Oklahoma State Department of Health
Creating a State of Health

August 22, 2019

License Number: AL2103

Ms. Roxanne Fanning, Administrator
Grandwood Assisted Living, Lc
2001 Sunrise Bouldvard
Grove, OK 74344

RE: Survey Event ID: T78S11

Dear Ms. Fanning:

On **August 1, 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 **August 1, 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,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2103	A. BUILDING _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDWOOD ASSISTED LIVING, LC	2001 SUNRISE BOULDVARD GROVE, OK 74344

(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 re-licensure survey was conducted on 07/29/19 through 08/01/19. Current census was 79. The following deficiencies were cited.	C 000		
C 398 SS=F	310:663-3-8(e) FOOD STORAGE, PREPARATION AND SERVICE (e) All staff assisting in, or responsible for food preparation shall have attended a food service training program offered or approved by the Department. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure 10 of 10 dietary employees responsible for food preparation had attended a food service training program approved by the Department. This failed practice had the widespread potential for more than minimal harm for all 79 residents who received their nutrition from the kitchen. Findings: On 07/30/19 at 10:00 a.m., a review of employee files revealed the following dietary employees had received food training from a certified dietary manager not from a food service training program approved by the Department: Cook/employee #1, Cook/employee #2, Cook/employee #3, Dietary/employee #4, Dietary/employee #5, Cook/employee #6,	C 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2103	A BUILDING _____ B WING _____	08/01/2019

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C 398	Continued From page 1 Cook/employee #7, Dietary supervisor/employee #8, Cook/employee #13, and Cook/employee #14. At 11:55 a.m., dietary supervisor/employee #8, cook/employee #13, and cook/employee #14 prepared and served the noon meal to all 79 residents who resided in the assisted living center. On 07/31/19 at 9:52 a.m., dietary supervisor/employee #8 stated she had received her food training from administrator #1, and she had provided food training to the dietary employees. She stated she had not attended a food service training program approved by the Department; nor had any of the dietary employees. At 10:16 a.m., administrator #1 stated the dietary employees received food training upon being hired and annually from the administrator #2/certified dietary manager. She stated she had not known her county required the dietary employees attended a food service training program approved by the Department. The Center did not provide documentation of the Certified Dietary Manager using an approved training curriculum. At 10:34 a.m., administrator #2/certified dietary manager stated she had not known she was qualified to provide food training to the dietary employees. She stated she had not known the dietary employees should have had food service training from a state approved program.	C 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2103	A BUILDING _____ B WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDWOOD ASSISTED LIVING, LC	2001 SUNRISE BOULDVARD GROVE, OK 74344

(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 701	Continued From page 2	C 701		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure hot water temperatures at faucets accessible to the residents did not exceed 115 degrees Fahrenheit (F) for the assisted living laundry and 5 (#1, 2, 3, 6,and #8) of 10 sampled residents' rooms. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 07/30/19 at 10:54 a.m., an environmental tour was begun with the assistance of maintenance/employee #16 to check hot water temperatures throughout the center. The following hot water temperatures in the rooms registered above the required 115 degrees F: Room 117 - 118.4 degrees F; Room 118 - 118.3 degrees F; Room 129 - 123.8 degrees F; Room 143 - 123.1 degrees F; and Room 146 - 122.9 degrees F.	C 701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2103	A BUILDING _____ B WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 701	Continued From page 3 At 3:11 p.m., the assisted living laundry door was found to be unlocked and the hot water in that laundry registered at 153.3 degrees F. Maintenance/employee #16 stated the door was left unlocked due to the employees going in and out of that room. At 3:22 p.m., administrator #1 stated 47 residents in the center were mobile and self motivating throughout the center; and those residents had access to the laundry room. She further stated one (1) resident washed and dried her own laundry in the laundry room whenever she desired. At 3:23 p.m., maintenance/employee #16 submitted a Water Temperature Report, dated 07/18/19, that documented hot water temperatures in rooms 112 and 116 at 116 degrees F, and the assisted living laundry room at 147 degrees F.	C 701		
C 922 SS=F	310:663-9-2(b) MEDICATION STAFFING (b) Unlicensed personnel administering medications shall have completed a training program that has been reviewed and approved by the Department. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure unlicensed employees who administered medications to 10 (#1 through #10) of 10 sampled residents had completed a medication administration program approved by the Oklahoma Stated Department of Health (OSDH). This failed practice had the widespread potential	C 922		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2103	A BUILDING. _____ B WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDWOOD ASSISTED LIVING, LC	2001 SUNRISE BOULDVARD GROVE, OK 74344

