Oklahoma State Department of Health
Creating a State of Health

November 6, 2019

License Number: AL5511

Ms. Regina Herring, Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: WJ2X11

Dear Ms. Herring:

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

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Glade Avenue Assisted Living**
Address: **2500 North Glade Avenue**
City, State, Zip: **Bethany, OK**
Provider #: **AL5511**
Complaint #: **OK00054207**
Investigation Date(s): **09/09/19 through 09/10/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were properly administered.	S
2. The center failed to have adequate staff to ensure an accident free environment.	S

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

An unannounced on-site investigation was initiated 09/09/19 at 9:00 a.m.

A sample of seven 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form, and Tag 1505 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form, and Tag 1914 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Julie Edmiaston RN 9/19/19

Julie Edmiaston RN, BSN

Date report completed: 09/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5511	A BUILDING _____ B WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING	2500 NORTH GLADE AVENUE BETHANY, OK 73008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An abbreviated survey was conducted on 09/09/19 through 09/10/19 to investigate complaint #OK00054207. Resident census was 49. Deficient practice was cited as follows.	C 000		
C1505 SS=F	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure medications were administered as directed by the physician for two (#1 and #7) of two sampled	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5511	A BUILDING _____ B WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 1 residents whose medications were administered by the staff. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #1 Resident #1 had a physician's order for Voltaren (Diclofenac) Gel 1% to apply 4 grams to neck three times a day. Resident #1 missed 12 doses of Voltaren Gel in August 2019. On 09/09/19 at 9:50 a.m., the administrator was asked if the staff charted the reason the Diclofenac Gel was not administered in August 2019. She stated no it was not charted They can't go back and chart it. She was asked if it was the center's policy to chart the reason a medication was not administered. She stated she did not know if it was the center's policy but it would be good practice to chart why it was not administered. On 09/10/19 at 10:30 a.m., resident #1 was asked if she had a physician's order for cream to be applied to her neck. She stated yes. She was asked if there were days she would not get her cream. She stated yes, because the cream was not brought down with my routine medications. Resident #7 Resident #7 was admitted with diagnoses to include seizure disorder, depression, pain, hypertension, coronary bypass and end stage renal disease. Resident #7 went to Dialysis three times a week. The record review of August medication administration record (MAR) documented resident #7 missed 14 doses of	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 2 Hydrocodone/Apap tab 10-325 milligram (mg) ordered for pain, 10 doses of Levicteram 500 mg for seizure disorder, 10 doses of Carvedilol 3.125 mg for hypertension, 11 doses of Lisinopril 5 mg for hypertension, 3 doses of Sevelemar 800 mg for end stage renal disease, 9 doses of sertraline 100 mg for depression, and 6 doses of Clopidogrel 75 mg for coronary disease. The record review of September MAR documented resident #7 missed medications for 4 of 9 days. Resident #7 missed 4 doses of Hydrocodone/Apap tab 10-325 milligram (mg) ordered for pain, 4 doses of Levicteram 500 mg for seizure disorder, 4 doses of Carvedilol 3.125 mg for hypertension, 4 doses of Lisinopril 5 mg for hypertension, 1 dose of Sevelemar 800 mg for end stage renal disease, 4 doses of sertraline 100 mg for depression, and 4 doses of Clopidogrel 75 mg for coronary disease On 09/09/19 at 4:30 p.m., the administrator stated she was unaware resident #7 had not been taking his medications as directed on dialysis days (three days a week). The administrator stated the staff should have notified the registered nurse (RN) or the licensed practical nurse (LPN). At 4:35 p.m., RN #1 was unaware resident #7 had not been taking his medications as directed by the physician on the days he went to dialysis. RN#1 stated the medication staff had not notified her. On 09/10/2019 at 9:45 a.m., advanced certification medication aide (ACMA) #3 stated, resident #7 does not take all his medications on the days he goes to Dialysis. She administers his noon pills at the next scheduled administration	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5511	A BUILDING _____ B WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING	2500 NORTH GLADE AVENUE BETHANY, OK 73008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 3 time. At 9:50 a.m , ACMA #4 reports she does not administer morning medications as ordered to resident #7 on the days he goes to dialysis. Policy The center's policy dated February 2019, documented, the person administering medications reviews the medication record to ascertain that all necessary doses were administered and that all administered doses were documented. The center's policy titled, 'Medication' not dated, documented give medication directly to resident at the time medication is to be taken.	C1505		
C1914 SS=E	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to report to the Oklahoma State Department of Health (OSDH) an incident report for two (#1 and #6) of two residents who sustained a fracture. This resulted in the potential for more than minimal harm at a pattern. Findings:	C1914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1914	Continued From page 4 Resident #1 The hospital discharge instructions for resident #1 dated March 2, 2019, documented a nondisplaced fracture of third metatarsal bone, right foot. On 09/09/19 at 3:55 p.m., the RN was asked to submit the report sent to OSDH for resident #1's foot fracture. She stated she had looked through the book and did not find it Resident #6 On 09/09/19 at 12.18 p.m., registered nurse (RN) #1 reported resident #6 had a fractured elbow. At 3:55 p.m., resident #6 reported injuring her elbow and having it "wrapped by the doctor" when she had fallen in her bathroom on 07/26/2019. At 5:00 p m., record review documented an internal incident report was completed, and an entry was made in the nurses progress notes On 09/10/19 at 11:40 a.m., RN #1 stated she was unable to provide an incident report that had been sent to the OSDH for the incident dated 07/26/2019.	C1914		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5511	GLADE AVENUE ASSISTED LIVING

