
Delivery via email to: ed@gladeavenueassistedliving.com

June 27, 2023

License Number: AL5511

Ms. Nikkita Bowler, Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

RE: Survey Event ID: DIDC11

Dear Ms. Bowler:

On **June 1, 2023**, agents from our office concluded a State Licensure survey with complaint investigations 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 1, 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,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT

Facility: Glade Avenue Assisted Living
Address: 2500 North Glade Avenue
City, State, Zip: Bethany, OK, 73008
Provider #: AL5511
Complaint #: OK00058628
Investigation Date(s): 05/30/23, 05/31/23, and 06/01/23

ALLEGATIONS

- | |
|---|
| 1. The center failed to ensure the residents right to a clean, comfortable environment free of pests. |
| 2. The center failed to provide services according to resident contracts. |
| 3. The center failed to ensure residents were not over sedated. |

An unannounced on-site investigation was initiated 05/30/2023 at 10:15 a.m.

A sample of 10 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 was conducted upon entrance and throughout the survey process. Residents were observed in their rooms, while participating in activities, during mealtimes, and when interacting with staff members. Staff were observed answering call lights, during medication administration, and when assisting residents with meals and personal care.

Sampled clinical records were reviewed for assessments, resident service agreements, physician orders, care plans, progress notes, activities of daily living logs and medication administration records. Grievance logs, resident council meeting minutes, incident reports, and in-services were reviewed. Facility monthly pest control logs were reviewed. Facility policies and procedures were reviewed.

Numerous residents, including sampled residents, were interviewed regarding the cleanliness of the facility and pests. Residents were interviewed regarding assistance with activities of daily living as agreed upon in their service contract. Residents were interviewed regarding medication administration. Maintenance and

housekeeping staff were interviewed regarding pest control and cleaning schedules. Staff members were interviewed regarding assistance provided to residents with activities of daily living and personal care. Staff was interviewed regarding medication being administered following physician orders and notifying the physician of any adverse effects of medications.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Leah Mays Digitally signed by Leah Mays
Date: 2023.06.08 01:31:54
-05'00'

Leah Mays, Clinical Health Facility Surveyor

Date report completed: 06/02/2023

INVESTIGATIVE REPORT

Facility: Glade Avenue Assisted Living
Address: 2500 North Glade Avenue
City, State, Zip: Oklahoma City, OK, 73008
Provider #: AL5511
Complaint #: OK00058909
Investigation Dates: 05/30/23, 05/31/23, and 06/01/23

ALLEGATIONS

1. The center failed to follow the physician's orders for medication administration

An unannounced on-site investigation was initiated 05/30/2023 at 10:15 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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 process. Residents were observed in their rooms, while participating in activities, and during mealtimes. Staff were observed answering call lights, during medication administration, and when assisting residents with meals and personal care.

Sampled clinical records were reviewed for assessments, physician orders, pharmacist medication reviews, medication administration records, care plans, progress notes, and incident reports. Grievance logs, resident council meeting minutes, and in-services were reviewed. Facility policies and procedures were reviewed.

Numerous residents, including sampled residents, were interviewed regarding medications administered as ordered by the physician. Staff members were interviewed regarding the process for medication administration and reporting medication errors.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Leah Mays Digitally signed by Leah Mays
Date: 2023.06.08 01:27:44
-05'00'

Leah Mays, Clinical Health Facility Surveyor

Date report completed: 06/02/2023

INVESTIGATIVE REPORT

Facility: Glade Avenue Assisted Living
Address: 2500 North Glade Avenue
City, State, Zip: Bethany, OK 73008
Provider #: AL5511
Complaint #: OK00060709
Investigation Date(s): 05/30/23 through 06/01/23

ALLEGATION(S)

- | |
|---|
| 1. The facility failed to ensure A) medications are administered according to physicians' orders and failed to ensure B) residents do not take unnecessary medications. |
| 2. The facility failed to ensure A) residents' representatives are notified of a new medication order and failed to ensure B) residents are treated with dignity and respect. |

An unannounced on-site investigation was initiated 05/30/2023 at 10:15 a.m.

