OKLAHOMA
State Department
of Health

Delivery via email to: ed@gladeavenueassistedliving.com

July 5, 2024

License Number: AL5511

Rishell Gresham (Palmer), Executive Director
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: 4D8Q11

Dear Rishell Gresham:

On **June 27, 2024,** representatives from the Oklahoma State Department of Health (OSDH) concluded a Relicensure survey with a complaint investigation 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: IDRCoordinator@health.ok.gov

or mail 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,

Tempal Killman

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

Enclosure

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 06/27/2024

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 relicensure survey was conducted from 06/26/24 through 06/27/24. A complaint investigation (#OK00065391) was conducted in conjunction with the survey. Facility Census: 54 The following is a list of abbrevations that will be used throughput this document CNA - certified nurse aide DON - director of nursing res - resident	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure foods were cooked to appropriate temperatures. The Executive Director identified 54 residents resided in the center. Findings: On 06/26/24 at 12:22 p.m., Cook #1 was preparing plates for lunch. There was no temperature log to indicate the temperature of the food being served. On 06/26/24 at 12:23 p.m., Cook #1 stated the	C 391		

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C 391	Continued From page 1 thermometer is broken so they have not been able to check the temperatures of food. On 06/26/24 at 12:45 p.m., the Executive Director stated the temperature should always be checked before serving the food.	C 391		
C 522 SS=E	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 (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 assessments were completed in a timely manner for three (#3, #7, and #8) of 10 resident records reviewed for timeliness of assessments. The Executive Director identified 54 residents resided in the facility. Findings: Res #3 Res #3 was admitted on 06/19/24. The comprehensive assessment had no date to	C 522		

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C 522	Continued From page 2 indicate when it completed, the assessment type was also left unmarked. Res #7 Res #7 was admitted on 06/13/23. No admission assessment was able to be located. No comprehensive assessment within 14 days of admission was able to be located. There was an annual assessment dated 10/21/23. Res #8 Res #8 admitted on 01/31/24. Res #8 had an admission assessment with no date and no signatures to indicate who completed the assessment or when. On 06/27/24 at 12:30 p.m., the DON stated assessments were to be completed the day they come in and then repeated in 30 days. They stated they are also to be completed annually or when a significant change in status occurs. They stated the computer system keeps up with when the assessments are due. They stated they were unable to locate the missing assessments or tell me when the assessments without dates were completed.	C 522		
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:	C 542		

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C 542	Continued From page 3 Based on record review and interview, the center failed to ensure assessments were coordinated and signed by a registered nurse or physician for two (#4, and #8) of 10 resident records reviewed for coordination of assessments. The Executive Director identified 54 residents resided in the facility. Findings: Res #4 Res #4 was admitted on 01/04/24. The preadmission assessment was completed on 12/19/23, but had no registered nurse or physician signature indicating coordination of care. Res #8 Res #8 admitted on 01/31/24. Res #8 had an admission assessment with no date and no registered nurse or physician signatures to indicate who completed or coordinated the assessment, or when. On 06/27/24 at 12:30 p.m., the DON stated the assessments for residents #4 and #8 did not have signatures of a registered nurse or physician for coordination of care, but they should have.	C 542		
C 711 SS=E	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317	C 711		

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C 711	Continued From page 4 through 324.21.	C 711		

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the center failed to ensure a safe and homelike environment for the residents.

The Executive Director identified 54 residents resided in the center. The room roster identified 29 residents resided on halls 300 and 400.

Findings:

A Service Inspection report, dated 02/05/24, documented that there were holes in the soffit screens allowing raccoons to enter the attic and that the center needed to use reinforced metal vent screens to prevent further reentry.

On 06/26/24 at 1:30 p.m., hall 300's ceiling was observed to have sheets of paint separated from the drywall in 3 separate spots down the hallway. There were yellow rings on the drywall and paint. One of the three areas had the drywall sagging with a crack in it. The hallway carpet was noted to have dark gray and black stains on them as well.

