
Delivery via email to: thearborslife@gmail.com

July 16, 2024

License Number: AL2404

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

RE: Survey Event ID: IYKS11

Dear Ms. McPherson:

On **May 16, 2024**, 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 **May 16, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care**. 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face-to-face, or virtual 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.

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER THE ARBORS ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 relicensure survey was conducted from 05/13/24 through 05/16/24. Facility Census: 14 The following abbreviations were used to write the report: ADLs - Activities of Daily Living ACMA - Advanced Certified Medication Assistant AL - Assisted Living CMA - Certified Medication Assistant CNA - Certified Nurse Aide HWD - Health Wellness Director LPN - Licensed Practical Nurse mcg - microgram Mg or mg - milligrams OSDH - Oklahoma State Department of Health RN - Registered nurse TIA - Transient Ischemic Attack	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: a. the designated hand washing sink was utilized at all times for handwashing by the dietary staff, and b. raw foods were washed prior to being served to residents.	C 391		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 391	Continued From page 1 Census: 14 Findings: On 05/14/24 at 12:10 p.m., during the serving of the noon meal, Cook #2 was served several plates, don serving gloves, remove the serving gloves, wash their hands in the three-compartment sink, don serving gloves and prepare a tuna salad sandwich for a resident. On 05/14/24 at 12:20 p.m., Cook #2 obtained a market cellophane package from the refrigerator that contained a tomato with long stems attached. Cook #2, removed the tomato from the packaging. Without washing the tomato, Cook #2 removed the stem from the single tomato, placed the tomato on a cutting board, sliced the tomato, placed the tomato slices on a small plate and nursing staff served the plate to residents. On 05/14/24 at 12:27 pm., Cook #2 was asked what the policy was for a designated hand washing sink. They stated the single sink near the door was the designated handwashing sink. They stated they had used the three-compartment sink for handwashing, "Out of habit." Cook #2 was asked if the tomato they had sliced, was in the market packaging. Cook #2 stated it was. They were asked if the tomato had been washed prior to being sliced and served to residents. They stated, they usually do but this tomato probably had not been washed.	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	C 522		

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C 522	Continued From page 2 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 facility failed to complete a significant change of assessment at the initiation of a plan of accommodation of needs for two (#2, and #6) of six sampled residents. Census: 14 The facility's undated "Resident Roster", provided on 05/13/24, documented nine residents received hospice or home health services. Findings: An "Assessment Timeframe's" policy dated 05/03/12, read in parts, "...According to O.S.D.H...[facility name] completes assessments as follows...Comprehensive Assessment..within five (5) of significant change..." 1. Resident #2 had diagnoses to include dementia, anxiety, repeated falls and pain. A "Hospice Certification of Plan of Care", dated 11/19/23, documented Resident #2 was to begin hospice services on 12/19/23 for the certification period of 12/19/23 to 03/17/24.	C 522		

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C 522	Continued From page 3 A "Change of Condition" assessment, dated 12/15/23, documented Resident #2 was alert, confused, had advanced stage dementia, and required one staff assistance for bathing, eating, dressing, transfers, toileting, and ambulation, and receiving hospice services. A "Plan of Accommodation" for Resident #2, dated 04/10/24, read in parts, "...declining physical health...on hospice services...the following plan provides..necessary assistance in order to remain living at...Center..." The form was dated as signed by the responsible party on 04/10/24. The records did not contain an assessment after the Change of Condition Assessment, dated 12/15/23, to identify the status of Resident #2, when the "Plan of Accommodation" was put into place four months later on 04/10/24. 2. Resident #6 had diagnoses to include severe dementia with agitation, Alzheimer's disease, pulmonary edema and pain. An "Annual Assessment", dated 07/11/23, documented Resident #6 was alert, had increased confusion, requires 24 hour care, one staff assistance for transfers ambulation, bathing, eating, dressing, toileting, ambulation, and received hospice services for bathing. The Hospice "Plan of Care Update Report", dated 10/12/23, documented the benefit period of 09/11/23 through 11/09/23. The record did not contain a change of status assessment at the time Resident #6 was admitted to hospice services.	C 522		

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C 522	Continued From page 4 A "Plan of Accommodation" for Resident #6, dated 04/09/24, read in parts, "...declining physical health...on hospice services...the following plan provides...necessary assistance in order to remain living here at...Center..." The records did not contain an assessment after the Annual assessment dated 07/11/23, to identify the status of Resident #6, when the Plan of Accommodation was put into place nine months later, on 04/09/24. On 05/15/24 at 3:25 p.m., the administrator and HWD were asked if a Change of Condition assessment was completed at the time the plan of accommodations were signed for Residents #2 and #6. The HWD stated the Change of Conditions had already been completed and a new assessment was not completed at the time the Plan of Accommodations were signed.	C 522		
C 532 SS=E	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history.	C 532		