A sample of three 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 was conducted upon entrance and at other various times throughout the survey. Resident halls were observed for a clean, sanitary, and homelike environment free of pests. A medication pass was observed to include medication reconciliation with several residents. Housekeeping was observed cleaning resident rooms.

Resident records were reviewed including the service agreements, closed records, assessments, physician's orders, care plans, and medication administration records. Resident records were reviewed for designated POA's. The center's incident reports were reviewed, pest control records, grievance reports, medication error reports and staff in servicing related to medication error reports. Medication administration policies and procedures were reviewed.

Residents were interviewed regarding medications, smoking, pest control, staffing, and abuse and neglect. Residents were interviewed related to care related issues and concerns.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Julie Edmiaston

Digitally signed by Julie
Edmiaston
Date: 2023.06.05 08:19:08 -05'00'

Julie Edmiaston RN, BSN

Date report completed: 06/02/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/01/2023
NAME OF PROVIDER OR SUPPLIER GLADE AVENUE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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
D 000	INITIAL COMMENTS A relicensure survey was conducted from 05/30/23 through 06/01/23. Complaint investigations (#OK00058628, OK00060709, and #OK00058909) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: B/P- Blood Pressure CNA- Certified Nurse Aide DBP- Diastolic Blood Pressure DON- Director of Nurses eMAR- Electronic Medication Administration Record ER- Emergency room fr- French size hrs- ours HTN- High Blood Pressure LPN- Licensed Practical Nurse MAR- Medication Administration Record MD- Doctor of Medicine mg- milligrams ml- milliliters mm/HG- millimeters of mercury PO- by mouth POA- Power of Attorney PRN- as needed Q- Every RN- Registered Nurse SBP- Systolic Blood Pressure tab- tablet	D 000		
D 653 SS=D	317:30-5-763(D)(viii)(III) INCIDENT REPORTING (III) Reports of incidents must be made to the member's ADvantage Case Manager via facsimile or by telephone within one business day of the reportable incident's discovery. A follow-up	D 653		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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D 653	Continued From page 1 report of the incident must be submitted via facsimile or mail to the member's ADvantage Case Manager within five business days after the incident. The final report must be filed with the member's ADvantage Case Manager and to the ADvantage Administration when the full investigation is complete not to exceed ten business days after the incident. This Rule is not met as evidenced by: Based on record review and interview, the center failed to report an abuse allegation within one Department business day of the discovery for three (#7, 9, and #11) of three sampled residents reviewed for allegations of abuse/mistreatment. The "Assisted Living Resident Condition and Care Overview," dated 05/30/23, documented 57 residents resided in the center. Findings: The "Elder Abuse, Neglect, and Exploitation" policy, dated 12/12/2022, read in parts, "...The Administrator of the assisted living center who becomes aware of abuse or neglect of a resident or misappropriation of a resident's property shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department. (310:663-19-4) ...Reporting of any suspected, alleged, or witnessed abuse, neglect, or exploitation will be completed according to state reporting requirements..." An "Incident Report Form" dated 05/26/2023, read in part, "...Allegations of Abuse/Mistreatment...The residents in question have all reported that staff member...was verbally abusive to them at different occasions. It has	D 653		