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C 922	Continued From page 4 for more than minimal harm. Findings: On 07/30/19 at 10:00 a.m., a review of employees' files documented medication administration technicians (MAT)/employees #9, 10, and #11 had not received their certificates from an OSDH approved program. On 07/30/19 at 9:32 a.m., MAT/employee #9 administered oral medications to resident #11, 12, and #13. A record review of the sampled residents' July 2019 medication administration records (MAR)revealed the following: MAT/employee #9 had administered oral medications to resident #1 through #13. MAT/employee #10 administered oral medications to #1 through #13. MAT/employee #11 administered oral medications to #1, 2, 4, 5, 9, and #10. MAT/employee #12 administered oral medications to #1 through #5, #9, and #10. On 07/31/19 at 10:10 a.m., MAT/employee #9 stated she was a DDS (developmentally disabled services) MAT and she administered oral medications, nasal sprays, and eye drops to all the residents in the assisted living, focus care area, and the memory care unit. At 10:16 a.m., administrator #1 stated four (4) of the employees who passed medications had attended a two day/16 hour program at a local DDS care home. She stated she had not known employees had to obtain a MAT certificate from	C 922		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2103	A. BUILDING: _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDWOOD ASSISTED LIVING, LC	2001 SUNRISE BOULDVARD GROVE, OK 74344

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C 922	Continued From page 5 an OSDH approved program.	C 922		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL2103	GRANDWOOD ASSISTED LIVING, LC

Type of Survey (select all that apply)

[2] [ ] [ ] [ ] [ ]

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
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. [illegible]25837	07/29/2019	08/01/2019	0.50	0.00	23.25	0.00	11.75	1.00
2. [illegible]35195	07/29/2019	08/01/2019	0.25	0.00	26.25	0.00	9.75	5.50
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**

AUG 23 2019

Oklahoma State Department of Health
Creating a State of Health

September 13, 2019

License Number: AL2103

Ms. Roxanne Fanning, Administrator
Grandwood Assisted Living, Lc
2001 Sunrise Bouldvard
Grove, OK 74344

RE: Survey Event T78S11

Dear Ms. Fanning:

On **August 1, 2019**, agents from our office completed an Assisted Living Center survey 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:

- **C0398:** The proposed plan for C0398 did not include interventions that include training that was state and county required regarding Food Handler's Permits obtained through the local County Health Department or online State Department of Health Food Handler's training.

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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 9/6/2019** **Facility Name:** Grandwood Assisted Living, LC **License Number:** AL 2103 **Survey Event ID:** T78S11 **Date Survey Completed: 8/1/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C398	Based on: This rule was not met as evidence by: Based on Observation, interview and record review, it was determined the center failed to ensure 10 of 10 dietary employees responsible for food preparation had attended a food service training program approved by the department. This failed practice had widespread potential for more than minimal harm for all 79 residents who received