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C 532	Continued From page 5 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure resident assessments accurately reflected the resident status: a. that required two staff assistance for ADLs for two (#2, and #6) of three sampled residents reviewed for level of care needs, b. with a modified pureed diet provided for one (#2) of two sampled residents reviewed for modified diets, and c. for hospice services provided for one (#4,) of four sampled residents reviewed for hospice services. Census: 14 Findings: 1. Resident #2 had diagnoses to include dementia, anxiety, and repeated falls. A "Change of Condition" assessment, dated 12/15/23, documented Resident #2 had advanced dementia, required one staff assistance to bath, eat, dress, transfer, toilet and ambulate, was to be provided a regular diet, and was on hospice services. Physician's Order", last updated on 01/26/24, did	C 532		

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C 532	Continued From page 6 not contain a diet order and did not address Resident #2 was to be provided a pureed textured diet for the noon meal On 05/13/24, at 12:10 p.m., Resident #2 was provided a pureed textured diet for the noon meal. The records did not include additional assessments or documentation of the resident's need for two staff assistance, or that a pureed diet was required. On 05/15/24 at 3:25 p.m., the administrator and HWD were asked why Resident #2 had been provided a pureed diet. The HWD stated it was the resident preference as they would spit out any food that had texture. They stated since it was a preference, it did not need to be on the assessment. 2. Resident #6 had diagnoses to include severe dementia with agitation, Alzheimer's disease, and pain. An "Annual Assessment", dated 07/11/23, documented Resident #6 had increased confusion, required 24 hour care with sitters, and one staff assistance with transfer, ambulation, bathing, eating, dressing, and received hospice services. On 05/14/24 at 8:00 a.m., two staff were observed to assist Resident #6 in transfer from their wheelchair to a stuffed chair in front of the television in the common area. On 05/15/24 a 2:26 p.m., CNA #1 was asked if any current resident required more than a one staff assistance with ADLs. CNA #1 stated three	C 532		

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C 532	Continued From page 7 residents required two staff assistance to ensure safety for transfers, toileting, dressing and bathing. They identified Residents #2 and #6, to have consistent needs of two staff assistance, and stated the facility staffed well to meet their needs. On 05/15/24 at 3:50 p.m., the Administrator and HWD were asked how many of the current residents required two staff assistance for any of the ADLs. They both stated, "None." They were asked why did staff providing care report three residents required two staff on a consistent basis to meet their ADL needs. The HWD stated, that is not true. No further information was provided regarding the accuracy of assessments for Residents #2 and #6. 3. Resident #4 had diagnoses to include dementia, and mood disorder. A "Fourteen Day Assessment", dated 11/19/23, documented Resident #4 was alert, confused, required one person assist for bathing, eating, dressing, transfers, toileting, ambulation and had requested Home Health services for skilled nursing and physical therapy. An "Oklahoma Recommended AL Resident Assessment", dated 12/19/23, documented Resident #4 had requested to be provided Home Health Services and Physical Therapy. The clinical record did not contain additional assessments after 12/19/23. A "Hospice Certification and Plan of Care", dated 01/09/24, documented Resident #4 was certified	C 532		

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C 532	Continued From page 8 for hospice services from 01/09/24 to 4/7/24. The record did not contain information that Resident #4 had been provided Home Health Services or Physical Therapy as requested on admission. The assessment did not document Resident #4 had been referred to Hospice or had received Hospice services. On 05/15/24 at 4:10 p.m., the HWD was asked if Resident #4 had been provided the requested Home Health Services, or Physical Therapy as requested on the 14 day admission assessment. The HWD stated Resident #4 did not qualify for Home Health and was placed on Hospice Services instead. No further information was provided regarding the inaccurate assessment or update of status.	C 532		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure Resident Assessments included: a. a signature by an RN or physician, or b. were signed by an RN or physician at the time the assessments were to be completed for four (#2, 3, 4, and #6) of six residents reviewed for resident assessments.	C 542		

