



Oklahoma State Department of Health
Creating a State of Health

August 2, 2019

License Number: AL5512

Ms. Regina Herring, Administrator
Glade Avenue South
2480 North Glade Avenue
Bethany, OK 73008

RE: Survey Event ID: 1W3K11

Dear Ms. Herring:

On **June 27, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is

Board of Health

Tom Bates, JD
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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) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sue Davis".

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5512	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/27/2019
NAME OF PROVIDER OR SUPPLIER GLADE AVENUE SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2480 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 re-licensure survey was conducted 06/25/19 and 06/26/19. Additional information pertaining to the survey was provided 06/27/19. Resident census was 25. Deficient practice was cited as follows.	C 000		
C 522 SS=G	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 observation, interview and record review the registered nurse (RN) failed to complete a significant change assessment for 1 (#7) of 8 residents whose mobility had declined and the resident developed multiple areas of skin breakdown, including a boil. Due to an inaccurate assessment, the center did not develop interventions to facilitate wound healing or prevent the development of additional skin breakdown. This failed practice resulted in actual harm, at a pattern. Findings: Resident #7 was admitted 6/30/17 with diagnoses to include dementia, hypertension and blood coagulation disorder. A comprehensive assessment, dated 12/01/18, documented the following: the resident had fair judgement and follows instructions; the resident's	C 522		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 522	Continued From page 1 mobility was fair with a one person assist; the resident would hold staff hands while ambulating, strength was good, gait was fair, had to have one person walking in front of resident because [the resident] walked on balls of feet; resident ambulatory with staff assistance; walked better with staff assistance then with a walker and uses a wheelchair much of the time due to tiredness and weakness; resident transferred, bathed, ate, dressed and toileted with one person assistance; resident incontinent of bladder and at times incontinent of bowel (very rare); resident's ability to communicate is poor and [the resident] did not speak, very happy, smiles; skin condition good; warm, clean, dry and intact; resident has a very dry, right heel somewhat boggy (beginning); skin prep. The last resident assessment, dated 12/01/18, is not accurate and does not reflect the resident's current status. The resident is non-weight bearing due to wound on right foot, the resident has a wound on left hip and several small wounds on coccyx area. The resident has swallow problems and is fed a puree diet. She requires total care for all activities of daily living and is totally incontinent of bowel and bladder. No significant change assessment had been completed. A plan of care was not developed with interventions to facilitate healing of wounds and to prevent the development of additional wounds. The resident's right foot progressed from being "boggy" on 12/01/18 to development of golf ball size wound with eschar and infection with a foul odor. In addition, the resident developed additional wounds. On 6/25/19 at 11:17a.m., the resident was observed in bed, laying on back, head of bed slightly elevated with bilateral heels resting on the	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 2 mattress instead of being floated off the mattress. The resident was not turned or repositioned in bed for over two hours. "Significant change" is defined as a major change in the resident's status that is not self limiting; affects more than one area of the resident's health status; and requires interdisciplinary review and/or revision of the care plan.	C 522			
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505			

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C1505	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the center failed to have physician ordered medications on the medication cart, available for administration, for 2 (#1 and #7) of 8 sampled residents who depended on the centers staff to order and administer their medications. This failed practice had the potential for more than minimal harm, at a pattern. Findings: Resident #1 On 06/25/19 2:00 p.m. during record review, the May and June 2019 physician orders documented itraconazole solution to be given twice daily (BID) for disseminated histoplasmosis. The May 2019 electronic medication administration record (eMAR) documented resident #1 had missed 24 doses of itraconazole and was on order. The June 2019 eMAR documented resident #1 had missed 20 doses of itraconazole and was on order.	C1505		

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C1505	Continued From page 4 On 06/26/19 at 9:20 a.m. employee #1 was asked to retrieve the physician ordered itraconazole from the medication cart. The medication was not available or found on the medication cart. The medication was found in the medication room in the resident's cubby where overflow medication was stored. The medication had been received by the center 05/09/19 and had not been placed on the medication cart for administration. Resident #7 Resident #7 had a physician's order for hydrocodone for pain. The order originated on 12/11/18. The clinical record documented the resident had received prn (as needed) hydrocodone on 3/05/19 for pain, 3/12/19 for foot pain and 4/05/19 for foot pain. The resident also had a physician order for lorazepam, to be administered as needed for bipolar disorder. The lorazepam was ordered 8/29/17. There was no documentation the lorazepam was administered. On 06/25/19 at 9:02 a.m., employee #1 was asked to retrieve the physician ordered hydrocodone (for pain) and the lorazepam (for bipolar) medication from the medication cart. Neither medication was located or found on the medication cart. The resident had foot pain in March and April due to a wound on her right foot. The nonverbal resident was assessed as being calm, happy and smiles but on 6/25/19 at 11:17.m., the resident was observed with a frown/grimace and tears in both eyes. The resident was asked if she was in pain and she did not respond.	C1505		