On 06/26/24 at 1:43 p.m., hall 400's ceiling was

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C 711	Continued From page 5 observed to have sheets of paint torn away from the drywall in 1 place with yellow rings on the drywall and the hallway carpet had gray and black stains throughout. On 06/26/24 at 2:20 the Executive Director stated there had been some flooding, but the new management company did not want them to use contractors and they have a new maintenance director that is supposed to be doing the work. They stated the roof had many patches, but they needed a new roof. The Executive Director stated that raccoons have come into the building and destroyed the activities room. They stated the maintenance director had cut back some tree limbs and put some metal flashing up over the hole identified as where the raccoons were getting in. On 06/26/24 at 2:28 p.m., the outside of the building to the right of the front door was observed to have metal flashing on the left corner of one of the dormers. One of the soffit vents had the metal net hanging down and one soffit vent had no metal necovering the opening. On 06/26/24 at 2:33 p.m., the activities room was observed with the metal ceiling grid all bent and no ceiling tiles in place. The rafters and air conditioning ducts were all exposed. There was insulation and debris all over the floor. This room was no longer being accessed by residents. On 06/26/24 at 2:37 the Maintenance Supervisor stated the raccoons were too heavy and made the ceiling grid fall. The plan was to put up new joists and drywall. They stated they expected the work to take 2 weeks. They stated another maintenance person was coming to help next week. They stated they had attached	C 711		

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C 711	Continued From page 6 condensation pans above the areas on hall 300 and 400 that had leaks and just needed to mud the areas. They stated the sagging area just needed a few screws to secure the drywall. On 06/27/24 ACMA #1 stated the ceiling has leaked since they started working here in September of 2023, and that is what the stains on the carpet are from.	C 711		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure staff were trained in first aid and cardiopulmonary resuscitation for two of six staff reviewed for first aid and cardiopulmonary resuscitation training. The Executive Director identified there were 54 residents residing in the facility. Findings: CNA #1 was hired on 05/22/24. There was no documentation of completed training for CPR or first aid in the employee file.	C 954		

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C 954	Continued From page 7 CNA #2 was hired on 04/17/24. There was no documentation of completed training for CPR or first aid in the employee file. On 06/27/24 at 1:48 p.m., the Executive Director stated the training should have been completed, but they were unable to locate the records of completion.	C 954		

OKLAHOMA
State Department of Health

Delivery via email to: Skye@gladeavenueassistedliving.com

August 14, 2024

License Number: **AL5511**

Ms. Skye Statum, Executive Director
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

Survey Event ID: 4D8Q11

Dear Ms. Statum:

On **June 27, 2024,** a Relicensure survey with a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **October 8, 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: 8/8/2024** **Facility Name:** Glade Avenue Assisted Living **License Number:** AL5512 **Survey Event ID:** 4DBQ11 **Date Survey Completed: 6/27/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: Observation, record review, and interview center failed to ensure foods were cooked to appropriate temperatures.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and plan of correction is NOT legal admission that a deficiency exists or, that this statement of deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or plan of correction. In addition, the preparation and submission of this plan of correction does NOT constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Facility will purchase new food thermometers and have 2 back-up thermometers for emergency use. Staff will be in-serviced on how to properly use thermometers and how to document on temperature logs. Food Director will be trained on regulations Chapter 257. Food Director will submit a bi-weekly audit to the Executive Director of the temperature logs that will then be added to the QA monthly minutes. The Executive Director will perform monthly audits of kitchen to monitor the use of thermometers and temperature logs. These audits will be added to the monthly QA minutes.
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 residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding. Staff training will be completed and ongoing training schedule will be developed and impleneted by Food Director and or Executive Director.
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?	A. Food Director will provide training to staff on a monthly or as-needed basis. B. The facility will have quarterly visits made by a dietician and a report in writing will be made to the Food Director and or Executive Director. C. Any supplies and or concerns will be addressed by the Food Director or any other designee staff from this department in the monthly QA minutes. D. The Food Director will monitor staff completing temperature logs on an ongoing basis.

