OKLAHOMA
State Department
of Health

Delivery via email to: Skye@gladeavenueassistedliving.com

November 20, 2024

License Number: AL5511

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

Survey Event ID: V80X11

Dear Ms. Statum:

On **November 7, 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,

Tempal Killman

Tempal Killman, Enforcement Analyst
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 #: **OK00066272**
Investigation Date(s): **11/06 and 11/07/24**

ALLEGATION
The center failed to maintain the center in safe, working condition to ensure a safe, clean, and homelike environment.

An unannounced on-site investigation was initiated 11/06/2024 at 8:16 a.m.

A sample of five residents, including any identified residents, were selected for the investigation based on the concerns relevant to the allegation.

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 rooms and other areas of the center were observed for the need of maintenance repairs.

Resident records including assessments, service plans, physician orders, and nursing notes were reviewed. Grievance reports were reviewed.

The attached State form, Statement of Deficiencies, 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: 11/18/2024

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 #: **OK00066930**
Investigation Date(s): **11/06 and 11/07/24**

ALLEGATION
The facility failed to ensure residents were free from physical, verbal, and psychosocial abuse.

An unannounced on-site investigation was initiated 11/06/2024 at 8:16 a.m.

A sample of five residents, including any identified residents, were selected for the investigation based on the concerns relevant to the allegation.

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. Residents were observed to be interacting with staff.

Resident records including assessments, service plans, physician orders, and nursing notes were reviewed. Grievance reports were reviewed.

The attached State form, Statement of Deficiencies, 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: 11/18/2024

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 11/07/2024

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 Complaint investigations (#OK00066272 and OK00066930) were conducted on 11/06/24 and 11/07/24. Facility Census: 73 The following is a list of abbreviations that will be used throughout this document. CMA - certified medication aide CNA - certified nursing assistant DON - director of nursing HTN - hypertension RCC - resident care coordinator	C 000		
C 701 SS=D	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to maintain hot water temperatures of at least 115 degrees Fahrenheit for two (#4 and #5) of two sampled residents whose water temperatures were checked.	C 701		

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 11/07/2024

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

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C 701	Continued From page 1 The DON identified 71 residents resided at the center. Findings: An undated faciilty policy titled "Hot Water Temperature Regulation Policy", read in part, "Regular Monitoring and Maintenance: Hot water temperatures will be checked weekly by designated maintenance personnel to ensure compliance...Temperature readings will be recorded and kept on file for at least 6 months." On 11/06/24 at 1:20 p.m., a sink hot water temperature was 102.7 degrees Fahrenheit. A tub hot water temperature was 104.5 degrees Fahrenheit. Resident #4 looked away when asked about the water temperature. On 11/06/24 at 1:21 p.m., the maintenance director stated the water temperatures were not the proper temperature. On 11/06/24 at 1:22 p.m., the maintenance director stated there was no testing of water temperatures since they had started in August. On 11/06/24 at 2:43 p.m., a tub hot water temperature was 110.2 degrees Fahrenheit. Resident #5 stated the water temperature was not warm.	C 701		
C1512 SS=D	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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	C1512		

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 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1512	Continued From page 2 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or	C1512		

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 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1512	Continued From page 3 clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure a resident was free from abuse for one (#1) of one sampled resident reviewed for abuse. The DON identified 71 residents resided in the center. Findings: An undated "Assisted Living Resident Rights" form, read in part, "Every resident shall have the right to receive courteous and respectful care and treatment...Every resident shall be free from mental and physical abuse." Resident #1 was admitted to the center on 12/01/17 with diagnoses which included depression, schizophrenia, dementia, HTN. A resident assessment form, dated 08/20/24, documented the resident was confused and had poor judgement.	C1512		

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	AL5511	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1512	Continued From page 4 An "Initial State Reportable Incident" form, dated 08/30/24, documented a staff member was speaking rudely to Resident #1 and grabbed them by the wrist and drug them. On 11/07/24 at 12:26 p.m. the administrator stated CNA #3 had demonstrated to them by taking both of their wrists and attempting to drag them. The administrator stated CNA #3 told them they were attempting to transfer Resident #1 by their wrist.	C1512		
C1972 SS=D	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure staff were provided abuse training within 90 days of employment for one (CMA #3) of five employee files reviewed. The DON identified 71 residents resided in the center. Findings: CMA #3 had a hire date of 05/02/24. There was	C1972		

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 11/07/2024

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

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C1972	Continued From page 5 no documentation CMA #3 had received abuse training upon hire. On 11/07/24 at 9:46 a.m., the administrator stated they did not think the facility was doing abuse training before they started. On 11/07/24 at 10:55 a.m., the RCC stated CMA #3 did not have abuse training until 08/28/24.	C1972		

OKLAHOMA
State Department of Health

Delivery via email to: Skye@gladeavenueassistedliving.com

December 9, 2024

License Number: AL5511

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

Survey Event ID: V80X11

Dear Ms. Statum:

On **November 7, 2024,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 22, 2025**.

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: 12/5/2024** **Facility Name:** Glade Assisted Living **License Number:** AL5511 NORTH Building **Survey Event ID:** V80X11 **Date Survey Completed: 11/7/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C701 Hot Water-Bathing	Based on: Observation, record review, and interview center failed to maintain hot water temperatures of at least 115 degrees Fahrenheit.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: 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?	1. Administrator will train Maintenance Director on Appendix A General Requirements to ensure maintenance Director understands the water temperatures should be maintained at 115 degrees Fahrenheit. Training will be added to the monthly QA meeting. 2. Maintenance Director will adjust hot water temperatures for resident #4 & #5 to ensure meet Appendix A General Requirements. The Temperatures will be documented and submitted to the Administrator and added to the monthly QA meeting notes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	1. 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. 2. Maintenance Director will train the maintenance team on Appendix A General Requirements. The Training will be reviewed by Administrator and added to the monthly QA meetings. 3. Maintenace team will perform random weekly hot water temperature checks in resdients apartment. Minimal of 5 apartments a week. The checks will be documented, reviewed by Maintenance Director, and water temperatures adjusted as needed to meet Appendix A. 4. The weekly hot water checks will be submitted to the Administrator monthly and reviewed in the monthly QA meetings.

