Oklahoma State Department of Health
Creating a State of Health

December 11, 2019

License Number: AL5507

Ms. Lisa Sanders, Administrator
Northhaven Place
7535 West Hefner Road
Oklahoma City, OK 73162

RE: Survey Event ID: 0I4R11

Dear Ms. Sanders:

On **November 19, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on November 19, 2019.

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

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

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;

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

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

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

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

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

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

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

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

Sincerely,

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

SD/ldc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5507	A BUILDING _____ B WING _____	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHHAVEN PLACE	7535 WEST HEFNER ROAD OKLAHOMA CITY, OK 73162

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 11/18/19 and 11/19/19. Current census was 22. The following deficient practices were cited.	C 000		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment form for 3 (#3, 5, and #6) of 8 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #3 Resident #3 moved into the center on 07/18/18 with diagnoses that included hypertension, memory difficulty, leukocytosis, hypokalemia, dysphagia, chronic kidney disease, osteoporosis, and atrioventricular heart block. Her most current comprehensive assessment, dated 11/09/19, did not contained a signature to indicate a personal interview had been conducted between the	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5507	A BUILDING _____ B WING _____	11/19/2019

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C 543	Continued From page 1 resident or resident's representative. On 11/18/19 at 2:00 p.m., the administrator and the licensed practical nurse (LPN) stated the assessment had not been signed by the resident's representative. RESIDENT #5 Resident #5 moved into the center on 08/22/18 with diagnoses that included bradycardia, hypertension, chronic kidney disease, and anemia. Her most current comprehensive annual assessment, dated 11/09/19, did not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. On 11/19/19 at 10:13 a.m., the registered nurse (RN) and LPN stated they had assessed the resident but had failed to have the resident sign the assessment at that time. RESIDENT #6 Resident #6 moved into the center on 06/30/18 with diagnoses that included diabetes mellitus type II, right above the knee amputation, hypertension, and osteoporosis. Her most current comprehensive assessment, dated 09/30/19, had not contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. At 11:10 a.m., the LPN stated she had assessed the resident and she did not know why the resident had not signed the assessment at that time.	C 543		

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	AL5507	A. BUILDING _____ B WING _____	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHHAVEN PLACE	7535 WEST HEFNER ROAD OKLAHOMA CITY, OK 73162

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C 701 SS=F	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure water temperatures did not exceed 115 degrees Fahrenheit (F) for 10 (#1, #2, and #6 through #13) of 13 sampled residents. This deficient practice had the widespread potential for more than minimal harm for all 22 residents. Findings: On 11/18/19 at 3:44 p.m., the following hot water temperatures were checked and the following temperatures registered: Resident #1 - 117.3 degrees F at the bathroom sink; Resident #2 - 117.6 degrees F at the bathroom sink; Resident #6 - 117.9 degrees F at the bathroom sink; Resident #7 - 118.1 degrees F at the bathroom sink; Resident #8 - 116.7 degrees F at the bathroom sink;	C 701		

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	AL5507	A. BUILDING _____ B. WING _____	11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 701	Continued From page 3 Resident #9 - 115.5 degrees F at the kitchen sink; Resident #10 - 116.7 degrees F at the kitchen sink; Resident #11 - 115.2 degrees F at the kitchen sink; Resident #12 - 118.6 degrees F at the bathroom sink; and Resident #13 - 119.1 degrees F at the bathroom sink. On 11/19/19 at 9:28 a.m., maintenance/employee #3 stated the building was supplied hot water by three tanks. She stated she checked the hot water daily and she thought state regulated the hot water temperature not to exceed 150 degrees F to 175 degrees F.	C 701		
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, and to participate in the planning of care and treatment or changes in care and treatment.	C1505		

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	AL5507	A BUILDING. _____ B WING _____	11/19/2019