Oklahoma State Department of Health

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D 653	Continued From page 2 been reported that...has yelled at them, made them feel like administering their medications was extremely inconvenient...gets angry/frustrated when discussing their preferred methods of care, and has slammed their doors when exiting the room. Upon being notified of these allegations on 05/22/23, [CNA #4] was suspended pending further investigation...Please include relevant history... [Resident #7, 9, and #11] alert, oriented, times three (person, place, and time)..." The allegation of abuse/mistreatment was made to the center on 05/22/23. A "Fax Cover Sheet," dated 05/26/23, read in parts, "...Initial report...Incident date 05/26/2023, Incident Type Allegations of Abuse/Mistreatment..." The allegation of abuse/mistreatment was reported to the Department on 05/26/23, four days later. A "Notification of Nurse Aide/Nontechnical Service Worker Abuse, Neglect, Mistreatment or Misappropriation of Property," dated 05/26/23, read in parts, "...Was employee suspended? Yes...If yes, enter employee suspension date. 05/23/2023...Was employee terminated? Yes...If yes, enter employee termination date. 05/26/23..." On 05/31/23 at 3:20 p.m., the Executive Director was asked when was the allegation of abuse reported. They stated Tuesday the 23rd of May. They were asked why the allegation was dated 05/26/23. They stated after it was reported they started the investigation and after we concluded everything, we turned it in. They were asked when CNA #4 was suspended. They stated on May 23, 2023.	D 653		

Oklahoma State Department of Health

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C 000	Continued From page 3	C 000		
C 000	INITIAL COMMENTS A relicensure survey was conducted from 05/30/23 through 06/01/23. A complaint investigation (#OK00058628, OK00060709 and #OK00058909) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: B/P- Blood Pressure CNA- Certified Nurse Aide DBP- Diastolic Blood Pressure DON/LPN- Director of Nurses/Licensed Practical Nurse eMAR- Electronic Medication Administration Record hrs- hours HTN- High Blood Pressure MAR- Medication Administration Record MD- Doctor of Medicine mm/HG- millimeters of mercury mg- milligrams PO- by mouth POA- Power of Attorney SBP- Systolic Blood Pressure tab- tablet Q- Every	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 4 (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for one (#5) of ten sampled residents. The "Assisted Living Resident Condition and Care Overview" report, dated 05/30/23, documented 57 residents resided in the facility. Findings: The facility's "Pre-Admission Appraisal" policy, dated 10/01/18, read in part, "...Oklahoma regulations stipulate the information to be obtained on the Comprehensive Assessment...A Comprehensive assessment must be completed within 14 days after admission, once every 12 months and promptly after a significant change in the resident's condition ..." Resident #5 was admitted on 03/04/22 with diagnoses of high functioning intellectual disability, diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. A comprehensive "Resident Assessment" form, dated 03/04/22, documented the resident was alert/oriented x 3 and required no assistance with activities of daily living. Resident #5's clinical record did not document a comprehensive assessment had been completed 12 months after the last comprehensive	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 5 assessment. On 06/01/23 at 9:00 a.m., the director of health and wellness was asked if Resident #5's comprehensive assessment was past due. The director of health and wellness reported "Yes, the resident should have had an annual comprehensive assessment done 03/04/23, but it had not yet been completed."	C 522		
C 541 SS=D	310:663-5-4(a) CONDUCT OF ASSESSMENT (a) The assessments shall be completed by appropriate participation of health professionals trained in the assessment process. This Rule is not met as evidenced by: Based on record review and interview, the center failed to complete an assessment by a trained health professional for one (#8) of ten sampled residents reviewed for assessments. The "Assisted Living Resident Condition and Care Overview" dated 05/30/23, documented 57 residents resided in the center. Findings: The "Resident Pre-Admission Appraisal" policy, dated 10/2018, read in parts, "...Oklahoma...All assessments must be coordinated and signed by a registered nurse or the resident's health care provider..." The "Resident Assessment Form," dated 11/11/22, read in parts, "...Annual Assessment...chronic pain, overactive bladder,	C 541		

Oklahoma State Department of Health

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C 541	Continued From page 6 idiopathic intracranial HTN..."	C 541		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to coordinate the assessment with the RN and/or physician for one (#8) of ten residents sampled for comprehensive assessments. The "Assisted Living Resident Condition and Care Overview" dated 05/30/23, documented 57 residents resided in the center. Findings: The "Resident Pre-Admission Appraisal" policy, dated 10/2018, read in parts, "...*Oklahoma: Regulations stipulate the information to be obtained on the Comprehensive Assessment. All assessments must be coordinated and signed by a registered nurse or the resident's personal Health Care Provider..." The "Resident Assessment Form," dated 11/11/22, read in parts, "...Annual Assessment...chronic pain, overactive bladder,	C 542		

