Oklahoma State Department of Health
Creating a State of Health

December 19, 2019

License Number: AL2404

Ms. Betty Brinley, Administrator
The Arbors Assisted Living Center
4502 West Randolph
Enid, OK 73703

Survey Event ID: FYL411

Dear Ms. Brinley:

On **September 10, 2019**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;

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(5) Include dates when corrective action will be completed for each violation; and
(6) Be signed by the administrator.

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

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

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

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

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: The Arbors
Address: 4502 West Randolph
City, State, Zip: Enid, OK 73703
Provider #: AL2404
Complaint #: OK00054324
Investigation Date(s): 09/10/19

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure staff followed proper infection control procedures with glucose monitoring equipment.	US
2. The center failed to provide an abuse free environment.	US
3. The center failed to provide adequate medical care.	S

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

An unannounced on-site investigation was initiated on Tuesday, September 10, 2019 at 1:15 p.m.

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

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

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

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

An investigation specific to resident's use of glucose monitoring equipment was conducted.

Only one resident was identified by staff who used a glucometer to perform finger stick blood sugar testing. The staff stated it had been months since there had been more than one resident using a glucometer. The resident was alert and fully oriented. She stated she did her own finger stick blood sugar testing and denied ever being told by staff at the center to use someone else's glucose monitoring equipment.

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

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

Four staff and three alert and oriented residents were interviewed and all denied ever witnessing or being the target of verbal abuse by the staff at the center.

Two staff, who were responsible for administering medications, stated they had been told to give medications for reasons other than why they were ordered on only one occasion and that was for a resident who had an episode of high blood pressure. The resident did not have a medication ordered for high blood pressure, so the nurse instructed the staff to give a pain pill and a pill for anxiety until the doctor could be contacted to order blood pressure medication.

The medication administration records for three residents who had been prescribed antianxiety medications documented the medication had been administered for anxiety and no other another reason. Two alert and oriented residents stated they did not have any concerns about their medications and received their as needed medications as they requested.

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

Allegation #3: Deficient practice was substantiated related to allegation #3. See the Statement of Deficiencies, Form 2567, and Tag C1505 for details.

The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.

Lisa McAlister, Survey Manager for

Teena Cornett, RN, CHFS IV

Date report completed: 09/12/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2404	A. BUILDING: _____ B. WING _____	C 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARBORS ASSISTED LIVING CENTER	4502 WEST RANDOLPH ENID, OK 73703

(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 An abbreviated survey was conducted to investigate complaint #OK00054324. The following deficient practice was cited. Resident census was 10.	C 000		
C1505 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the center failed to follow physician's orders regarding blood oxygen saturations for 1 (#1) of 1 sampled resident who had physician	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2404	A. BUILDING: _____ B. WING _____	C 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARBORS ASSISTED LIVING CENTER	4502 WEST RANDOLPH ENID, OK 73703

(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
C1505	Continued From page 1 ordered instructions for maintaining parameters for blood oxygen saturation. Resident #1 expired, in the center, at 3:45a.m. on 09/06/19. The death certificate documented the immediate cause of death as "Respiratory Failure." This failed practice resulted in isolated actual harm. Findings: Resident #1 was admitted to the center 09/03/19 with diagnoses to include COPD (chronic obstructive pulmonary disease) and type two diabetes mellitus. The resident had Physician's Admission Orders and a Physician Order, from a third party home health agency providing services, dated 09/05/19, with the following order: "Call home health agency .....for O2 sats [Oxygen saturations] below 88%. May titrate O2 [oxygen] up to 4L (liters) per NC [nasal cannula] to maintain O2 sats at 88% or above." The Medication Administration Record (MAR) documented "O2 2l NC continuous. Check Sats while on room air." The MAR identified the oxygen saturation levels were to be checked three times a day at 8a.m., 3p.m. and 8p.m. The physician also ordered a daily weight and the MAR documented resident #1 was to have a daily weight for CHF and for staff to call the "attending provider if pt [patient] has weight gain of 2-3 pounds in one day or 4-5 pounds in 5 days." The MAR documented resident #1weighed 245 pounds on 09/04/19 but there was no weight documented on 09/05/19. At the time resident #1 was admitted, the center had licensed nurse staffing during the day by an [LPN]/LVN (credentialed as a licensed vocational nurse with a multistate license), but no licensed nurse staffing at night. The staff at night	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2404	A. BUILDING: _____ B. WING _____	C 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARBORS ASSISTED LIVING CENTER	4502 WEST RANDOLPH ENID, OK 73703