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C 542	Continued From page 9 Census: 14 1. A "Change of Condition" assessment, dated 05/16/23, for Resident #2, documented the RN had not reviewed and signed the assessment until 07/11/23 when the assessment was locked as completed. The assessment had not been signed by a physician. A "Change of Condition" assessment, dated 12/15/23 was signed by the LPN/HWD on 1/12/23, and locked as completed on 01/02/24. The assessment had not been signed by an RN or physician. 2. An "Admission Assessment", dated 04/24/23, for Resident #3, contained no signatures of the person completing the assessment or a review/coordination of care signature by an RN or physician. The assessment was locked as completed on 03/07/24, eleven months after the assessment was due. An "Admission Assessment", dated 04/24/23, was signed by the LPN/HWD on 04/24/34. The assessment was not signed by an RN or locked as completed until 07/11/23. 3. An "Admission Assessment", dated 11/29/23, for Resident #4, contained no signatures. The assessment was locked as completed on 03/26/24, four months after the assessment was due. A "Fourteen Day" assessment, dated 12/18/23 was signed by the LPN/HWD on 12/18/23. The assessment had not been signed by an RN or a physician.	C 542		

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C 542	Continued From page 10 An "Oklahoma Recommended AL Resident Assessment/14 day Assessment", dated 12/18/23 was signed by the LPN/HWD on 12/18/23. The assessment had not been signed by an RN or a physician. 4. An "Annual Assessment", dated 07/11/23, for Resident #6 was signed by the LPN/HWD on 07/11/23. The RN signed the assessment on 09/28/23, and the assessment was locked as completed on 09/28/23, two months after the assessment was due. On 05/15/23 at 3:25 p.m., the Administrator and HWD were asked how often the RN was in the building to sign the assessments. The HWD stated, "When we call her." They were asked if an RN or physician did not sign the resident assessments, how were the assessments considered complete. The HWD stated, "They are complete because I did the assessments." They were asked if the RN or a physician signed the residents at the time the assessments were completed by the LPN/HWD, when the assessments were due. No comment was made.	C 542		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract.	C1304		

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C1304	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure food portion sizes were served per the approved menu and in accordance with resident service contracts for three (#2, #3, and #4) of three residents reviewed for meal services. Census: 14 1. A "Resident Admission Agreement", dated 08/29/22, for Resident #2, documented in parts, "...Three nutritional, well-balanced meals per day are included..." 2. A "Resident Admission Agreement", dated 04/12/23, for Resident #3, documented in parts, "...Three nutritional, well-balanced meals per day are included..." 3. A "Resident Admission Agreement", dated 12/04/23, for Resident #4, documented in parts, "...Three nutritional, well-balanced meals per day are included..." An undated "Spring/Summer 2024" menu, documented the following was to be served: -one piece of honey mustard chicken; - a #8 (one half cup) of rice; - a #8 (one half cup) of mixed vegetables; - one baked roll; and	C1304		

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NAME OF PROVIDER OR SUPPLIER THE ARBORS ASSISTED LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1304	Continued From page 12 - a #8 (one half cup) of mandarin orange salad. On 05/14/24 at 11:52 a.m., Cook #2 was observed to organize a serve line to include undetermined sized serving utensils in the vegetables, and mandarin orange salad. Cook #2 was observed to use a household serving spoon and provide one and one-half scoop of vegetables, and a large household serving spoon for the mandarin orange salad. Cook #2 was asked how they determined what size scoop/serving of the prepared foods were to be served to each resident. After a review of the menu with the surveyor, Cook #2 stated they did not know what was meant by the #8 next to the foods to be served. Cook #2 stated the serving sizes provided were smaller than one half cup servings.	C1304		
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 13 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 observations, record reviews, and interviews, the facility failed to ensure: a. hand and equipment sanitation were utilized for wound and skin treatments for two (#3 and #5) of two sampled residents with wound or skin treatments, b. medications were administered per physician orders for three (#3, 4, and #7) of four sampled residents reviewed for physician orders or observed during medication administration, and c. assess and monitor two (#3 and #4) of three sampled residents reviewed for falls, while taking physician ordered anticoagulant medications. Census: 14 1. A "Physician Order", dated 05/06/24, documented Resident #5 was to have Silvasorb	C1505		