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 Food Director will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-services in the community in-service binder. Bi-weekly and monthly audits conducted by Food Director and Executive Director and reviewed during the QA meeting. Montoring 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?	10/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye Statum** OAC 310:663-25-4(F)	**Date 8/8/2024**

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	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: 8/8/2024** **Facility Name:** Glade Assisted Living **License Number:** AL5511 **Survey Event ID:** 4DBQ11 **Date Survey Completed: 6/27/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: Observation, record review, and interview center failed to complete comprehensive assessment in accordance with the following regulations.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and plan of correction is NOT legal admission that a deficiency exists or, that this statement of deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or plan of correction. In addition, the preparation and submission of this plan of correction does NOT constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Executive Director will train the facilities RN(s) on the OSDH regulation 310:663-5-2(b) Assessment Timeframes. Training will be added to the QA monthly minutes. Resident #3,#7, #8 will have a new comprehensive assessment completed by facilities RN. The comprehensive assessments will be reviewed by Executive Director for proper completion based on OSDH regulation 310:663-5-2(b). Facility will create an audit of all residents due dates on assessments and will be added to a spreadsheet. The audit will be reviewed by the Executive Director monthly and added to the QA monthly minutes.
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 residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding. Executive Directtor will train the RN and or new RN's on the timeframes of the assessments based on the OSDH regulation 310:663-5-2(b).
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?	1 Executive Directtor will train the RN and or new RN's on the timeframes of the assessments based on the OSDH regulation 310:663-5-2(b). 2. Facility RN will create and maintain a master spreadsheet of all residents assessments Due Dates. 3. The spreadsheet of the assessments and which residents are due for the month will be reviewed in the monthly QA.

OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	ED and/or Director of Nursing will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits of spreadsheet of assessments due dates will conducted by Executive Director and reviewed during the QA meeting. Montoring of audits 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?	10/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye Statum** OAC 310:663-25-4(F)	**Date 8/8/2024**

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	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: 8/8/2024** **Facility Name:** Glade Assisted Living **License Number:** AL5511 **Survey Event ID:** 4DBQ11 **Date Survey Completed: 6/27/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C542	Based on: Observation, record review, and interview center failed to ensure assessments were conducted and signed by the RN or physician.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and plan of correction is NOT legal admission that a deficiency exists or, that this statement of deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or plan of correction. In addition, the preparation and submission of this plan of correction does NOT constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Executive Director will train the facilities RN(s) on the OSDH regulation 310:663-5-4(b) Conduct of Assessment. Training will be added to the QA monthly minutes. Resident #4, #8 will have a new comprehensive assessment completed and signed by facilities RN. The comprehensive assessments will be reviewed by Executive Director to audt for RN signature. Facility will create an audit to review for RN signature of all residents assessments and will be added to a spreadsheet. The audit will be reviewed by the Executive Director monthly and added to the QA monthly minutes.
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 residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding. Executive Directtor will train the RN and or new RN's on the Conduct of Assessment OSDH regulation 310:663-5-4(b).
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?	1 Executive Directtor will train the RN and or new RN's on the Conduct of assessments based on the OSDH regulation 310:663-5-4(b). 2. Facility RN will create and maintain a master spreadsheet of all residents assessments to ensure the RN signature is on assessment. 3. The spreadsheet of the assessments will be reviewed in the monthly QA.
OSDH Response: Element accepted Yes ☐ No ☐	

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	ED and/or Director of Nursing will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits of spreadsheet of assessments with RN signature will conducted by Executive Director and reviewed during the QA meeting. Montoring of audits 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?	10/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye Statum** OAC 310:663-25-4(F)	**Date 8/8/2024**