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C5015	Continued From page 5	C5015		
C5015 SS=G	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident;	C5015		

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5512	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING. _____	(X3) DATE SURVEY COMPLETED 06/27/2019
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C5015	Continued From page 7 Ulcers/Wounds was not included on the plan of care, there were no care plan interventions included on what wound care was ordered, who would be providing the wound care, how often the wounds were to be assessed and how to prevent additional wounds from developing. The care plan also did not identify interventions on how to communicate with the resident who, according to the assessment, "does not speak." The resident had prn pain medication prescribed but there was no indication how staff would communicate with the resident regarding the resident's pain level and need for medication or how the pain would be assessed since the resident did not talk. Even though the resident was identified as a full code, the resident was identified as receiving hospice services, as noted on the assessments dated 12/01/17 and 12/01/18. A nurses note, dated 03/25/19, documented the center had a meeting with hospice regarding the residents wound. It was agreed the best course of action would be for the center to provide wound care to the resident's wounds. At the meeting, hospice staff informed the center they had not been treating the wound for healing, and "no plans were being made to attempt to heal the wound as [the resident] was "a hospice patient." The center had deferred the wound treatments to hospice and did not follow-up with hospice when the wound did not respond to treatment, until 3/25/19. The wound was first documented on 12/01/18 and the center did not take over treatments until 3/25/19, after the wound became larger, had purulent drainage, developed a foul odor and was necrotic. It could not be determined from the clinical record what additional services the resident required, who would provide the services	C5015		

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C5015	<i>Continued From page 8</i> and who would monitor the delivery of those services. The Resident's right foot wound was identified on the resident assessment, dated 12/01/18. The assessment documented the resident's right heel was "somewhat boggy" and the resident had declined in all areas of activities of daily living. On 3/15/19, the physician documented the wound was a "3 cm circular lesion, non-draining hardened with eschar on the surface." On 4/05/19, the physician documented the wound on the residents right heel was the size of a "golf ball, necrotic, foul smelling, with evidence of osteomyelitis." Hospice notes, dated 3/27/19, documented on a "Narrative Statement," the resident had right arm contractures (post stroke), no longer walks independently, developed dysphagia and was fed a puree meal by staff and demonstrated a slight weight loss of 2 pounds in 2 months. Hospice also identified the resident had "pressure ulcers on bilateral heels." (Neither the contracture or "bilateral" heel wounds were identified or documented by the center, only the right heel.) Hospice documented the resident was assessed using a Karnofsky Performance Scale Index and scored 30%. According to the Karnofsky Performance Scale, 30% indicates the resident is "unable to care for self; requires equivalent of institution or hospital care and in summary, the resident is "severely disabled; hospital admission is indicated although death not imminent." The resident's needs exceeded the level of care the facility would provide without a plan of accommodation. The nurses notes document hospice would provide a pillow "to float heels." The resident was	C5015		

Oklahoma State Department of Health

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C5015	Continued From page 9 observed not being turned and repositioned for over two hours and the heels/feet were observed resting on the mattress even though nurses notes document "pillows" were being utilized frequently for positioning. On 6/03/19, a dietary progress note documented the resident had a "stage 4" pressure ulcer. The dietician recommended a multivitamin with minerals, vitamin C 500 mg two times a day, zinc sulfate 50 mg every day and Ensure two times a day. There was no documentation these interventions were implemented by the center. On 06/26/19 at 3:21 p.m. the resident was observed to have a malodorous right heel. The nurse described the dark center as necrotic and measured 3 centimeters (cm) x 2.5 cm; the wound measured 4 cm x 5 cm. There were 12 small, white circular patches surrounding the wound. The white pieces looked like dressing fibers embedded around the edge of the wound and matched the fibers on the dressing. The dressing (mepilex) was supposed to be changed daily. The resident also developed wounds on the sacral area as identified on a nurses note date 3/27/19. The nurse stated the sacrum/coccyx pressure ulcer measured 7 cm x 2.7 cm. The resident also had a left hip boil which staff stated could have formed by the resident not being turned frequently enough. The boil was draining and the physician prescribed an antibiotic. On 4/05/19, the physician documented the resident was end-of-life but the resident's care needs extend beyond hospice services.	C5015		

STATE WORKLOAD REPORT

 Provider/Supplier Number
 AL5512

 Provider/Supplier Name
 GLADE AVENUE SOUTH

Type of Survey (select all that apply)