(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
C1505	Continued From page 2 consisted of long term care aides (LTCA), certified medication aides (LTCA/CMA), and long term care aides with medication administration technician training (LTCA/MAT). The resident's blood oxygen saturation was documented on the September MAR as follows: 09/03/19 at 8:00 a.m., 84% 09/03/19 at 3:00 p.m., 95% 09/04/19 at 8:00 a.m., 89% 09/04/19 at 3:00 p.m., 95% 09/04/19 at 8:00 p.m., 89% 09/05/10 at 8:00 a.m., no oxygen saturation documented 09/05/19 at 3:00 p.m., 83% 09/05/19 at 8:00 p.m., 77% [As noted, a blood oxygen saturation level was not recorded for 09/05/19 at 8:00 a.m.] No documentation was provided that a licensed nurse or the home health agency was notified when the resident's blood oxygen saturation level was 83% and 77% on 09/05/19. There was no documentation the resident's oxygen was increased up to 4 liters per minute as the physician's order directed. There was no documentation the resident's respiratory status was assessed by a licensed nurse on 09/05/19. On 09/10/19 at 3:30 p.m., the administrator stated resident #1 was admitted with severe COPD and was on oxygen for low blood oxygen saturations. On the night of 09/06/19, both LTCAs on duty helped the resident to the bathroom at approximately 3:30-3:40a.m.. On the way back to bed, the resident suddenly collapsed and expired. There was no documentation the resident's blood oxygen saturation levels were obtained as	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2404	A. BUILDING: _____ B. WING _____	C 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARBORS ASSISTED LIVING CENTER	4502 WEST RANDOLPH ENID, OK 73703

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C1505	Continued From page 3 ordered, that the resident's oxygen was adjusted, or that the LPN was contacted or informed of the low saturation levels until after the resident expired. There was no documentation of an assessment of the resident when the resident's oxygen saturation was less than 88%. At 4:00 p.m., LTCA/MAT #1 stated resident #1's blood oxygen saturation levels were always low, so LPN #1 gave all the unlicensed care providers an inservice to show them how to manage resident #1's blood oxygen levels by obtaining the resident's blood oxygen saturation levels and adjusting the oxygen flow. The nurse provided this training because licensed staff was not available 24 hours per day to assess the resident's blood oxygen saturations and adjust the oxygen flow to maintain blood oxygen saturations above 88%. Adjusting a resident's oxygen flow rate is beyond the scope of responsibility for any unlicensed direct care staff.	C1505		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL2404	THE ARBORS ASSISTED LIVING CENTER

Type of Survey (select all that apply)

[3] [ ] [ ] [ ] [ ]

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 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. 36967	09/10/2019	09/10/2019	0.50	0.00	4.25	0.75	0.00	2.50
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

Oklahoma State Department of Health
Creating a State of Health

December 27, 2019

License Number: AL2404

Ms. Betty Brinley, Administrator
The Arbors Assisted Living Center
4502 West Randolph
Enid, OK 73703

Survey Event ID: FYL411

Dear Ms. Brinley:

On September 10, 2019, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- Please provide clarification of Element #3 of the Plan of Correction: What staff will be in serviced and trained to monitor blood oxygen levels.

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/

Enclosure

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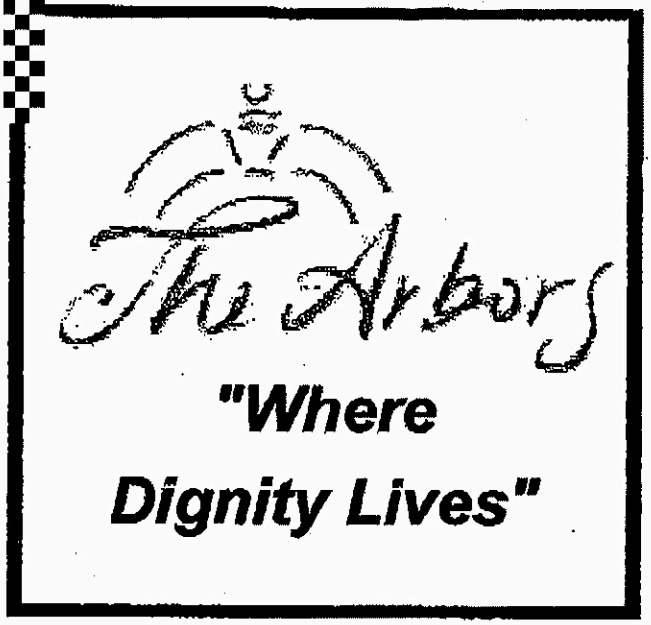

