OKLAHOMA
State Department
of Health

Delivery via email to: roxanne@mlcconsult.com

June 21, 2023

License Number: AL2103

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

RE: Survey Event ID: TEBA11

Dear Ms. Fanning:

On **June 1, 2023**, 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 June 1, 2023.

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

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

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

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

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

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 _____	06/01/2023

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
D 000	INITIAL COMMENTS A relicensure survey was conducted from 05/30/23 through 06/01/23.	D 000		
C 000	INITIAL COMMENTS A relicensure survey was conducted from 05/30/23 through 06/01/23. Listed below are abbreviations that will be used throughout the document BP - blood pressure CMA - certified medication aide DM- dietary manager DON- director of nursing MAR - medication administration record MAT- medication administration technician mg - milligram ml - milliliter TAR- treatment administration record	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the ice machine was clean. The "Assisted Living Resident Condition and Care Overview" report, dated 05/30/23, documented 82 residents resided in the facility.	C 391		

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C 391	Continued From page 1 Findings: An "Ice Machine Cleaning" procedure, dated, 07/27/22, documented to inspect the chamber daily for build-up of mold or other contaminants and clean accordingly. Monthly, clean the compartment with catering neutral cleanser with single use cloth, including the ice drop flap. Rinse the compartment thoroughly with water and wipe dry with single use cloth. On 5/30/23 at 11:30 a.m., a tour of the kitchen was conducted. An accumulation of brown residue inside the ice machine chamber ice drop flap was observed. On 05/30/23 at 11:33 a.m., the DM was asked when the ice machine was last cleaned. They stated "I don't know, but I will get it done by the end of today." The DM stated "that looks pretty bad."	C 391		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center	C 522		

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C 522	Continued From page 2 failed to ensure comprehensive assessments were completed for one (#6) of ten sampled residents. The "Assisted Living Resident Condition and Care Overview" report, dated 05/30/23, documented 82 residents resided in the facility. 1. Resident #6 was admitted on 07/03/2013 with diagnoses of multiple sclerosis, hypertension, diabetes mellitus, and chronic obstructive pulmonary disease. There was no documentation a comprehensive assessment was completed in 2021. On 05/31/23 at 2:30 p.m., the corporate nurse reported she could not find the 2021 assessment.	C 522		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated,	C1505		

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C1505	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure physician orders were followed for: a. monitoring blood pressure for one (#8) of ten sampled residents reviewed for medications, and b. obtaining monthly weights for three (#4, 6, and #9) of ten sampled residents reviewed for monthly weights, and c. ensuring ordered medications were available for three (#2, 8, and #10) of ten sampled residents reviewed for medication availability. The "Assisted Living Resident Condition and Care Overview" report, dated 05/30/23, documented 82 residents resided in the facility.	C1505		

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C1505	Continued From page 4 Findings: A "Medication Supply" policy, dated 07/27/22, documented a minimum of seven days' supply will be maintained in building at all times. The facility will communicate with physician regarding any medication unavailable to resident due to insurance issues or other outside factors and obtain direction from physician as to how to proceed. Any medication unavailable for purchase will be discontinued by physician order. When a 7-day supply of medication is remaining, it should be reordered from the resident's pharmacy of choice or emergency pharmacy. New orders should be transmitted to the pharmacy via phone or fax by the nursing staff immediately upon receipt from the prescribing physician. New orders include any change in direction, strength, or pharmacy of choice. If pharmacy is unable to provide immediate delivery a secondary pharmacy must be contacted. If medication is not filled immediately, the DON/Director must be notified in order to rectify the situation. 1. Resident #8 had diagnoses which included hypertension, chronic kidney disease, and dementia with severe agitation. A physician order, dated 12/17/21, documented lisinopril (anti-hypertensive medication) 20 mg once daily; hold medication if BP is less than 100/60. A physician order, dated 04/18/23, documented docusate sodium (stool softener) 100 mg once daily. The March 2023, April 2023, and May 2023 MAR had no documentation of blood pressure prior to	C1505		

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C1505	Continued From page 5 administration of lisinopril. Lisinopril was administered without a documented blood pressure on 76 occasions during this time frame. A MAR, dated May 2023, documented docusate sodium was not administered on eight of eighteen opportunities. The MAR documented awaiting arrival from pharmacy as reason the medication was not administered. On 05/31/23 at 3:08 p.m., DON #1 was made aware of the March 2023, April 203, and May 2023 MAR. DON #1 stated the CMA should have documented a blood pressure prior to lisinopril administration, but there is no documentation to prove it was done. On 06/01/23 at 9:40 a.m., DON #2 was made aware of the May 2023 MAR. DON #2 stated the resident should have received docusate sodium every day. DON #2 stated not having been aware the resident had not received the ordered medication. They stated this was a violation of the facility medication policy. 2. Resident #9 had diagnoses which included hypertension, diabetes mellitus, chronic kidney disease, and anemia. A physician order, dated 10/18/21, documented to obtain weight monthly on facility scale. The medical record had no weight documented for January 2023 or March 2023. On 5/31/23 at 2:29 p.m., DON #1 stated monthly weights should be obtained per orders and documented on the TAR but there were no weights documented for January 2023 or March 2023 for resident #9.	C1505		