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	All current dietary staff who cook/prepare food was certified under the ServeSafe Food Handler Training course on 8/7/2019 completed by our Regional Dietary Manager.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Within 30 days of hire an employee who will be preparing or handling food will be trained by the Regional Dietary Manager and certified by the ServeSafe Food Handler Training.
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?	ServeSafe Food Handler Training will be completed within the first 30 days of hire.
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: Administrator will conduct audits of each new dietary employee's orientation paperwork monthly to ensure the ServeSafe Training has occurred and a certificate is present. QA team will review quarterly and ensure ServeSafe Training is completed upon hire and annually Once QA team has ensured the process is effective and all dietary staff who handle food has acquired appropriate certification, the QA team will continue to monitor for one year for effectiveness and it will be documented in the QA meeting notes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/7/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.			**Date 9/6/2019**
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: 9/6/2019** **Facility Name:** Grandwood Assisted Living, LC **License Number:** AL 2103 **Survey Event ID:** T78S11 **Date Survey Completed: 8/1/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C701	Based on: This rule was not met as evidence by: Based on Observation, interview and record review, it was determined the center failed to ensure hot water temperatures at faucets accessible to the residents did not exceed 115 degrees Fahrenheit for the assisted living laundry and 5 of the 10 sampled rooms. 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: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Upon the findings the laundry room was immediately locked, and staff was counseled on keeping the door locked at all times until an automatic lock was put on the laundry room door. Room temps will be checked 3x/week for thirty days and maint will immediately adjust water temps accordingly.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Water Temps will be taken in different resident units each time to ensure they are within compliance throughout the building.
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?	Water temps to be checked three times per week for thirty days, at that time if water temps are stable at that time we will check the temps 2x/week. If after 30 days water temps are not stable we will continue to monitor three times per week until they are stable.
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: Water temps will be taken by maintenance three times per week and turned into administrator who will review them for compliance. QA team will review water temps quarterly. Water temps will be checked in random rooms in each unit and documented on water temp report log, log will be maintained by the maint employee and copies to be given to Administrator.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/30/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required	Date 8/30/2019

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: 9/6/2019** **Facility Name:** Grandwood Assisted Living, LC **License Number:** AL 2103 **Survey Event ID:** T78S11 **Date Survey Completed: 8/1/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C922	Based on: This rule was not met as evidence by: Based on Observation, interview and record review, it was determined the center failed to ensure unlicensed employees who administered medications to 10 of 10 sampled residents had completed a medication administration program approved by the OSDH. This failed practice had the widespread potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Once it was brought to the administrator's attention that DDS MATs were not allowed to pass medication in the assisted living setting all DDS MATs were removed from the treatment cart. Employees were sent to an appropriate MAT course.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DDS MATs will no longer be allowed to pass meds to any residents within the assisted living. MATs will only be utilized to pass medications if they attend a MAT class and provide proof that the class has been approved by OSDH or completed at a vo-tech facility and not a residential care facility for the developmentally disabled.
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?	Administrator will audit any new hires having a MAT certification within 24 hours of hire to ensure proper training has been received.
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: MAT certifications will be reviewed by administration and HR to ensure appropriate courses have been completed prior to hiring. QA team will review employee binders quarterly reviewing all MAT certifications. Copies of MAT Certification will be kept in employee binders and sent to HR for verification of appropriate training.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/29/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date 9/6/2019**
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

September 17, 2019

License Number: AL2103
Survey Event ID: T78S11

Ms. Roxanne Fanning, Administrator
Grandwood Assited Living, L.C.
3720 E. 2nd Street
Edmond, OK 73034

This letter replaces letter dated September 13, 2019

Dear Ms. Fanning:

On August 1, 2019, a State Licensure survey was conducted at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. **Your plan of correction is acceptable.**

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 30,2019.**

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 Coordinator
Oklahoma State Department of Health

Oklahoma State Department of Health
Creating a State of Health

October 16, 2019

License Number: AL2103

Ms. Roxanne Fanning, Administrator
Grandwood Assisted Living, Lc
2001 Sunrise Bouldvard
Grove, OK 74344

RE: Survey Event T78S12

Dear Ms. Fanning:

On **September 24, 2019,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **Auguste 1, 2019*,** have now been corrected effective **August 30, 2019.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL2103	A. BUILDING: _____ B. WING _____	R 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDWOOD ASSISTED LIVING, LC	2001 SUNRISE BOULDVARD GROVE, OK 74344

(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 conducted on 09/23/19 and 09/24/19. Current census was 79. All deficiencies were cleared.	{C 000}		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL2103	GRANDWOOD ASSISTED LIVING, LC

Type of Survey (select all that apply)

2	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
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)
1. 35195	09/23/2019	09/24/2019	0.50	0.00	2.50	0.00	4.50	1.75
2.								
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**

OCT 17 2019