OKLAHOMA
State Department
of Health

Delivery via email to: ed@gladeavenueassistedliving.com

January 26, 2024

License Number: AL5511

Ms. Rishell Gresham, Executive Director/Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: 62KJ11

Dear Ms. Gresham:

On **January 5, 2024,** 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 Services**, then **click on Long Term Care**. 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) 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face to face, or a virtual 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.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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 #: **OK0061918**
Investigation Date(s): **01/04/24 and 01/05/24**

ALLEGATIONS

1. The center failed to ensure medications were administered by qualified staff and failed to have and/or implement an effective pharmacy policy to ensure accurate count of medications.
2. The center failed to ensure medications were administered by qualified staff.
3. The center failed to ensure assistance with activities of daily living in a timely manner and according to the contract and the plan of care.
4. The center failed to ensure adequate staff was provided to meet the needs of the residents.
5. The center failed to ensure a clean, sanitary, and homelike environment.

An unannounced on-site investigation was initiated 05/04/2023 at 10:35 a.m.

A sample of four 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs and assistance with emergent medical needs.

Facility staffing schedules were reviewed for staffing patterns and compared to the State mandated staffing requirements. Grievance reports and State reportables were reviewed.

Resident records including assessments, care plans, physician orders, nursing notes, medication administration records, and Activities of Daily Living (ADL) sheets reviewed.

Residents were interviewed regarding if they felt their care needs were being met and if they received their medications as ordered. Staff were interviewed regarding facility's policy for administering medications, ensuring a clean, sanitary, and homelike environment and, providing the residents with their care needs.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/22/2024

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 #: **OK0061918**
Investigation Date(s): **01/04/24 and 01/05/24**

ALLEGATIONS

1. The center failed to ensure insulin was administered according to the physician's orders.
2. The center failed to ensure staff were qualified to administer insulin.
3. The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 05/04/2023 at 10:35 a.m.

A sample of four 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs and assistance with emergent medical needs.

Facility staffing schedules were reviewed for staffing patterns and compared to the State mandated staffing requirements. Grievance reports and State reportables were reviewed.

Resident records including assessments, care plans, physician orders, nursing notes, medication administration records, and Activities of Daily Living (ADL) sheets reviewed.

Residents were interviewed regarding if they felt their care needs were being met and if they received their medications as ordered. Staff were interviewed regarding facility's policy for administering medications, ensuring a clean, sanitary, and homelike environment and, providing the residents with their care needs.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/22/2024

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 #: **OK0061918**
Investigation Date(s): **01/04/24 and 01/05/24**

ALLEGATIONS

1. The facility failed to ensure residents received emergency care in a timely manner.
2. The facility failed to ensure adequate staff to provide care for dependent residents.

An unannounced on-site investigation was initiated 05/04/2023 at 10:35 a.m.

A sample of four 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs and assistance with emergent medical needs.

Facility staffing schedules were reviewed for staffing patterns and compared to the State mandated staffing requirements. Grievance reports and State reportables were reviewed.

Resident records including assessments, care plans, physician orders, nursing notes, treatment records, and Activities of Daily Living (ADL) sheets reviewed.

Residents were interviewed regarding if they felt their care needs were being met and if they received timely emergent care. Staff were interviewed regarding facility's policy to ensure adequate staffing and their ability to provide the residents with their care needs.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/22/2024

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 _____	C 01/05/2024

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 complaint investigations (#OK00061571, OK00061699, and OK00061918) was conducted on 01/04/24 and 01/05/24. Facility Census: 69	C 000		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the facility failed to ensure two medication administration aides had a current certification to administer insulin for three (#2, 3, and #5) of four sampled residents reviewed for medication administration. The Executive Director identified 69 residents resided in the facility. The facility identified eight residents received insulin. Findings: A "Medication administration" policy, amended 10-01-17, read in part, "...Each assisted living center shall adopt written procedures to ensure safe administration of medications..."	C 921		

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 _____	C 01/05/2024

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 921	Continued From page 1 CMA #1's advanced medication aide certification expired on 08/31/23. CMA #5's medication administration certification did not document they had been certified in insulin administration. 1. Resident #2 had diagnoses which included other specified diabetes mellitus and type 2 diabetes mellitus with hyperosmolarity. A "Physician's Order", dated 05/01/23, documented, Ozempic 2/1.5 ml, inject 0.5 ml sub-q daily on Saturday. The September 2023 MAR documented, Ozempic 2/1.5 ml was given by CMA #1, three of five opportunities and insulin glargine was given 13 of 60 opportunities. The October 2023 MAR documented, Ozempic 2/1.5 ml was given by CMA #1, three of four opportunities and insulin glargine was given 17 of 62 opportunities. The October 2023 MAR documented, insulin glargine 100u/ml was given by CMA #5, three of 63 opportunities. The November 2023 MAR documented, insulin glargine 100u/ml was given by CMA #1, two of 60 opportunities. The December 2023 MAR documented, insulin glargine 100u/ml was given by CMA #1, eight of ten opportunities. A "Physician's Order", dated 12/11/23, documented, Ozempic 4 mg/3 ml, inject 0.75 ml sub-q weekly.	C 921		