Type of Survey (select all that apply)

[3] [ ] [ ] [ ] [ ]

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

Extent of Survey (select all that apply)

[ ] [ ] [ ] [ ] [ ]

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30875	09/09/2019	09/10/2019	1.00	0.00	11.00	0.00	4.00	3.00
2. 41872	09/09/2019	09/10/2019	1.00	0.00	11.00	0.00	3.25	4.00
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**

NOV 0 8 2019

Oklahoma State Department of Health
Creating a State of Health

November 27, 2019

License Number: AL5511

Ms. Regina Herring, Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: WJ2X11

Dear Ms. Herring:

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

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **October 10, 2019**.

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,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/ks

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/7/2019** **Facility Name:** Glade Avenue Assisted Living **License Number:** 5511 **Survey Event ID:** WJ2X11 **Date Survey Completed: 9/10/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Observation, interview and record review it was determined that the facility failed to ensure medications were administered as directed by physician

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All medications that were not being given due to discrepancy of dyalisis times were changed immediately to fit residents chair time. Night shift LPN and RCC will complete and review MAR, Cart and med room Audit weekly. ED/LPN will review MAR routinely to ensure all medications and treatments have been given per current phycians order. As well as no blanks in MAR. If blanks are found they will be investigated and reason addressed appropriatly. If medications have been missed PCP will be notified. Staff was inserviced by Boomer Pharmacy and facility DON on treatment drop down to ensure the treatments are being administered per phycians orders. As well as the procedure when medications are missed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All resident that admit to the facility on dyalisis or any other routine outpatient services medications will be reviewed and adjusted to fit their time out of the facility. Night shift LPN and RCC will complete and review MAR, Cart and med room Audit weekly. ED/LPN will review MAR routinely to ensure all medications and treatments have been given per current phycians order. As well as no blanks in MAR. If blanks are found it will be investigated immediately and appropriatly. If medications have been missed PCP will be notified and missed med will be documented appropriately. Staff was inserviced by Boomer Pharmacy and facility DON on treatment drop down to ensure the treatments are being administered per phycians orders. As well as the procedure when medication is missed
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?	All resident that admit to the facility on dyalisis or any other routine outpatient services medications will be reviewed and adjusted to fit their time out of the facility. Night shift LPN and RCC will complete and review MAR,