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C1505	Continued From page 14 ointment to the coccyx, and covered with a foam dressing, twice weekly on Monday and Thursday, and as needed for a decubitus on the coccyx. On 05/13/24 at 1:30 p.m., the HWD obtained the needed items for wound treatment, entered the room, washed their hands, donned gloves and cleaned a coccyx wound with gauze and wound cleanser. With the same gloved hand, the HWD put the prescribed ointment on the gloved fingers, and applied the ointment to the open wound on the coccyx. the HWD was asked what the facility policy was regarding going from dirty to clean during wound care. After review of the facility policy, the HWD stated, I should have washed my hands and changed gloves and did not. 2. "Physician Orders", for Resident #3 included: a. On 04/11/23, Sinemet extended release 50/200 mg (Carbidopa/Levodopa), two tablets were to be administered three times a day for Parkinson's Disease, b. On 05/01/23, Rivaroxaban [an anticoagulant medication] 20 mg was to be administered daily for atrial fibrillation, c. On 05/11/23, Diclofenac gel was to be applied to bilateral knees every six hours as needed, and the use of a dosing card was to ensure the appropriate 4 gram dose was administered, and d. On 05/10/24, lidocaine patch 5%, was to be applied to the hip for 9 days. An undated "Incident/Accident Report", documented Resident #3 had fallen in the dining area, stated the resident reported that his pants were falling down, so they reached to pull up their pants. The form included vital signs and the resident had three areas of abrasions. The form was signed by an ACMA.	C1505		

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C1505	Continued From page 15 The clinical record did not contain documentation Resident #3 had been assessed or monitored by a licensed nurse after a fall. On 05/15/24 at 8:10 a.m., CMA #4 was observed to prepare oral medications, a patch and gel for Resident #3. A medication card labeled Carbidopa [Sinemet], documented the dosage to be 48.7/195 mg, administer two tablets three times a day. CMA #4 obtained four gloves then entered into Resident #3's room. While placing the four gloves on a table next to the resident's recliner, one glove fell to the floor. CMA #1 picked up the soiled glove and placed in back on the table with the other three gloves. CMA #4, administered the oral medication, washed their hands, donned two gloves, and applied the lidocaine patch to Resident #3's left hip. CMA #4, changed gloves to wear the remaining two gloves placed on the table, measured the lidocaine gel, placed on the gloved hands and rubbed the gel into Resident's hands and wrists per the resident request. CMA #4 was asked if there was a reason the dosage for Sinemet was different than the dose administered. CMA #4 stated the computer program did not have the correct dose to choose from when entering the dose for the medication. CMA #4 was asked if the physician or the computer vendor had been notified to correct the entry or change the order. They stated, "That would be the nurse to do that." CMA #4 was asked what was the facility protocol for the use of a gloved that had been dropped on the floor. CMA #4 stated, "I should have gotten a different glove." On 05/15/24 at 4:00 p.m., the HWD was asked how Resident #3 had been assessed or monitored after a fall of a resident that has	C1505		

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C1505	Continued From page 16 physician orders for a blood thinner. They stated, Resident #3 was looked at the following day, but we don't have to document, so it is not documented. No further information was provided regarding monitoring Resident #3 after a fall. 3. "Physician Orders", dated 09/14/23, for Resident #7 documented they were to be administered the following medications: a. chewable aspirin 81 mg daily for atrial fibrillation and congestive heart failure; and b. Vitamin D-2, 50 mcg daily for a Vitamin D deficiency. On 05/14/24, at 8:35 a.m., CMA #1 prepared oral medications for Resident #7 to include a chewable 81 mg aspirin, and 2000 units of Vitamin D-3. All of the oral medications were placed in the same medication cup. Upon entering the resident room, CMA #1 informed Resident #7, their morning medications were ready, and handed the cup of medications to Resident #7. CMA #1 did not provide information the chewable aspirin was included in the medication cup with all of the other medications. CMA #1 was asked if there was a reason instruction was not provided to Resident #7 for the chewable aspirin. They stated the resident had always swallowed the medications whole, and probably should have let the nurse know. CMA #1 was asked to verify the Vitamin D order and the label of the medication card. CMA #1 stated they do not match and should have been clarified by the nurse. 4. A "Physician Order", dated 12/01/23, documented Resident #4 was to be administered Eliquis, an anticoagulant medication, 2.5 mg	C1505		

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C1505	Continued From page 17 twice a day for a history of TIAs. An "Incident/Accident Report", dated 04/22/24, documented Resident #4 had fallen while self ambulating to the bathroom. The clinical record did not contain documentation Resident #4 had been assessed or monitored after a fall. A "Physician Order", dated 04/25/24, documented Resident #4 was to be administered Tramadol 50 mg every morning and at bedtime for pain. The MAR, dated May 2024, documented Tramadol was placed on hold, and not to give on 05/01/24 thru 05/02/24, then the medication was discontinued. The clinical record did not contain a physician order to hold or discontinue the Tramadol. On 05/14/24 at 4:15 p.m., the HWD was asked if Resident #4 had been assessed and monitored by a licensed nurse after they fell on 04/22/24. They stated they had looked at the resident the following day but did not document an assessment or resident status. The HWD was asked to provide the physician order to hold and discontinue the Tramadol. They stated the resident is constantly requesting to change orders. No further information was provided.	C1505		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may	C5010		