Oklahoma State Department of Health

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C 542	Continued From page 7 idiopathic intracranial HTN..."	C 542		
C 543 SS=D	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 record review and interview, the center failed to ensure a personal interview was completed for one (#8) of ten sampled residents reviewed for comprehensive assessments. The "Assisted Living Resident Condition and Care Overview," dated 05/30/23, documented 57 residents resided in the center. Findings: The "Resident Pre-Admission Appraisal" policy, dated 10/2018, read in parts, "...The Director of Health and Wellness begins the pre-placement meeting with proper introductions and explanations to promote trust, comfort, and honesty...Explain the purpose of the appraisal is	C 543		

Oklahoma State Department of Health

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C 543	Continued From page 8 to determine the level and type of services that will be available for the resident at the time of move-in, as well as to meet state licensing requirements..." Resident #8's "Resident Assessment Form" dated 11/11/22, read in parts, "...Annual Assessment...chronic pain, overactive bladder, idiopathic intracranial HTN..." On 05/31/23 at 10:40 a.m., the DON/LPN was asked if the assessment included a personal interview with the resident. They reported it was not signed by the resident and we just need to do a new assessment.	C 543		
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. Every resident shall have the right to refuse	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5511	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/01/2023
NAME OF PROVIDER OR SUPPLIER GLADE AVENUE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 9 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 record review and interview, the center failed to: a) follow physician's order to report high blood pressure readings greater than 140/90 mm/Hg for one (#6) of one sampled resident reviewed with blood pressure parameters and, b) failed to notify a resident's representative for a new medication prescribed for one (#6) of one sampled resident with a new medication. The "Assisted Living Resident Condition and Care Overview," dated 05/30/23, documented 57 residents resided in the center with medication assistance. Findings: The "Medication Administration" policy, dated 2/2019, read in parts, "... The Community staff will comply with resident's healthcare practitioner	C1505		

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C1505	Continued From page 10 orders, state laws and regulations may be applicable...Medication administration or assistance is documented on the Medication Administration Record/Electronic Medication Administration record and maintained as part of the resident medical record..." 1. Resident #6 diagnoses include peripheral artery disease, hypertension, and hyperlipidemia. Resident #6's "Plan of Care" dated 10/24/22, read in parts, "...Medication...Requires complete supervision and administration of all medication...The staff at Glade Ave Assisted Living will administer all medication as ordered by physician..." Resident #6's "Physician's Order" dated May 5, 2023, read in parts, "... Amlodipine tab 10 mg (Norvasc) take 1 tablet by mouth daily-Hold if SBP <100, DBP<70 and notify MD if B/P >140" /90 for HTN...." Resident #6's "MAR" dated May 2023, read in parts, documented the following blood pressures: a. 05/14/23-179/84, b. 05/16/23-147/73, c. 05/17/23-143/87, d. 05/18/23-173/100, e. 05/21/23-151/73, f. 05/22/23-145/69, g. 05/23/23-200/103, h. 05/26/23-146/87, i. 05/27/23-173/81 and, j. 05/28/23-143/85. On 05/31/23 at 12:06 p.m., the DON/LPN was asked how many times Resident #6 had a blood pressure reading over 140/90 in May 2023. They	C1505		

