Oklahoma State Department of Health
Creating a State of Health

December 23, 2019

License Number: AL5511

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

**Survey Event ID: LRD811**

Dear Ms. Herring:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **December 11, 2019.** No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

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

Oklahoma State
Department of Health

# INVESTIGATIVE REPORT

**Facility:** **Glade Avenue Assisted Living**
**Address:** **2500 North Glade Avenue**
**City, State, Zip:** **Bethany, OK 73008**
**Provider #:** **AL5511**
**Complaint #:** **OK00054416**
**Investigation Date(s):** **12/10/16 through 12/11/19**

| ALLEGATION(S) | S = SUBSTANTIATED<br>US = UNSUBSTANTIATED |
|---|---|
| 1. The center failed to ensure residents had a safe environment and that medications were administered as ordered. | US |

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

An unannounced on-site investigation was initiated on Tuesday, December 10, 2019 at 1:45 p.m.

A sample of five residents was selected for the investigation based on the concerns relevant to the allegation.

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.

The assisted living center did not have a resident by the named resident identified in the complaint allegation.

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

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

An investigation specific to the incident identified in the complaint allegation on 09/21/19 with an unauthorized visitor was investigated; in addition to resident's medications being administered on the evening of 09/21/19.

On 09/21/19 the employee who had a visitor at the center after business hours was no longer employed at the center at the time of the investigation. The police were called to the center on the evening of 09/21/19. The employee who was assaulted by the other employee's visitor had the option of filing charges and he too was no longer employed at the center at the time of the investigation. The employee and the employee's visitor left the center on the evening of 09/21/19 and the employee had never returned to the center and was therefore terminated. It was determined in the video footage the incident occurred behind the nurse's station in the medication room not within residents view. The resident's interviewed denied any encounters with disruptive

staff or witnessed any staff fighting. The medication administration records on the evening of 09/21/19 indicated medications had been administered to the residents by other staff members.

**Determination Summary and Follow-Up Action:**

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

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

Thank you for bringing these concerns to our attention.

Julie Edmiaston RN, BSN

Julie Edmiaston RN, BSN

Date report completed: 12/16/2019

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 _____ | 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<br><br>On 12/10/19 through 12/11/19 complaint #OK00054416 was investigated. Census was 52. No deficient practice was cited. | 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 | | | | |

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 | 6.00 | 0.00 | 2.00 | 2.50 |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
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| 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 23 2019