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C5010	Continued From page 18 receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a system in place to ensure the coordination of care with third party providers for: a. residents that were receiving hospice services for four (#2, 4, 5, and #6) of four sampled	C5010		

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C5010	Continued From page 19 residents reviewed for hospice services; and b. a resident that received home health services for one (#3) of one sampled residents reviewed for home health services. Census: 14 Findings: The "Resident Roster" matrix form provided by the facility on 05/13/24 at 11:15 a.m., documented nine residents received either hospice or home health services. 1. Resident #2 had diagnoses to include dementia and anxiety. A "Change of Condition Assessment", dated 12/15/23, documented Resident #2 had advanced dementia, required one staff assistance with ADL, and was receiving hospice services. A "Hospice Certification and Plan of Care" form, dated 12/19/23, documented the certification period to be 12/19/23 to 03/17/24. The "Resident Roster" matrix form provided by the facility on 05/13/24 at 11:15 a.m., documented Resident #2 currently received hospice or home health. The clinical record did not contain an updated certification of plan of care. The clinical record did not contain documentation of communication between the facility and hospice to ensure what care Resident #2 had received from hospice. On 05/15/24, at 3:25 p.m., the HWD was asked what system was in place to ensure hospice care	C5010		

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C5010	Continued From page 20 was coordinated and monitored by the facility. They stated the facility had a sign in sheet at the front door. No additional information was provided regarding the specific personal or medical care Resident #2 had been provided by hospice staff. 2. Resident #3 had diagnoses to include Alzheimer's Disease, chest pain, chronic kidney disease, pulmonary edema, congestive heart failure, esophageal obstruction, metabolic encephalopathy and Parkinson's Disease. An "Admission Assessment", dated 04/10/23, documented Resident #3 required one staff assistance for bathing and toileting. The assessment did not indicate Resident #3 had home health or hospice services in place. An "Admission Assessment", dated 04/24/23, documented Resident #3 required one staff assistance for bathing. The assessment did not indicate Resident #3 had home health or hospice services in place. An "Annual Assessment", dated 04/03/24, documented Resident #3 required one staff assistance for bathing and toileting. The assessment did not indicate Resident #3 had home health or hospice service in place. The clinical record contained no documentation Resident #3 had received hospice or home health. The "Resident Roster" matrix form provided by the facility on 05/13/24 at 11:15 a.m., documented Resident #3 currently received hospice or home health.	C5010		

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C5010	Continued From page 21 On 05/15/24 at 3:55 p.m., the HWD was asked if Resident #3 had received hospice or home health services. They stated the resident was currently on home health services. No further information was provided to support the monitoring or coordination of care regarding home health services. 3. Resident #4 had diagnoses to include dementia and a history of TIAs. An "Admission/14 Day Assessment", dated 11/18/23, documented Resident #4 required one staff assistance for ADLs, and had requested home health for skilled nursing and therapy. The clinical record did not contain documentation Resident #4 had been referred to home health as requested. A "Patient Information Report", dated 01/08/24, documented the form was completed for re-admission to hospice and would be effective 01/09/24. A "Hospice Certification and Plan of Care", dated 01/09/24, documented the certification period of service to be 01/09/24 to 04/07/24. A "Aide Care Plan Report", dated 01/09/24, documented the service dated to be 01/09/24 to 04/07/24. The hospice certification and aide care plan had not been updated after 04/07/24. The clinical record documented Resident #4 had been visited by hospice on the following dates: 04/04/24; 04/09/24; 04/15/24; 04/23/24; 04/25/24;	C5010		

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C5010	Continued From page 22 05/02/24; and 05/07/24. The clinical record did not document the rationale that Resident #4 had been seen by hospice for seven visits after the certification date had ended. The "Resident Roster" matrix form provided by the facility on 05/13/24 at 11:15 a.m., documented Resident #4 currently received hospice or home health services. On 05/15/24 at 4:10 p.m., the HWD was asked if Resident #4 had been referred to home health as requested on the "Admission Assessment", dated 11/18/23. They stated Resident #4 did not qualify for home health but was then referred to hospice and has been receiving hospice services. The HWD was asked how the facility was monitoring and coordinating care if the certification period had ended and the facility continued to allow hospice staff to care for the resident. No information was provided. 4. Resident #5 had diagnoses to include bacterial infection and a pressure ulcer to the coccyx. A "Patient Information Report", dated 10/09/23, documented a referral for a new admission to hospice had been received and services were to begin on 10/09/23. A "Hospice Certification and Plan of Care", dated 10/09/23, documented the certification period for services was 10/09/23 to 01/06/24. A "Change of Condition Assessment", dated 10/30/23, documented Resident #5 required one staff assistance for bathing, dressing, transfers, toileting, and ambulation. The assessment	C5010		