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C1505	Continued From page 11 stated ten times the systolic blood pressure was over 140 and twice the diastolic was over 90. The DON was asked to submit documentation of physician notification. They verified with another staff member and reported there was no place in the eMAR to document the physician was notified, so that had not been done. The DON was asked about the B/P reading of 200/103 and would they expect it to be repeated. They stated, "I would expect it to be brought to my attention." They were asked if they had been notified. They reported they were probably notified. They reported they could not guarantee the blood pressure readings were reported to the physician because they did not have a record of them. The DON was asked about the center's blood pressure policy. They stated they would follow the physician's orders. 2. Resident #6's "Progress Note," dated 05/16/23, read in parts, "...Today the patient is seen for a routine visit, she presents with anxiety, and insomnia. The staff reports that she's been anxious and in talking with her she reports a falling out with [family member] which is all that she can think about, literally, she is persevering [when someone "gets stuck" on a topic or an idea] the entire 15 minutes we talk...Physical Exam...Thin body habitus. Very disheveled appearing. This lady looks very uncomfortable at the moment, with increased heart rate, increased respiratory rate, and pressured speech... Diagnosis, Assessment and Plan...Depression Ativan .25 mg every 8 hours to get things under control emotionally speaking...Document reviewed, approved, and e-signed by [Name Deleted-Physician] ..." Resident #6's "Verbal Order Form," dated 05/17/23, read in parts, "...Ativan 0.25 mg PO	C1505		

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C1505	Continued From page 12 Q8hr routine Anxiety... Nurse Taking Order: DON/LPN...Physician's signature...Date 05/17/23..." Resident #6's "MAR," dated May, 2023, read in parts, "...Lorazepam (Ativan) tab 0.5 mg take 1/2 tab (0.25 mg) by mouth every 8 hours..." The MAR documented Resident #6 received Ativan as physician ordered from May 18, 2023 through May 25, 2023 until it was placed on hold per resident representative's request on May 25, 2023. On 05/31/23 at 12:06 p.m., the DON/LPN was asked if they notified Resident #6's POA when they received a new medication (Ativan) on 05/18/23. They reported they did not notify Resident's 6's representative. The DON/LPN was asked if it was the center's policy to notify a resident's POA when starting a new medication. They stated, "We normally contact them on everything." They were asked if it was the center's policy. They stated that was the policy.	C1505		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1)	C1911		

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C1911	Continued From page 13 Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the center failed to report an abuse allegation within one Department business day of the discovery for three (#7, 9, and #11) of three sampled residents reviewed for allegations of abuse/mistreatment. The "Assisted Living Resident Condition and Care Overview," dated 05/30/23, documented 57 residents resided in the center. Findings: The "Elder Abuse, Neglect, and Exploitation" policy, dated 12/12/2022, read in parts, "...The Administrator of the assisted living center who becomes aware of abuse or neglect of a resident or misappropriation of a resident's property shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department. (310:663-19-4) ...Reporting of any suspected, alleged, or witnessed abuse,	C1911		

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C1911	Continued From page 14 neglect, or exploitation will be completed according to state reporting requirements..." An "Incident Report Form" dated 05/26/2023, read in parts, "...Allegations of Abuse/Mistreatment...The residents in question have all reported that staff member...was verbally abusive to them at different occasions. It has been reported that...has yelled at them, made them feel like administering their medications was extremely inconvenient...gets angry/frustrated when discussing their preferred methods of care, and has slammed their doors when exiting the room. Upon being notified of these allegations on 05/22/23, [CNA #4] was suspended pending further investigation...Please include relevant history... [Resident #7, 9, and #11] alert, oriented, times three (person, place, and time) ..." The allegation of abuse/mistreatment was made to the center on 05/22/23. A "Fax Cover Sheet," dated 05/26/23, read in parts, "...Initial report...Incident date 05/26/2023, Incident Type Allegations of Abuse/Mistreatment..." The allegation of abuse/mistreatment was reported four days later to the Department on 05/26/23. A "Notification of Nurse Aide/Nontechnical Service Worker Abuse, Neglect, Mistreatment or Misappropriation of Property," dated 05/26/23, read in parts, "...Was employee suspended? Yes...If yes, enter employee suspension date. 05/23/2023...Was employee terminated? Yes...If yes, enter employee termination date. 05/26/23..." On 05/31/23 at 3:20 p.m., the Executive Director was asked when was the allegation of abuse reported. They stated Tuesday the 23rd of May.	C1911		