	Cart and med room Audit weekly. ED/LPN will review MAR routinely to ensure to ensure all medications are available per phycians order. As well as no blanks in MAR. If blanks are found it will be investigated and reason addressed appropiatly. If medications have been missed PCP will be notified. Staff was inserviced by Boomer Pharmacy and facility DON on treatment drop down to ensure the treatments are being administered per phycians orders. As well as when the medication is missed. Facility management will review all medication issues during morning meeting and QA.
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.	Pharmacy and nurse consultant provided by pharmacy routinely Consultant report to be reviewed in QA Random MAR audits to be done by RN and DON. RN, DON and ED to review audit logs weekly
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/10/2019
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Reggie Herring OAC 310:663-25-4(F)	**Date 11/7/2019**
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: 11/7/2019** **Facility Name:** Glade Avenue Assisted Living **License Number:** 5511 **Survey Event ID:** WJ2X11 **Date Survey Completed: 9/10/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1914	Based on: Interview and record review it was determined the center failed to report the Oklahoma State Department of Health (OSDH) an incident report for two of two residents who sustained a fracture

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's response here to each deficiency cited. (Optional)

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Any information received by the facility upon admission/re-admission reveiling or disclosing a FX will be immediately reported to the ED/Admin so that they can be reported to the State of Oklahoma. All incident reports will be reviewed in morning meeting to review the potential need for a reportable incident. Daily reports implemented and will be sent to RN and Administrator when they are not in community to ensure proper protocol for all incidents are followed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any information received by the facility upon admission/re-admission reveiling or disclosing a FX will be immediately reported to the ED/Admin so that they can be reported to the State of Oklahoma. All incident reports will be reviewed in morning meeting to review the potential need for a reportable incident. Daily reports implemented and will be sent to RN and Administrator when they are not in community to ensure proper protocol for all incidents are followed. An inservice was completed on 9/21/2019 on Incident reporting protocol. RN will review Incident reports monthly. DON will be orientated on how to complete a State Reportable Incident to ensure if Admin and ED are out of the community the report it completed in appropriate time frame
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?	Any information received by the facility upon admission/re-admission reveiling or disclosing a FX will be immediately reported to the ED/Admin so that they can be reported to the State of Oklahoma. All incident reports will be reviewed in morning meeting to review the potential need for a reportable incident. Daily reports implemented and will be sent to RN and Administrator when they are not in community to ensure proper protocol for all

	incidents are followed. An inservice was completed on 9/21/2019 on Incident reporting protocol. RN will review Incident reports monthly. DON will be orientated on how to complete a State Reportable Incident to ensure if Admin and ED are out of the community the report it completed in appropriate time frame All Incident Reports will be reviewed in QA to ensure proper protocol was followed and all appropriate reports were completed
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.	Morning Meetings will be completed with members of Management to review all Incident Reports for the past 24hrs Daily Report sent to RN and Admin with any incidents for the past 24hrs RN to review Incident Report book Monthly All Incident Reports and Admissions/Re-admissions will be reviewed in QA
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/10/2019
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Reggie Herring OAC 310:663-25-4(F)	**Date 11/7/2019**
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

December 26, 2019

License Number: AL5511

Ms. Regina Herring, Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: WJ2X12

Dear Ms. Herring:

On **December 11, 2019,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **September 10, 2019,** have now been corrected effective **October 10, 2019.**

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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc
Enclosure

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
	AL5511	A. BUILDING: _____ B. WING _____	R-C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE ASSISTED LIVING	2500 NORTH GLADE AVENUE BETHANY, OK 73008

(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. Census was 52. All deficient practice was cleared.	{C 000}		

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

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5511	GLADE AVENUE ASSISTED LIVING

Type of Survey (select all that apply)

3	D			

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

Extent of Survey (select all that apply)

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 30875	12/10/2019	12/11/2019	0.25	0.00	1.00	0.00	1.00	1.00
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**