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C5010	Continued From page 23 documented Resident #5 was on hospice services. The clinical record documented Resident #5 had been seen by hospice staff, after the certification date, as follows: a. January 2024 on days 12, 16, 18, 24, and 25; b. February 2024 on days 15, 27, 28, and 29; c. March 2024 on days 14, 19, 21, 25, and 28; d. April 2024 on days 4, 9, 15, 23, and 25; and e. May 2024 on days 2, and 7. The clinical record did not document the rationale that Resident #5 had been seen by hospice for 21 visits after the certification date had ended. The "Resident Roster" matrix form provided by the facility on 05/13/24 at 11:15 a.m., documented Resident #5 currently received hospice or home health. On 05/15/24 at 4:25 p.m., the HWD was asked when was Resident #5 placed on hospice services. They stated according to the record the plan of care is 10/09/23 to 01/06/24. The HWD was asked if the services had been renewed or updated after 01/06/24. They stated Resident #5 had been on hospice then improved. The HWD was asked how the facility ensured monitoring and coordination of care. They provided no response. 5. Resident #6 had diagnoses to include dementia, Alzheimer's Disease and pulmonary edema. An "Change of Condition Assessment", dated 07/11/23, documented Resident #6 required one staff assistance with ADLs, and received hospice services to assist with showers.	C5010		

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C5010	Continued From page 24 A "Hospice Assessment and Plan of Care Update Report", dated 10/12/23, documented the level of care summary to be from 09/28/23 to 10/12/23. An "Aide Care Plan Report", documented service episode dates 09/11/23 to 11/09/23. The clinical record did not contain a level of care or care plan updated after 10/12/23, or rationale of the aide care plan report extended past the service care dates. The clinical record contained documentation Resident #6 has been seen by hospice after the documented dates of service as follows: a. November 2023, on days 8, 15, 17, 20, 22, and 29; b. December 2023, on days 1, 6, 8, 13, 15, 18, 20, 22, and 27; c. January 2024, on days 3, 12, 16, 18, 24, and 25; c. February 2024, on days 27, 28, and 29; d. March 2024, on days 14, 21, 25, and 28; e. April 2024, on days 4, 9, 15, 23, and 25; and f. May 2024, on days 2, and 7. The clinical record did not document the rationale of Resident #6 having been seen by hospice for 35 visits after the documented end of service care date of 10/12/23. The "Resident Roster" matrix form provided by the facility on 05/13/24 at 11:15 a.m., documented Resident #6 received hospice or home health. On 05/15/24 at 4:30 p.m., the HWD was asked how monitoring and coordination of care was being completed by the facility. No verbal	C5010		

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C5010	Continued From page 25 response was provided. The HWD then provided a "Hospice Comprehensive Assessment and Plan of Care Update Report, dated 05/08/24, that documented the service dates from 04/25/24 to 05/19/24. The form contained a fax date of 05/15/24 at 11:10 a.m. No explanation was provided, and no further information was provided for all dates in question for monitoring and coordination of care.	C5010		

Delivery via email to: thearborslife@gmail.com

August 14, 2024

License Number: AL2404

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

RE: Survey Event IYKS11

Dear Ms. McPherson:

On **May 16, 2024**, 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:

- **Tag C0391 and C1304 have correction dates prior to exit. Allow for monitoring**
- **Tag C0522 and C5010 correction dates did not allow for monitoring**