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C1505	Continued From page 4 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 interview and record review, it was determined the center failed to ensure laboratory tests were obtained for 2 (#1 and #6) of 3 sampled residents who had physicians' ordered hemoglobin A1c (a laboratory test to determine average blood sugar levels over the past 2-3 months) testing for diabetes mellitus. Findings: RESIDENT #1 Resident #1 moved into the center on 4/27/19 with diagnoses that included diabetes mellitus type II. Physician's orders for resident #1, dated 07/01/19, documented a hemoglobin A1c laboratory test was to be drawn every February, June, and October. On 11/19/19 at 10:01 a.m., there was no October 2019 hemoglobin A1c laboratory test result available for resident #1. At 1:56 p.m., the licensed practical nurse (LPN) stated resident #1 had not had the physician ordered hemoglobin A1c laboratory test drawn in October 2019. RESIDENT #6 Resident #6 moved into the center on 06/30/18 with diagnoses that included diabetes mellitus type II. She had a physician's order for a	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5507	A. BUILDING _____ B. WING _____	11/19/2019

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NORTHHAVEN PLACE	7535 WEST HEFNER ROAD OKLAHOMA CITY, OK 73162

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C1505	Continued From page 5 hemoglobin A1c to be drawn every February, June, and October. On 11/19/19 at 10:35 a.m., there was no October 2019 hemoglobin A1c laboratory test result available for resident #6. At 11:55 a.m., the LPN stated resident #6 had not had the physician ordered hemoglobin A1c laboratory test drawn in October 2019.	C1505		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5507	NORTHHAVEN PLACE

Type of Survey (select all that apply)

2				

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

Extent of Survey (select all that apply)

A				

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 35195	11/18/2019	11/19/2019	0.50	0.00	12.50	0.00	4.50	2.50
2. 42023	11/18/2019	11/19/2019	0.00	0.00	12.50	0.00	1.50	2.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

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

DEC 12 2019

Oklahoma State Department of Health
Creating a State of Health

January 9, 2020

License Number: AL5507

Ms. Lisa Sanders, Administrator
Northhaven Place
7535 West Hefner Road
Oklahoma City, OK 73162

RE: Survey Event 0I4R11

Dear Ms. Sanders:

On November 19, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 23, 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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/24/2019** **Facility Name:** Northhaven Place **License Number:** AL5507 **Survey Event ID:** 0I4R11 **Date Survey Completed: 11/19/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C543 SS=E	Based on: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment form for 3 (#3, #5, and #6) of 8 sampled residents. This failed practice had the potential for more than minimal harm, at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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?	Care Services Manager (CSM) and Registered Nurse completed Comprehensive Assessments on residents #3, #5 and #6 with a personal interview conducted between the resident and/or the resident's representative and the person completing the form by 12/2/2019.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents have the potential to be affectd by the alleged 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?	Care Services Manager (CSM), licensed designee and/or Registered Nurse will ensure that comprehensive assessment contains a signature to indicate a personal interview has been conducted between the resident or the resident's representative and the person that completed the assessment form for current residents and new admissions. Care Services Manager (CSM) and Executive Director (ED) were inserviced on 12/18/2019 by the Regional Director of Care Services (RDCS) on the requirement for the assisted living center to ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of section 310.663-5-4 (c).

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.	Care Services Manager, licensed designee and/or Registerd Nurse will be responsible for sustained compliance. Care Services Manager (CSM), licensed designee and/or Registered Nurse will do random audits of 4 resident Comprehensive Assessments for signature of resident or resident's responsible party 2 times a week for 4 weeks, then 2 random residents a week for 4 weeks then 1 random resident a week for 4 weeks. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three months of compliance. Monitoring records wil be maintained by the Excutive Director and/or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/23/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature – Administrator signature required. OAC 310:663-25-4(F)	**Date 12/24/2019**