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C1911	Continued From page 15 They were asked why the allegation was dated 05/26/23. They stated after it was reported they started the investigation and after we concluded everything, we turned it in. They were asked when CNA #4 was suspended. They stated on May 23, 2023.	C1911		
C1951 SS=D	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to maintain organized and accurate records related to medication administration being available for review for one (#1) of 10 sampled residents reviewed for medications being administered per physician orders. The "Assisted Living Resident Condition and Care Overview" form, dated 05/30/23, documented 57 residents resided in the facility. Findings: The facility's "Medication Administration" policy, dated 02/01/19, read in part, "...Medication administration or assistance is documented on the Medication Administration Record (MAR)/Electronic Medication Administration Record (eMAR) and maintained as part of the resident medical record..."	C1951		

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C1951	Continued From page 16 The facility's "Preservation and Thinning of Records" policy dated 03/15/22, read in part, "The resident record is retained in a manner that maintains accessibility, confidentiality, and safety of the record ...For current residents, the thinned sections must be labeled, filed and available on site in the Community ..." Resident #1 was admitted to the facility on 06/30/17 with diagnoses which included major depressive disorder and Schizophrenia. On 05/31/23 at 9:00 a.m., the Executive Director was asked to provide the MARs for Resident #1 for the timeframe of 07/01/21 through 12/31/22. On 06/01/23 at 11:00 a.m., the Executive Director was asked if they had been able to locate the MARs for 07/01/21 through 12/31/22 for Resident #1. The Executive Director reported no MARs for the requested time frame could be found for Resident #1. The Executive director reported another management company was over the facility before the current management company took over 01/01/23, and medical records were found to be incomplete.	C1951		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the	C5010		

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C5010	Continued From page 17 provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to monitor services and coordinate care provided by home health for one (#3) of seven sampled residents reviewed for home health/hospice services. The "Assisted Living Resident Condition and Care Overview," dated 05/30/23, documented 17 residents received home health services and 8 residents received hospice services. Findings:	C5010		

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C5010	Continued From page 18 The facility's "Third Party Provider" policy, dated 08/27/20, read in part, "...The Executive Director and the Director of Health and Wellness is responsible for the facilitation, coordination and collaboration of care and services by third-party providers...Third-Party providers shall comply with community and resident record documentation requirements ...The service should be provided in accordance with resident's service plan...Third-party providers will: Coordinate with the community regarding resident's service plan and follow community standards and policies in delivery of those services. Provide weekly communication of resident clinical status related to ordered care and services, including documentation in the third-party record. Providers will complete and sign a Coordination of Care form for residents receiving services during their visit..." A "Level of Care Assessment" form for Resident #3, dated 03/16/23, documented foley catheter managed by home health weekly. Resident # 3 was admitted to the facility on 03/28/23 with diagnoses which included benign prostatic hyperplasia. The "Resident Assessment" form, dated 03/28/23, documented special treatments and procedures needs for urinary catheter. A "Physician's Order," dated 03/28/23, documented Sodium Chloride Solution 0.9% Irrigation use with syringe for irrigation daily and PRN to flush catheter for sediment. A "Nurse's Notes," dated 03/28/23, documented arrived at facility this a.m. with a 16 fr with 10 ml balloon urinary catheter.	C5010		