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C1505	Continued From page 6 3. Resident #10 had diagnoses which included seizures, hypertension, dementia, and urinary retention. A physician order, dated 01/28/23, documented alprazolam (anxiety medication) 0.25 mg three times a day for anxiety. A physician order, dated 03/19/23, documented Senna Plus (laxative medication) 8.6mg/50mg give two tablets twice daily for constipation. A physician order, dated 04/01/23, documented morphine sulfate (pain medication) 100/5ml give 0.5 ml three times a day for pain/air hunger. A physician order, dated 04/04/23, documented divalproex (anti-seizure medication) 125 mg capsule every 12 hours for seizures. A MAR, dated April 2023, documented the resident missed 24 doses of alprazolam. The MAR documented awaiting arrival from pharmacy as reason the medication was not administered. A MAR, dated April 2023, documented the resident missed 19 doses of divalproex. The MAR documented awaiting arrival from pharmacy as reason the medication was not administered. A MAR, dated April 2023, documented the resident missed five doses of morphine sulfate. The MAR documented awaiting arrival from pharmacy as reason the medication was not administered. A MAR, dated May 2023, documented the resident missed four doses of morphine sulfate. The MAR documented awaiting arrival from	C1505		

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C1505	Continued From page 7 pharmacy as reason the medication was not administered. A MAR, dated May 2023, documented the resident missed five doses of Senna Plus. The MAR documented awaiting arrival from pharmacy as reason the medication was not administered. On 06/01/23 at 9:40 a.m., DON #2 was made aware of the resident's April 2023 and May 2023 MAR. DON #2 stated the missed medications due to unavailability were inexcusable. DON #2 stated the CMA had not made them aware of the lack of medications but should have. They stated the resident should not have missed medications due to poor staff communication. 4. Resident #4 was admitted on 09/27/22 with diagnoses of anxiety, depression, cerebral infarction, and hypertension. A physician order, dated 12/17/22, documented to obtain monthly weight. A TAR, dated March 2023, contained no documentation of a monthly weight. 5. Resident #6 was admitted on 07/03/2013 with diagnoses of multiple sclerosis, hypertension, diabetes mellitus, and chronic obstructive pulmonary disease. A physician order, dated 01/18/19, documented to obtain monthly weight. A TAR, dated April 2023, contained no documentation of a monthly weight.	C1505		

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C1505	Continued From page 8 On 05/31/23 at 3:13 p.m., DON #1 stated the monthly weights should have been obtained and documented. 6. Resident #2 was admitted on 03/04/22 with diagnoses of chronic obstructive pulmonary disease, hypertension, and arteriosclerotic heart disease. A physician order, dated 03/29/23, documented to administer budesonide/form 160-4.5 inhaler two puffs twice a day. A physician order, dated 05/06/23, documented to administer budesonide/form 160-4.5 inhaler two puffs twice daily for 30 days. A MAR, dated May 2023, documented the budesonide/form 160-4.5 inhaler was not administered 40 out of 62 scheduled times. The MAR documented awaiting arrival from pharmacy as reason the medication was not administered. On 06/01/23 at 8:12 a.m., MAT #1 was asked what the procedure was for reordering medications. They stated they re-order medications seven days before the medication runs out. On 06/01/23 at 8:20 a.m., MAT #1 was asked how long resident #2 went without their budesonide/form 160-4.5 inhaler. They stated at least 2 weeks. MAT #1 was asked if resident #2 was out of budesonide from 5/12/23-5/31/23. They stated "yes, he was." On 06/01/23 at 10:01 DON #1 was asked if resident #2 went without his budesonide/form 160-4.5 inhaler for 19 days, from 05/12/23 through 05/31/22. DON #1 stated the resident	C1505		

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C1505	Continued From page 9 had missed doses on those days.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: roxanne@mlcconsult.com

August 9, 2023

License Number: AL2103

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

RE: Survey Event TEBA11

Dear Ms. Fanning:

On **June 1, 2023**, 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 have been corrected and you were in substantial compliance by **July 15, 2023**.