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/24/2019** **Facility Name:** Northhaven Place **License Number:** AL5507 **Survey Event ID:** OI4R11 **Date Survey Completed: 11/19/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C701 SS=F	Based on: observation, interview and record review, it was determined the center failed to ensure water temperatures did not exceed 115 degrees Fahrenheit (F) for 10 (#1, #2, and #6 through #13) of 13 sampled residents. This deficient practice had the wide spread potential for more than minimal harm for all 22 residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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 Center has replaced the spindle in the Symmons 7-700 Thermostatic Mixing Valve that controls the water temperature of the hot water feeding the residents apartments and common areas. The repairs were completed on 12/3/2019.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents have the potential to be affected by alleged 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?	Maintenance staff and/or designee will test hot water in resident accessible sinks and log results of temperatures. If temperature is not in acceptable range, the Area Facilities Manager will be notified for possible adjustments to machine, as needed. Audits of water temps started on 12/04/2019 to include daily checks to ensure water temps less than 115 degrees Fahrenheit (F). Maintenance Staff and Executive Director were inserviced by the Regional Director of Care Services (RDCS) on 12/18/2019 on the requirement that each Assisted Living Center shall comply with hot water standards set forth in Appendex A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.)
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:	Maintenance staff and/or designee will be responsible for sustained compliance.

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.	Maintenance staff and/or designee will obtain hot water temperatures in 10 random resident rooms to ensure safe range 2 times a day for 4 weeks, then 7 random resident rooms 2 times a day for 4 weeks then 4 resident rooms 2 times a day for 4 weeks. Audit results will be reviewed monthly in QI meetings and QI committee wil determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring records will be maintained by the Executive Director and/or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ **No** ☐	
5. On what date will corrective action be completed?	1/23/2020
OSDH Response: Element accepted Yes ☐ **No** ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 12/24/2019**

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/24/2019** **Facility Name:** Northhaven Place **License Number:** AL5507 **Survey Event ID:** 0I4R11 **Date Survey Completed: 11/19/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505 SS=E	Based on: interview and record review, it was determined the center failed to ensure laboratory tests were obtained for 2 (#1 and #6) of 3 sampled residents who had physician ordered hemoglobin A1c (a laboratory test to determine average blood sugar levels over the past 2-3 months) testing for diabetes mellitus.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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?	Care Services Manager (CSM) obtained order clarification for HgA1C to be collected for Resident #1 and #6. HgA1C lab for residents #1 and #6 were obtained on or before 12/04/2019.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents have the potential to be affected by alleged 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?	1. For new admissions, the Care Services Manager (CSM) and/or designee will review physician orders and order any required laboratory tests within 24 hours of admission. Any noted non-compliance of missing labs will result in immediate action of community calling laboratory to have tests obtained immediately and/or physician will be contacted for clarification. 2. For current residents, the Care Services Manager (CSM) and/or designee resident records will be audited for lab orders/results. Any noted concerns will immediately be rectified/communicated/or physician notified. Care Services Manager (CSM) and Executive Director were inserviced by the Regional Director of Care Services (RDCS) on 12/18/2019 on the requirements regarding laboratory testing per physicians orders and timely follow-up on any noted non-compliance.
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.	Care Services Manager and/or designee will be responsible for sustained compliance. Care Services Manager and/or designee will audit resident records for laboratory orders and results 3 times per week x 4 weeks, then 2 times per week x 4 weeks and then weekly x 4 weeks to ensure laboratory compliance Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring records will be maintained by Executive Director and/or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ **No** ☐	
5. On what date will corrective action be completed?	1/23/2020
OSDH Response: Element accepted Yes ☐ **No** ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 12/24/2019**

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health
Creating a State of Health

February 18, 2020

License Number: AL5507

Ms. Lisa Sanders, Administrator
Northhaven Place
7535 West Hefner Road
Oklahoma City, OK 73162

RE: Survey Event 0I4R12

Dear Ms. Sanders:

On **February 6, 2020,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 19, 2019,** have now been corrected effective **January 23, 2020.**

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

Sincerely,

Katie Stagner

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

SD/kgs

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
	AL5507	A. BUILDING. _____ B. WING _____	R 02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHHAVEN PLACE	7535 WEST HEFNER ROAD OKLAHOMA CITY, OK 73162

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS A follow-up survey was conducted on 02/06/2020. Current census was 27. All deficient practices were cleared.	{C 000}		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5507	NORTHHAVEN PLACE

Type of Survey (select all that apply)

2	D			

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

Extent of Survey (select all that apply)

A				

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. [illegible]35195	02/06/2020	02/06/2020	0.50	0.00	2.25	0.00	2.25	0.50
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**