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C5010	Continued From page 19 Resident #3's "Plan of Care," dated 03/28/23, did not document home health services or the resident's foley catheter. A "Glade Avenue Assisted Living Outside Provider Report" sheet, dated 04/08/23, documented a home health aide visit with documented vitals. A "Nurse's Notes," dated 04/10/23, documented resident went to VA with home health service related to blood in catheter and returned with no new orders. A "Nurse's Notes," dated 04/12/23, documented resident complained of catheter being clogged and needing to be flushed. Resident sent to VA ER for procedure. A "Glade Avenue Assisted Living Outside Provider Report" sheet, dated 05/13/23, documented a home health aide visit with documented vitals. The sheet documented a significant change in condition for blood in urine and pain while urinating. A "Glade Avenue Assisted Living Outside Provider Report" sheet, dated 05/29/23, documented supervised shower. On 05/31/23 at 11:24 a.m., Resident #3 was observed signing back into the facility with home health aide. The resident was observed to have a foley catheter in place. On 06/01/23 at 10:30 a.m., the Director of Health and Wellness was asked how care was coordinated with home health/hospice agency. The Director of Health and Wellness reported the home health/hospice staff are supposed to	C5010			

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C5010	Continued From page 20 complete an outside provider form after each of the resident's visits and the service plan from the home health agency should be in the resident's chart. On 06/01/23 at 10:30 a.m., the Director of Health and Wellness was asked to provide the home health care plan of service completed by the home health agency. The Director of Health and Wellness reported it had been requested from the home health service to be faxed over this a.m. On 06/01/23 at 10:45 a.m., Resident #3 reported the home health agency had not flushed the foley catheter weekly as agreed upon and it had been leaking from being clogged with sediment. The resident reported he had to go to the emergency room due to the foley being clogged up with sediment because the home health refused to flush the foley catheter as agreed upon. The resident reported he was looking to switch to another home health agency that would manage his foley catheter. On 06/01/23 at 11:30 a.m., the Director of Health and Wellness was asked when did they become aware that Resident #3's foley was not being flushed as agreed upon in the service plan with home health services. The Director reported being contacted by the facility's nurse that the catheter was leaking. The Director reported he called the home health agency and was told they would not be providing that service to the resident because the Veterans Affairs did not reimburse the agency well enough to send out a licensed nurse to provide skilled nursing services. The Director reported being unaware that the home health agency was not flushing Resident #3's foley catheter until the resident was sent to the ER on 05/13/23.	C5010		

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C5010	Continued From page 21 On 06/01/23 at 12:50 p.m., the Director was asked if the home health's service plan had arrived. The director reported no service plan for Resident #3 had arrived and they were also having trouble getting this agency to complete the communication tool with each visit. The Director reported the resident's son had been contacted about getting a new home health agency that would provide the skilled nursing services for the resident.	C5010		

Delivery via email to: ed@gladeavenueassistedliving.com

July 13, 2023

License Number: AL5511

Nakkita Bowler, Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

RE: Survey Event DIDC11

Dear Ms. Bowler:

On **June 1, 2023**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C0541, C0542, C0543, C1505, C1911, C1951, & C5010:** The correction dates exceed the 60-day implementation date. The facility received the letter to notify them of the survey results on 06/27/23. They have 60 days to implement the plan of correction up to 08/27/23. C-541, C-542, C-543, C-1505, C-1911, C-1951, and C-5010 plan of correction date start on 09/01/23 through 09/08/23.

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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/10/2023

Facility Name: Glade Avenue Assisted Living

License Number: AL5511

Survey Event ID: DIDC11

Date Survey Completed: 6/1/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: D653

Based on: record review and interview, the center failed to report an abuse allegation within one Department business day of the discovery for three sampled residents

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Staff was in-serviced on 6/7/2023, 6/8/2023 and 6/23/2023 on reporting abuse allegations within one business day of discovery.

Current residents residing in the community have the potential to be affected by the deficient practices. To date, no residents have experienced a negative outcome pertaining to the listed findings. Staff training was completed on 6/7/2023, 6/8/2023 and 6/23/2023, to provide education on abuse allegations and reporting within one department business day.

Director of Health and Wellness or designee will train staff on reporting abuse allegations within one department business day.

ED and/ or Director of Health and Wellness will be responsible for sustained compliance.

ED and/ or designee will maintain documentation of completed in-service that were conducted on 6/7/2023, 6/8/2023, and 6/23/2023. In the community in service binder.