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 05/13/24 through 05/16/24. Facility Census: 14 The following abbreviations were used to write the report: ADLs - Activities of Daily Living ACMA - Advanced Certified Medication Assistant AL - Assisted Living CMA - Certified Medication Assistant CNA - Certified Nurse Aide HWD - Health Wellness Director LPN - Licensed Practical Nurse mcg - microgram Mg or mg - milligrams OSDH - Oklahoma State Department of Health RN - Registered nurse TIA - Transient Ischemic Attack	C 000	Refer to POC Template, Survey Event ID#IYKS11 ID Prefix Tag C 391 Refer to POC Template, Survey Event ID#IYKS11 ID Prefix Tag C 522 Refer to POC Template, Survey Event ID#IYKS11 ID Prefix Tag C 532 Refer to POC Template, Survey Event ID#IYKS11 ID Prefix Tag C 542 Refer to POC Template, Survey Event ID#IYKS11 ID Prefix Tag C 1304 Refer to POC Template, Survey Event ID#IYKS11 ID Prefix Tag C 1505 Refer to POC Template, Survey Event ID#IYKS11 ID Prefix Tag C 5010	
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: a. the designated hand washing sink was utilized at all times for handwashing by the dietary staff, and b. raw foods were washed prior to being served to residents.	C 391		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 391	Continued From page 1 Census: 14 Findings: On 05/14/24 at 12:10 p.m., during the serving of the noon meal, Cook #2 was served several plates, don serving gloves, remove the serving gloves, wash their hands in the three-compartment sink, don serving gloves and prepare a tuna salad sandwich for a resident. On 05/14/24 at 12:20 p.m., Cook #2 obtained a market cellophane package from the refrigerator that contained a tomato with long stems attached. Cook #2, removed the tomato from the packaging. Without washing the tomato, Cook #2 removed the stem from the single tomato, placed the tomato on a cutting board, sliced the tomato, placed the tomato slices on a small plate and nursing staff served the plate to residents. On 05/14/24 at 12:27 pm., Cook #2 was asked what the policy was for a designated hand washing sink. They stated the single sink near the door was the designated handwashing sink. They stated they had used the three-compartment sink for handwashing, "Out of habit." Cook #2 was asked if the tomato they had sliced, was in the market packaging. Cook #2 stated it was. They were asked if the tomato had been washed prior to being sliced and served to residents. They stated, they usually do but this tomato probably had not been washed.	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	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 2 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 facility failed to complete a significant change of assessment at the initiation of a plan of accommodation of needs for two (#2, and #6) of six sampled residents. Census: 14 The facility's undated "Resident Roster", provided on 05/13/24, documented nine residents received hospice or home health services. Findings: An "Assessment Timeframe's" policy dated 05/03/12, read in parts, "...According to O.S.D.H...[facility name] completes assessments as follows...Comprehensive Assessment..within five (5) of significant change..." 1. Resident #2 had diagnoses to include dementia, anxiety, repeated falls and pain. A "Hospice Certification of Plan of Care", dated 11/19/23, documented Resident #2 was to begin hospice services on 12/19/23 for the certification period of 12/19/23 to 03/17/24.	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 3 A "Change of Condition" assessment, dated 12/15/23, documented Resident #2 was alert, confused, had advanced stage dementia, and required one staff assistance for bathing, eating, dressing, transfers, toileting, and ambulation, and receiving hospice services. A "Plan of Accommodation" for Resident #2, dated 04/10/24, read in parts, "...declining physical health...on hospice services...the following plan provides..necessary assistance in order to remain living at...Center..." The form was dated as signed by the responsible party on 04/10/24. The records did not contain an assessment after the Change of Condition Assessment, dated 12/15/23, to identify the status of Resident #2, when the "Plan of Accommodation" was put into place four months later on 04/10/24. 2. Resident #6 had diagnoses to include severe dementia with agitation, Alzheimer's disease, pulmonary edema and pain. An "Annual Assessment", dated 07/11/23, documented Resident #6 was alert, had increased confusion, requires 24 hour care, one staff assistance for transfers ambulation, bathing, eating, dressing, toileting, ambulation, and received hospice services for bathing. The Hospice "Plan of Care Update Report", dated 10/12/23, documented the benefit period of 09/11/23 through 11/09/23. The record did not contain a change of status assessment at the time Resident #6 was admitted to hospice services.	C 522		

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C 522	Continued From page 4 A "Plan of Accommodation" for Resident #6, dated 04/09/24, read in parts, "...declining physical health...on hospice services...the following plan provides...necessary assistance in order to remain living here at...Center..." The records did not contain an assessment after the Annual assessment dated 07/11/23, to identify the status of Resident #6, when the Plan of Accommodation was put into place nine months later, on 04/09/24. On 05/15/24 at 3:25 p.m., the administrator and HWD were asked if a Change of Condition assessment was completed at the time the plan of accommodations were signed for Residents #2 and #6. The HWD stated the Change of Conditions had already been completed and a new assessment was not completed at the time the Plan of Accommodations were signed.	C 522		
C 532 SS=E	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history.	C 532		

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C 532	Continued From page 5 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure resident assessments accurately reflected the resident status: a. that required two staff assistance for ADLs for two (#2, and #6) of three sampled residents reviewed for level of care needs, b. with a modified pureed diet provided for one (#2) of two sampled residents reviewed for modified diets, and c. for hospice services provided for one (#4,) of four sampled residents reviewed for hospice services. Census: 14 Findings: 1. Resident #2 had diagnoses to include dementia, anxiety, and repeated falls. A "Change of Condition" assessment, dated 12/15/23, documented Resident #2 had advanced dementia, required one staff assistance to bath, eat, dress, transfer, toilet and ambulate, was to be provided a regular diet, and was on hospice services. Physician's Order", last updated on 01/26/24, did	C 532		