Assisted Living Cente

4502 West Randolpl
Enid OK 7370
(580)242-450
FAX (580)242-273
bbrinley@suddenlink.ne

- ✔ **Exercise Program**
- ✔ **24 Hour Staffing**
- ✔ **3 Tasty Meals & Snacks Daily**
- ✔ **Personal Care Services**
- ✔ **Heart-Healthy Diets**
- ✔ **Respite Care**
- ✔ **Arranged Transportation**
- ✔ **Nursing Supervision**
- ✔ **Employment Opportunities**
- ✔ **Volunteer Opportunities**
- ✔ **Resident Service Projects**
- ✔ **A "Haven Before Heaven"**

FAX #: 405 271-2206
Date: 12-20-19
To: OSDH - Protective Health
From: Betty Brinley
Message: Survey Event 9-10-19

DEC 23 2019

STATEMENT OF CONFIDENTIALITY: The documen transmitted by this facsimile contains information from The Arbors Assisted Living Center and may be confidential and privileged information. This information is intended for the use the addressee named on this transmittal sheet. If you are no the addressee, any disclosure, photocopying, distribution o use of its contents is prohibited. If you have received this fa in error, please call immediately so that we may arrange t retrieve the original document. If you have any question regarding this fax or if there are problems with th transmission, call 242-4500.

# of Pages (Including this sheet) 2

Received Time Dec. 23. 2019 11:03AM No. 3154

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/20/2019
Facility Name: The Arbors Assisted Living Center
License Number: AL 2404
Survey Event ID: FYL411 DEC 23 2019
Date Survey Completed: 9/10/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Failed to follow physician's orders regarding blood oxygen saturations

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The LPN in charge of healthcare management was slow to recognize gravity of new resident's respiratory condition.

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?	The nurse responsible at this timeframe no longer is employed.
OSDH Response: Element accepted Yes ☐ No ☒	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The current LPN delivers professional medical supervision for all residents in a timely manner.
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?	Inservice training covering monitoring blood oxygen levels & to report any variance immediately to nurse on duty.
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.	Schedule quarterly inservice training/reminders Monitor training & results by evaluating residents with respiratory issues; include documentation in Q.A. Mtgs. Q.A. Log to include current resident documentation of progress and/or challenges Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☒	
5. On what date will corrective action be completed?	Click here to enter a date when corrective action will be completed.
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Brian Long **Date 12/20/2019**
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.

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.

10012013

Oklahoma State Department of Health
Creating a State of Health

January 15, 2020

License Number: AL2404

Ms. Betty Brinley, Administrator
The Arbors Assisted Living Center
4502 West Randolph
Enid, OK 73703

Survey Event ID: FYL411

Dear Ms. Brinley:

On September 10, 2019, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 20, 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,

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

SD/jt

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
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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: 12/20/2019
Facility Name: The Arbors Assisted Living Center
License Number: AL 2404
Survey Event ID: FYL411
Date Survey Completed: 9/10/2019

RECEIVED
JAN 10 2020
Long Term Care

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Failed to follow physician's orders regarding blood oxygen saturations

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The LPN in charge of healthcare management was slow to recognize gravity of new resident's respiratory condition.

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?	The nurse responsible at this timeframe no longer is employed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The current LPN delivers professional medical supervision for all residents in a timely manner.
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?	Inservice training covering monitoring blood oxygen levels & to report any variance immediately to nurse on duty (this includes all C.N.A.'s, CMA's, & MAT's)
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.	Schedule quarterly inservice training/reminders Monitor training & results by evaluating residents with respiratory issues; include documentation in Q.A. Mtgs. Q.A. Log to include current resident documentation of progress and/or challenges Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/20/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Betty Brenly **Date 1/6/2020**
OAC 310:663-25-4(F)

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health
Creating a State of Health

February 12, 2020

License Number: AL2404

Ms. Inez McPherson, Administrator
The Arbors Assisted Living Center
4502 West Randolph
Enid, OK 73703

Survey Event ID: FYL412

Dear Ms. McPherson:

A revisit conducted **February 6, 2020**, revealed that your facility corrected deficiencies effective **January 18, 2020**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me at (405) 271-6868.

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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure:

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA *(President)*
Edward A Legako, MD *(Vice-President)*
Becky Payton *(Secretary)*
Jenny Alexopulos, DO
Terry R Gerard II, DO
Charles W Grim, DDS, MHSA
R Murali Krishna, MD
Ronald D Osterhout
Charles Skillings

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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
	AL2404	A. BUILDING _____ B. WING _____	R 02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARBORS ASSISTED LIVING CENTER	4502 WEST RANDOLPH ENID, OK 73703

(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 02/06/2020. Resident census was 14. The deficient practice was 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
AL2404	THE ARBORS ASSISTED LIVING CENTER

Type of Survey (select all that apply)

3	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 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. 36967	02/06/2020	02/06/2020	0.25	0.00	0.75	0.00	0.25	0.25
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**