OK 73601		
(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
{C5010}	Continued From page 2 This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to coordinate with a third party provider for administration of daily insulin for 1 (#4) 1 sampled resident who had home health services. This deficient practice had the isolated potential for more than minimal harm. Findings: Resident #4's home health plan of care from 01/29/2020 to 03/28/2020 documented: "Skilled nurse for administration of subcutaneous insulin of Toujeo 60 units every day. Toujeo 60 units will be given between the hours of 8 a.m. and 9 a.m. every day." On 02/11/2020 at 2:25 p.m., resident #4's medication administration record (MAR) for February 2020 was reviewed with licensed practical nurse (LPN) #1 and registered nurse (RN) #1 for the time home health had administered resident #4's Toujeo insulin. The MAR documented six of eleven days Toujeo insulin was not administered in the time frame as ordered. RN #1 and LPN #1 stated they were not aware of the administration times as ordered on the home health plan of care, or if the insulin had been given late on the following days: 02/04/2020 administered at 9:43 a.m. 02/05/2020 administered at 9:42 a.m. 02/07/2020 administered at 9:31 a.m. 02/08/2020 administered at 9:14 a.m. 02/09/2020 administered at 9:09 a.m. and 02/11/2020 administered at 9:25 a.m.	{C5010}		