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

Respectfully,

Tempal Killman

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 6/27/2023
	Facility Name: Grandwood Assisted Living
	License Number: AL2103
	Survey Event ID: TEBA11
	Date Survey Completed: 6/1/2023

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the ice machine was clean.

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?	Immediate cleaning of ice machine conducted. Staff inservieced on policy and procedure of cleaning the ice machine.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents were monitored to ensure no illness that could be related to unclean ice machine. NO RESIDENTS FOUND TO BE IN HARM at time of survery or after d/t deficient practice.
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?	Ice machine to be cleaned monthly and documentation kept to be reviewed as requested. Ice machine cleanliess to be checked quarterly with audit. Admin/ED/Dietary Manager to perform random weekly checks to ensure cleanliness is being maintained.
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.	Scheduled and random checks to be completed. Admin to review audits/weekly checks/cleaning documentation routinely to ensure that cleanliness of the ice machine and that protocols put into place are effective. QA to review audits, check sheets and cleaning documentation Quarterly Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 6/30/23

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/27/2023** **Facility Name:** Grandwood Assisted Living **License Number:** AL2103 **Survey Event ID:** TEBA11 **Date Survey Completed: 6/1/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: This REQUIRMENT is not met as evidended by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed for one (#6) of ten sampled residents

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?	No issues/concerns related to the care of the resident d/t assessment not being present in the building. We are unable to locate 2021 assessment
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Audit of assessments has been completed to identify previous assessments not completed.
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?	Corp RN to monitor assessments as completed by DON's and LPN we are now electronically scanning assessments to a secure server system to avoid future issues
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: Random Charts will be audited monthly (5) to ensure all assessments are present and completed Chart audit results will be brought to the QA committee and reviewed and followed up on
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Ryanne Jane	**Date** Enter a date of signature.	6/30/23

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 6/27/2023
	Facility Name: Grandwood Assisted Living
	License Number: AL2103
	Survey Event ID: TEBA11
	Date Survey Completed: 6/30/2023

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: This REQUIRMENT is not met as evidence by: Based on observation, record review, and interview, the facility failed to ensure that physician orders were followed: a. monitoring blood pressure for one (#8) of ten sampleted residents reviewed for medications, and b. obtaining monthly weights for three (#4,6, and 9) of ten sampled residents reviewd for monthly weights, and c. ensuring ordered medications were available for three (#2,8,10) of ten sampleted residents reviewed for medication availability.

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?	a. Resident #8 effective 6/1/23 a BP was put in place on MAR b. All weights were entered as late entry and were documented on 5/2023 TAR Immediate audit completed of MAR and TAR to review orders, notices given to nurses for residents that were missing vital sign orders, weights, and medication. Audit given to DON's to review and fix Medication was obtained and brought into the building within 24 hours of survey ending.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An immediate audit completed of VS and weights. Routine audits to be completed by admin 2x/month to ensure Immediate identification of residents who are without medication/corresponding vitals/weights will immediately be brought to the DON's attention and followed up until rectified.
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?	Daily reports printed by CMAs (med exception report) to be reviewed and meds to be followed up on that are not in the building. The report will be turned into the DONs/Admin for review. Issues that persists pass 48 hours will be communicated to the Corp nurse to ensure that she is aware. Meds that will not be in the building as ordered, will require a TO from the PCP for medication to be put on hold until med is received. Routine audits to be completed by admin of MARs and

	TARs and given to DON and Corp RN All new residents will have new orders reviewed by DONs to ensure that medication that requires vital signs has corresponding vitals, weights are entered as ordered in the quick MAR-Corporate RN To follow up with all new admit orders and review in quick MAR to ensure that corresponding VS are attached to correct order, Weight order is present. All residents who use our primary pharmacy will be on a cycle fill and have automatic refills starting 9/1/2023
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: Effectiveness will be evaluated with the audits, random checks, monitoring daily reports QA committee to review audit summaries, randomly review 5 MARs/TARs during QA meeting, Corp RN to review all audits upon completion and attend QA to discuss any ongoing issues or concerns Records will be monitored routinely by Admin and Corp RN and quarterly during QA
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 06/27/23

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

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

Items Below Are For OSDH Use Only

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

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

OKLAHOMA
State Department
of Health

Delivery via email to: roxanne@mlcconsult.com

September 12, 2023

License Number: AL2103

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

RE: Survey Event TEBA12

Dear Ms. Fanning:

On **September 11, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 1, 2023,** have now been corrected effective **July 15, 2023.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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 09/11/2023

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
{D 000}	INITIAL COMMENTS	{D 000}		
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 09/11/23. The facility was in substantial compliance.	{C 000}		

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