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C 532	Continued From page 6 not contain a diet order and did not address Resident #2 was to be provided a pureed textured diet for the noon meal On 05/13/24, at 12:10 p.m., Resident #2 was provided a pureed textured diet for the noon meal. The records did not include additional assessments or documentation of the resident's need for two staff assistance, or that a pureed diet was required. On 05/15/24 at 3:25 p.m., the administrator and HWD were asked why Resident #2 had been provided a pureed diet. The HWD stated it was the resident preference as they would spit out any food that had texture. They stated since it was a preference, it did not need to be on the assessment. 2. Resident #6 had diagnoses to include severe dementia with agitation, Alzheimer's disease, and pain. An "Annual Assessment", dated 07/11/23, documented Resident #6 had increased confusion, required 24 hour care with sitters, and one staff assistance with transfer, ambulation, bathing, eating, dressing, and received hospice services. On 05/14/24 at 8:00 a.m., two staff were observed to assist Resident #6 in transfer from their wheelchair to a stuffed chair in front of the television in the common area. On 05/15/24 a 2:26 p.m., CNA #1 was asked if any current resident required more than a one staff assistance with ADLs. CNA #1 stated three	C 532		

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C 532	Continued From page 7 residents required two staff assistance to ensure safety for transfers, toileting, dressing and bathing. They identified Residents #2 and #6, to have consistent needs of two staff assistance, and stated the facility staffed well to meet their needs. On 05/15/24 at 3:50 p.m., the Administrator and HWD were asked how many of the current residents required two staff assistance for any of the ADLs. They both stated, "None." They were asked why did staff providing care report three residents required two staff on a consistent basis to meet their ADL needs. The HWD stated, that is not true. No further information was provided regarding the accuracy of assessments for Residents #2 and #6. 3. Resident #4 had diagnoses to include dementia, and mood disorder. A "Fourteen Day Assessment", dated 11/19/23, documented Resident #4 was alert, confused, required one person assist for bathing, eating, dressing, transfers, toileting, ambulation and had requested Home Health services for skilled nursing and physical therapy. An "Oklahoma Recommended AL Resident Assessment", dated 12/19/23, documented Resident #4 had requested to be provided Home Health Services and Physical Therapy. The clinical record did not contain additional assessments after 12/19/23. A "Hospice Certification and Plan of Care", dated 01/09/24, documented Resident #4 was certified	C 532		

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C 532	Continued From page 8 for hospice services from 01/09/24 to 4/7/24. The record did not contain information that Resident #4 had been provided Home Health Services or Physical Therapy as requested on admission. The assessment did not document Resident #4 had been referred to Hospice or had received Hospice services. On 05/15/24 at 4:10 p.m., the HWD was asked if Resident #4 had been provided the requested Home Health Services, or Physical Therapy as requested on the 14 day admission assessment. The HWD stated Resident #4 did not qualify for Home Health and was placed on Hospice Services instead. No further information was provided regarding the inaccurate assessment or update of status.	C 532		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure Resident Assessments included: a. a signature by an RN or physician, or b. were signed by an RN or physician at the time the assessments were to be completed for four (#2, 3, 4, and #6) of six residents reviewed for resident assessments.	C 542		

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C 542	Continued From page 9 Census: 14 1. A "Change of Condition" assessment, dated 05/16/23, for Resident #2, documented the RN had not reviewed and signed the assessment until 07/11/23 when the assessment was locked as completed. The assessment had not been signed by a physician. A "Change of Condition" assessment, dated 12/15/23 was signed by the LPN/HWD on 1/12/23, and locked as completed on 01/02/24. The assessment had not been signed by an RN or physician. 2. An "Admission Assessment", dated 04/24/23, for Resident #3, contained no signatures of the person completing the assessment or a review/coordination of care signature by an RN or physician. The assessment was locked as completed on 03/07/24, eleven months after the assessment was due. An "Admission Assessment", dated 04/24/23, was signed by the LPN/HWD on 04/24/34. The assessment was not signed by an RN or locked as completed until 07/11/23. 3. An "Admission Assessment", dated 11/29/23, for Resident #4, contained no signatures. The assessment was locked as completed on 03/26/24, four months after the assessment was due. A "Fourteen Day" assessment, dated 12/18/23 was signed by the LPN/HWD on 12/18/23. The assessment had not been signed by an RN or a physician.	C 542		