OKLAHOMA
State Department
of Health

Delivery via email to: mhunter@enlivant.com

June 27, 2023

License Number: AL5507

Mr. Michael Hunter, Administrator
Northhaven Place
7535 West Hefner Road
Oklahoma City, OK 73162

RE: Survey Event ID: P0IL11

Dear Mr. Hunter:

On **June 14, 2023**, agents from our office concluded a State Licensure survey in conjunction with a complaint survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **June 14, 2023**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Northhaven Place**
Address: **7535 West Hefner Road**
City, State, Zip: **Oklahoma City, OK, 73162**
Provider #: **AL5507**
Complaint #: **OK00060757**
Investigation Dates: **06/12/23, 06/13/23, and 06/14/23**

ALLEGATIONS

The facility failed to ensure a clean, safe and homelike environment.

An unannounced on-site investigation was initiated 06/12/2023 at 2:00 p.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility and resident apartments was conducted upon entrance and throughout the survey. Residents were observed in their room, during meals, participating in activities, during medication administration, and receiving assistance from staff with ambulation. Residents with double occupancy apartments were observed ambulating in their rooms. Staff was observed to provide laundry and housekeeping services for residents. Staff was observed to provide assistance with personal care and ambulation for residents.

Sampled clinical records were reviewed for physician orders, care plans, assessments, and activities of daily living. Facility policy and procedures, grievance logs, resident council minutes, and incident reports were reviewed. Pet health records were reviewed for compliance. Resident service agreements were for reviewed.

Residents were interviewed related to the cleanliness of the facility, concerns with lingering odors, and adequate apartment size. Staff were interviewed related to having adequate facility accommodations to safely provide assistance and care for residents. Staff were interviewed related to cleaning schedules and assisting residents with their pets.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 06/15/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Northhaven Place**
Address: **7535 West Hefner Road**
City, State, Zip: **Oklahoma City, OK 73162**
Provider #: **AL 55**
Complaint #: **OK00059119**
Investigation Date(s): **06/12/23 through 06/14/23**

ALLEGATION(S)

1. The facility failed to ensure residents' right for visitors of choice.

An unannounced on-site investigation was initiated 06/12/2023 at 2:00 p.m.

A sample of nine residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and throughout the survey. Residents were observed during medication administration, during meal times, while receiving personal care, while participating in group activities, and visits from family members. Visitors were assisted by staff to enter the facility and socialize with residents.

Sampled clinical records, including closed records, were reviewed for physician orders, care plans, assessments, and activities of daily living. Facility policy and procedures, grievance logs, resident council minutes, and incident reports were reviewed. Allegations of abuse/mistreatment investigation records were reviewed.

Residents were interviewed related to visitors of choice and interaction with staff. Staff were interviewed related to resident's rights and facility visitation policy.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 06/16/2023

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 _____	C 06/14/2023

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 relicensure survey was conducted from 06/12/23 through 06/14/23. Complaint investigations (#OK00059119 and OK00060757) were conducted in conjunction with the survey.	C 000		
C 544 SS=E	310:663-5-4(d) CONDUCT OF ASSESSMENT (d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be available upon request to the following: (1) the resident; (2) the resident's personal physician; (3) the resident's representative; and (4) the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain residents' assessments for two (#1 and #4) of eight sampled residents reviewed for comprehensive assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 06/12/23, documented 26 residents resided in the facility. Findings: The facility's "Care Management Protocol & Assessment Process" policy, dated 02/01/17, read in part. "In order to manage care for each resident on an individual basis, it is important to identify the resident's individual needs and wants...This is accomplished through our assessment process...The evaluations are to be completed prior to move-in, to determine if the resident is appropriate for our community, it needs to be reviewed upon move-in, to determine	C 544		

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 _____	C 06/14/2023

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 544	Continued From page 1 if there are any changes since the last evaluation was completed (usually 2 weeks)...The evaluations are clinical related, and are part of the resident's permanent record...The original evaluation remains in a plastic sleeve throughout the resident's stay..." 1. Resident #1 was admitted to the facility on 11/09/22. Resident #1's medical record did not contain an admission assessment or a comprehensive assessment completed within 14 days of admission. 2. Resident #4 was admitted to the facility on 08/12/21. Resident #4's medical record did not contain an admission assessment or a comprehensive assessment completed within 14 days of admission. On 06/13/23 at 2:00 p.m., the Care Service Manager was asked if resident #1 and #4 had an admission assessment or comprehensive assessment that was completed within 14 days of admission. The Care Service Manager reported the assessments completed at admission for Resident #1 and Resident #4 were unable to be located. The Care Service Manager reported that all resident assessments should be kept for 5 years in the residents' medical record.	C 544		

OKLAHOMA
State Department
of Health

Delivery via email to: mhunter@enlivant.com

August 9, 2023

License Number: AL5507

Mr. Michael Hunter, Administrator
Northhaven Place
7535 West Hefner Road
Oklahoma City, OK 73162

Survey Event ID: P0IL11

Dear Mr. Hunter:

On **June 14, 2023,** a Licensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **July 26, 2023**.

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

Respectfully,

Tempal Killman

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/7/2023** **Facility Name:** Northhaven Place **License Number:** AL5507 **Survey Event ID:** POIL11 **Date Survey Completed: 6/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C544	Based on: Based on record review and interview, the facilityfailed to maintain residents' assessments for two(#1 and #4) of eight sampled residents reviewedfor comprehensive assessments.

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 an 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?	On 7/10/23, Care Service Manager (CSM) completed Resident #1's and #4's state assessment, state assessments are current, active and in resident's file.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	By 7/14/23, CSM and or designee will audit current resident charts to assess for completion of admission state assessment, CSM to address findings as necessary.
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?	On 7/10/23 Regional Director of Care Services (RDCS) provided education to Executive Director (ED) and CSM on requirement for completion and maintenance of admission and comprehensive assessments.
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.	Beginning 7/10/23, ED and/or designee will review new resident files to ensure the admission and comprehensive state assessments have been completed and on file weekly for 4 weeks, bi-weekly for 4 weeks, then monthly for 1 month. 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. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/26/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Michael Hunter OAC 310:663-25-4(F)	Date 7/11/2023

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

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

Items Below Are For OSDH Use Only

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

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

OKLAHOMA
State Department
of Health

Delivery via email to: mihunter@moradalakehefner.com

September 7, 2023

License Number: AL5507

Mr. Michael Hunter, Administrator
Northhaven Place
7535 West Hefner Road
Oklahoma City, OK 73162

RE: Survey Event P0IL12

Dear Mr. Hunter:

On **September 5, 2023,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 14, 2023,** have now been corrected effective **July 26, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5507	A. BUILDING: _____ B. WING _____	R-C 09/05/2023

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 An offsite/paper revisit was conducted on 09/05/23. The facility was in substantial compliance.	{C 000}		

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