Tracking and trending of abuse allegations and reporting will be reported and reviewed during the QA meeting.

Monitoring of records will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.

8/1/2023

Administrator's Signature Nikkita Bowler

Date 7/12/2023

OAC 310:663-25-4(F)			
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: 7/10/2023

Facility Name: Glade Avenue Assisted Living

License Number: AL5511

Survey Event ID: DIDC11

Date Survey Completed: 6/1/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522

Based on: record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

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.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Nikkita Bowler

OAC 310:663-25-4(F)

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Licensed nursing staff will be in-serviced on 7/14/2023 on completion of comprehensive assessments completed annually, change of condition, and admission

Current residents in the community have the potential to be affected by deficient practices. To date, no residents have experienced a negative outcome to the listed finding. Licensed staff training will be completed on 7/14/2023, to provide education of completion of comprehensive assessment will be completed every 12 months.

Director of Health and Wellness or designee will train licensed staff on the completion of comprehensive assessments every 12 months.

ED and/ or Director of Health and Wellness will be responsible for sustained compliance.

ED and/ or designee will maintain documentation of completed in-service held on 7/14/2023 in the community in-service binder.

Tracking and Trending of comprehensive assessments will be reported and reviewed during the QA meeting.

Monitoring of records will be attached to the QA meeting and maintained by Executive Director to ensure compliance.

7/1/2023

Date 7/12/2023

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.
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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: 7/10/2023	
	Facility Name: Glade Avenue Assisted Living	
	License Number: AL5511	
	Survey Event ID: DIDC11	
Date Survey Completed: 6/1/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C541	Based on: record review and interview the center failed to complete an assessment by a trained health professional.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Responses to cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.		
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?		Licensed nursing staff will be in-serviced on 7/14/2023 on completion of comprehensive assessments are completed annually, change of condition and admission
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 in the community have the potential to be affected by deficient practices. To date, no residents have experienced a negative outcome to the listed finding. Licensed staff training will be completed on 7/14/2023, to provide education on the completion of comprehensive assessment will be completed every 12 months by a trained health professional.
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?		Director of Health and Wellness or designee will train licensed staff on the completion of comprehensive assessments by a trained health professional.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		ED and/ or Director of Health and Wellness will be responsible for sustained compliance.
a. How the correction will be evaluated for effectiveness;		ED and/ or designee will maintain documentation of completed in-service held on 7/14/2023 in the community in-service binder.
b. How the correction will be incorporated into the center's quality assurance system; and		Tracking and trending of comprehensive assessments will be reported and reviewed during the QA meeting.
c. How monitoring records will be kept to evidence the correction.		Monitoring of records will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		9/8/2023
OSDH Response: Element accepted Yes ☐ No ☐		

Administrator's Signature Nikkita Bowler 		Date 7/12/2023	
OAC 310:663-25-4(F)			
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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: Glade Avenue Assisted Living

License Number: AL5511

Survey Event ID: DIDC11

Date Survey Completed: 6/1/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C542

Based on: record review and interview the center failed to coordinate the assessment with the RN/ and or Physician.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Licensed nursing staff will be in-serviced on 7/14/2023 in the coordination of assessments with RN/ and or Physician

Current residents in the community have the potential to be affected by deficient practices. To date, no residents have experienced a negative outcome to the listed finding. Licensed nursing staff training will be completed on 7/14/2023, to ensure the coordination of assessments with RN/ and or Physician.

Director of Health and Wellness or designee will train licensed nursing staff on coordination of assessments with RN/ and or Physician.

ED and/ or Director of Health and Wellness will be responsible for sustained compliance.

ED and/ or Director will maintain documentation of completed in-service held on 7/14/2023 in the community in-service binder.

Tracking and trending of assessment coordination will be reported and reviewed during the QA meeting.

Monitoring of records will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.

9/7/2023

Administrator's Signature Nikkita Bowler

OAC 310:663-25-4(F)

Date 7/12/2023

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