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 _____	C 01/05/2024

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 921	Continued From page 2 A "Physician's Order", dated 12/21/23, documented, insulin glargine 100u/ml, inject 20 units sub-q twice daily. 2. Resident #3 had diagnoses which included chronic kidney disease and Type 2 diabetes mellitus. A "Physician's Order", dated 05/02/23, documented, Lantus 100/ml, inject 30 units sub-q twice daily. A "Physician's Order", dated 05/02/23, documented, Novolin R, inject 5 units sub-q before meals. The September 2023 MAR documented, Lantus 100/ml was given by CMA #1, 15 of 59 opportunities and Novolin R 100/ml was given 16 of 89 opportunities. The October 2023 MAR documented, Lantus 100/ml was given by CMA #1, 16 out of 62 opportunities and Novolin R 100/ml was given 18 of 62 opportunities. The December 2023 MAR documented, Lantus 100/ml was given by CMA #1, 10 of 62 opportunities and Novolin R 100/ml was given 11 of 93 opportunities. 3. Resident #5 had diagnosis which included type 2 diabetes mellitus with hyperglycemia. A "Physician's order, dated 09/01/23, documented, Lantus 100/ml, inject 15 units sub-q every morning. A "Physician's order, dated 09/01/23,	C 921		

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 _____	C 01/05/2024

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 921	Continued From page 3 documented, Lantus 100/ml, inject 1 units sub-q every evening. The September 2023 MAR documented, Lantus 100/ml was given by CMA #1, four of 39 opportunities in the morning and ten of 30 opportunities in the evening. The October 2023 MAR documented, Lantus 100/ml was given by CMA #1, six of 62 opportunities in the morning and 11 of 62 opportunities in the evening. The October 2023 MAR documented, Lantus 100/ml was given by CMA #5, one of 62 opportunities in the morning and two of 62 opportunities in the evening. The November 2023 MAR documented, Lantus 100/ml was given by CMA #1, two of 60 opportunities in the evening. The December 2023 MAR documented, Lantus 100/ml was given by CMA #1, three of 62 opportunities in the morning and seven of 62 opportunities in the evening. On 01/05/23 at 11:36 a.m., the DON stated the policy for insulin administration was the medication aided were to be certified in insulin administration. They stated themselves and the medication aides were allowed to administer insulin. On 01/05/23 at 11:37 a.m., the DON stated CMA #1's certification for insulin administration had expired on 08/31/23 and at the time of insulin administration, CMA #1 was not certified to administer insulin.	C 921		

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 _____	C 01/05/2024

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 921	Continued From page 4 On 01/05/23 at 11:39 a.m., the DON stated CMA #5 was not certified to administer insulin. On 01/05/23 at 11:40 a.m., the DON stated CMA #1 had administered insulin to all three residents and CMA #5 had administered to two of the three residents.	C 921		

OKLAHOMA
State Department
of Health

Delivery via email to: ed@gladeavenueassistedliving.com

February 8, 2024

License Number: AL5511

Ms. Rishell Grisham, Executive Director
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: 62KJ11

Dear Ms. Grisham:

On **January 5, 2024**, agents from our office completed a complaint investigation 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:

- **The Plan of Correction does not state that CMA #5 is not to administer insulin until they have a current certification to do so.**

Please provide an amended plan of correction for these deficiencies and return it as soon as possible.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 2/2/2024

Facility Name: Glade Avenue AL

License Number: AL5511

Survey Event ID: 62KJ11

Date Survey Completed: 1/22/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921	Based on: Record review and Interview, the facility failed to ensure two medication administration aides had a current certification to administer insulin.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

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?	Director of Nursing and Resident Care Coordinator will set up a system that will keep them updated with all staff certifications the month before they become due.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	CMA #1 certification has been updated and CMA #5 has since been enrolled in an Insulin certification class to receive her insulin certification.
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 Nursing has updated all certifications due in the Tickler, staff will be notified a month before the due date.
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.	ED and /or the Director of Nursing will be responsible for sustained compliance. ED and/or DON and RCC will implement the Tickler to ensure all staff certifications are up to date. Tickler will be brought to QA meetings for review. All staff certifications will be kept in a binder and reviewed weekly aside from the tickler.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/2/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Rishell Gresham** **Date 2/2/2024**

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

Delivery via email to: alex.baggs@milestoneretirement.com; ed@gladeavenueassistedliving.com

February 22, 2024

License Number: AL5511

Mr. Alex Baggs, Administrator
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: 62KJ11

Dear Mr. Baggs:

On **January 5, 2024,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **February 2, 2024**.

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 2/2/2024

Facility Name: Glade Avenue AL

License Number: AL5511

Survey Event ID: 62KJ11

Date Survey Completed: 1/22/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921	Based on: Record review and Interview, the facility failed to ensure two medication administration aides had a current certification to administer insulin.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

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?	Director of Nursing and Resident Care Coordinator will set up a system that will keep them updated with all staff certifications the month before they become due.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	CMA #1 certification has been updated and CMA #5 has since been enrolled in an Insulin certification class to receive her insulin certification. CMA #5 will not be administering insulin until certified to do so.
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 Nursing has updated all certifications due in the Tickler, staff will be notified a month before the due date.
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.	ED and /or the Director of Nursing will be responsible for sustained compliance. ED and/or DON and RCC will implement the Tickler to ensure all staff certifications are up to date. Tickler will be brought to QA meetings for review. All staff certifications will be kept in a binder and reviewed weekly aside from the tickler.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/2/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Rishell Gresham** OAC 310:663-25-4(F)	**Date 2/2/2024**

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	2/8/2024	**Submitted by**	Rishell Gresham

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.