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	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: 8/8/2024** **Facility Name:** Glade Assisted Living **License Number:** AL5511 **Survey Event ID:** 4DBQ11 **Date Survey Completed: 6/27/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C711	Based on: Observation, record review, and interview center failed to ensure a safe and homelike environment for the residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and plan of correction is NOT legal admission that a deficiency exists or, that this statement of deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or plan of correction. In addition, the preparation and submission of this plan of correction does NOT constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Facility will hire an outside company that specializes in wildlife to rid the facility of raccoons and to assist in the future if any raccons return. Facility will have maintenance team repair any open areas outside community allowing the raccoons access into the facility. Facility will train staff and administration on how to report any possible evidence of raccoons. Facility will repair ceilings, dry wall, and paint ceilings. Facility will have carpet cleaning schedule and ensure carpets are cleaned on a regular bases.
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 residing in the community have the potential to be affected by the deficient practices. To date, the residents activity area was closed related to the raccoons and activites were relocated into another common area. Activity area will be free from raccoons and celing area replaced. Residents have not experienced a negative outcome pertaining to the temporary change.
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?	1 Executive Director and or Maintenance Director will train the staff and administration on completing a maintenance repair form and trained on reporting any signs of raccoons. 2. Facility will create and maintain a maintemance binder that will be located at the front desk. The maintenance team will review all work order forms daily. 3. Work orders will be reviewed by the ED and added to the monthly QA.
OSDH Response: Element accepted Yes ☐ No ☐	

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	ED and/or Maintenance Director will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits of spreadsheet of direct care staff CPR/FA due dates will be reviewed by Executive Director or designee and reviewed during the QA meeting. Montoring of work orders 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?	10/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye Statum** OAC 310:663-25-4(F)	**Date 8/8/2024**

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	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: 8/8/2024** **Facility Name:** Glade Assisted Living **License Number:** AL5511 **Survey Event ID:** 4DBQ11 **Date Survey Completed: 6/27/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C954	Based on: Observation, record review, and interview center failed to ensure staff were trained on first aid and CPR.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and plan of correction is NOT legal admission that a deficiency exists or, that this statement of deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or plan of correction. In addition, the preparation and submission of this plan of correction does NOT constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of an conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Facility will train CNA #1 and CNA #2 on First Aid and CPR. Facility will perform an audit of all direct care staff First Aid/CPR training. The training due dates will be added to a spreadsheet and any direct care staff that has past due or does not having training will be trained by facility. The audit and spreadsheet will be added to the monthly QA minutes. The audit will be reviewed by the Executive Director monthly and added to the QA monthly minutes.
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 residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding. Facility will train direct care staff on first aid and CPR upon hire. New Direct Care Staff will be added to the spreadsheet and the spreadsheet will be reviewed by the Executive Director monthly.
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?	1 Executive Director will train the Director of Nursing and administration on OSDH regulation on 310:663-9-5(d) Staff Qualifications. 2. Facility will create and maintain a master spreadsheet of all direct care staff CPR/First aid training and due dates. 3. The spreadsheet will be reviewed by the ED and added to the monthly QA.
OSDH Response: Element accepted Yes ☐ No ☐	

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	ED and/or Director of Nursing will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service of the Director of Nursing and administration in the community in-service binder. Monthly audits of spreadsheet of direct care staff CPR/FA due dates will be reviewed by Executive Director or designee and reviewed during the QA meeting. Montoring of audits 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?	10/8/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye Statum** OAC 310:663-25-4(F)	**Date 8/8/2024**

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	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

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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: Skye@gladeavenueassistedliving.com

October 11, 2024

License Number: AL5511

Ms. Skye Statum, Executive Director
Glade Avenue Assisted Living
2500 North Glade Avenue
Bethany, OK 73008

RE: Survey Event 4D8Q12

Dear Ms. Statum:

On **October 9, 2024,** an off-site paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 27, 2024,** have now been corrected effective **October 8, 2024.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5511	A. BUILDING: _____ B. WING _____	R-C 10/09/2024

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 An offsite/paper revisit was conducted on 10/09/24. The facility was in substantial compliance.	{C 000}		

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