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. Maintenace team will perform random weekly hot water temperature checks in resdients apartment. Minimal of 5 apartments a week. The checks will be documented, reviewed by Maintenance Director, and water temperatures adjusted as needed to meet Appendix A. 2.The weekly hot water checks will be submitted to the Administrator monthly and reviewed in the monthly QA meetings. 3. Efforts and Outcomes will be identified and documented in the QA monthly meetings.
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 will be reviewed by Executive Director and added to the monthly 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?	1/22/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Skye Statum** OAC 310:663-25-4(F)	**Date 12/2/2024**

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	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: 12/5/2024** **Facility Name:** Glade Assisted Living **License Number:** AL5511 NORTH Building **Survey Event ID:** V80X11 **Date Survey Completed: 11/7/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1512 Resident Rights-Abuse/neglect	Based on: Observation, record review, and interview center failed to maintain to ensure a resident was free from abuse.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: 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?	1. Administrator already followed facilities policy and procedures and reported to OSDH, suspened staff, investigated, and terminated the staff member within 5days of the initial report. The incident was already added to the QA monthly notes. Administrator already implemented a new hire orientation that included training on Abuse in Neglect as of August 2024. 2. Administrator will train the Management team on Policy and Procedures concerning allegations of abuse, neglect, and reporting requirements. Training will be added to the monthly QA meetings. 3. New staff will be trained on Abuse, Neglect, and Resident Rights within 90 days of hire and every 6 months. Training will be added in the employee file and in the inservice Binder. 4. Administrator will perform an employee file audit monthly of new hires to enure the Abuse/Neglect/ and Resident rights training has been completed. Findings of Audit will be added to the monthly QA meeting notes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	1. Current residents residing in the community have the potential to be affected by the deficient practices. 2. Administrator and Managers will follow Policy and Procedures on reporting Abuse, Neglect, and any violation of Resident Rights. 3. Facility will terminate any employee that is found to be abusive or neglectful to residents.

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. Residents will be informed of the Grievance Procedures, Reporting Abuse/Neglect and any violation of resident rights and who and how to report such allegations. Training will be held by Administrator or designee. Documentation of training will be added to the monthly QA meetings. 2. New staff will be trained on Abuse, Neglect, and Resident Rights within 90 days of hire and every 6 months. Training will be added in the employee file and in the inservice Binder. 3. Administrator or designee will perform an employee file audit monthly of new hires to enure the Abuse/Neglect/ and Resident rights training has been completed. Findings of Audit will be reviewed by Administrator and added to the monthly QA meeting notes.
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 Managers 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 will be reviewed by Executive Director and added to the monthly 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?	1/22/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Skye Statum OAC 310:663-25-4(F)	**Date 12/5/2024**

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: 12/5/2024** **Facility Name:** Glade Assisted Living **License Number:** AL5511 NORTH Building **Survey Event ID:** V80X11 **Date Survey Completed: 11/7/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1972 POLICIES (Training on Abuse/Neglect within 90 days.	Based on: Observation, record review, and interview center failed to ensure staff were provided abuse training within 90 days of employment.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: 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?	1. Administrator already terminated staff member #3 when the original allegation was investigated in August 2924. 2. Administrator already followed facilities policy and procedures and reported to OSDH, suspened staff, investigated, and terminated the staff member within 5days of the initial report. The incident was already added to the QA monthly notes. Administrator already implemented a new hire orientation that included training on Abuse in Neglect as of August 2024. 3. Administrator will train the Management team on Policy and Procedures concerning allegations of abuse, neglect, and reporting requirements. Training will be added to the monthly QA meetings. 4. New staff will be trained on Abuse, Neglect, and Resident Rights within 90 days of hire and every 6 months. Training will be added in the employee file and in the inservice Binder. 5. Administrator will perform an employee file audit monthly of new hires to enure the Abuse/Neglect/ and Resident rights training has been completed. Findings of Audit will be added to the monthly QA meeting notes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	1. Current residents residing in the community have the potential to be affected by the deficient practices. 2. Administrator and Managers will follow Policy and Procedures on reporting Abuse, Neglect, and any violation of Resident Rights. 3. Facility will terminate any employee that is found to be abusive or neglectful to residents.

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. Residents will be informed of the Grievance Procedures, Reporting Abuse/Neglect and any violation of resident rights and who and how to report such allegations. Training will be held by Administrator or designee. Documentation of training will be added to the monthly QA meetings. 2. New staff will be trained on Abuse, Neglect, and Resident Rights within 90 days of hire and every 6 months. Training will be added in the employee file and in the inservice Binder. 3. Administrator or designee will perform an employee file audit monthly of new hires to enure the Abuse/Neglect/ and Resident rights training has been completed. Findings of Audit will be reviewed by Administrator and added to the monthly QA meeting notes.
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 Managers 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 will be reviewed by Executive Director and added to the monthly 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?	1/22/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Skye Statum OAC 310:663-25-4(F)	**Date 12/5/2024**

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

Delivery via email to: Skye@gladeavenueassistedliving.com

January 23, 2025

License Number: AL5511

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

RE: Survey Event V80X12

Dear Ms. Statum:

On **January 22, 2025,** an off-site paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **November 7, 2024,** have now been corrected effective **January 22, 2025.**

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 01/22/2025

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 01/22/25. 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