2				
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 A Complaint Investigation
 B Dumping Investigation
 C Federal Monitoring
 D Follow-up Visit
 M Other

 E Initial Certification
 F Inspection of Care
 G Validation
 H Life Safety Code

 I Recertification
 J Sanctions/Hearing
 K State License
 L CHOW

Extent of Survey (select all that apply)

A				
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 A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. <i>me</i> 34460	06/25/2019	06/27/2019	0.50	0.00	18.50	0.00	3.25	4.75
2. <i>me</i> 41872	06/25/2019	06/27/2019	0.00	0.00	18.00	0.00	4.00	2.00
3. <i>me</i> 42023	06/25/2019	06/27/2019	0.50	0.00	18.75	0.00	1.25	0.00
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours.....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

 AUG 05 2019 *jm*



Oklahoma State Department of Health
Creating a State of Health

August 22, 2019

License Number: AL5512

Ms. Regina Herring, Administrator
Glade Avenue South
2480 North Glade Avenue
Bethany, OK 73008

RE: Survey Event 1W3K11

Dear Ms. Herring:

On June 27, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. 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 **July 15, 2019**.

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) 271-6868.

Sincerely,

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

KS/ DC

Board of Health

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Interim Commissioner of Health

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Edward A Legako, MD (*Vice-President*)
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R Murali Krishna, MD
Ronald D Osterhout
Charles Skillings

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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 8/8/2019	
	Facility Name: Glade Avenue South Assisted Living	
	License Number: 5512	
	Survey Event ID: 1w3k11	
		Date Survey Completed: 6/27/2019
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C522	Based on: Observation, interview and record review the registered nurse (RN) failed to complete a significant change assessment for a resident whose mobility had declined and the resident developed multiple areas of skin breakdown, including a boil.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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?		The Plan of Care and Comprehensive Assessment were immediately updated by the RN to reflect the residents decline in mobility and increased level of care as well as diet and wound care
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Rn will complete Assessment per state regulations and immediately upon significant change. RN will review/compare all assessments routinely. Skin assessments by the RN/LPN will be completed weekly. An in-service was completed on 7/8/2019 by wound care specialist Kari Harman with all direct care staff (CNA, CMA, LPN) to go over Skin observations, repositioning, importance of keeping them clean and dry. Rounds will be supervised Q shift. Repositioning schedule implemented for residents with wounds or at risk.
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?		RN will complete Assessments per state regulations and immediately upon significant change. RN will review/compare all assessments routinely. New wound care assessments implemented for LPN/RN to complete at least weekly for residents with current wounds. This form will have details of wound and healing process. This will be signed off on by RN, LPN, ED, Dietary and HomeHealth or Hospice. Skin assessments by the RN/LPN will be completed weekly. An in-service was completed on 7/8/2019 by wound care specialist Kari Harman with all direct care staff (CNA, CMA, LPN) to go over Skin observations, repositioning, importance of keeping them clean and dry. Rounds will be supervised Q shift. Repositioning schedule implemented for residents with wounds or at risk.
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.		QA meeting will review each individual resident for any necessary changes that could potentially require them to need a significant change assessment QA meeting will review each individual resident for any necessary changes that could potentially require them to need a significant change assessment LPNs will monitor changes routinely of resident changes and notified RN if a significant change assessment needs to be completed Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/8/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Reggie Herring OAC 310:663-25-4(F)		Date 8/8/2019	
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: 8/8/2019	
	Facility Name: Glade Avenue South Assisted Living	
	License Number: 5512	
	Survey Event ID: 1w3k11	
Date Survey Completed: 6/27/2019		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1505	Based on: Observation, interview and record review it was determined that the facility failed to have physicians ordered medication on the medication cart, available for administration	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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?	All medications that were not currently available were ordered and made available on medication cart. The medication that was found in the residents cubby was placed on the medication cart and administered per physicians orders thereafter. Night shift LPN to complete and review MAR, Cart and med room and will Audit to ensure all medications are available per phycians order. A pain scale was placed in non-verbal residents care plans.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Night shift LPN and Facility RCC's will complete an Audit of the medication carts, MARs and Medication room weekly. While completing this they will be looking for medications that are ordered but out of the facility, that are expired and new orders to ensure the medication has been delivered and in the medication cart. A log will be kept and reviewed by the DON, RN and ED weekly as well as random routine checks to ensure this is being done properly. A book will be kept on the medication cart to log all medications that are not currently in the facility with steps taken and appropriate persons notified. An inservice was completed by Darla Spears, the facility Pharmacy Consultant to review the ordering process and steps that can be taken to ensure medications are delivered in an appropriate time. Admin and pharm owner communicated via telephone regarding the issue of out of facility meds. And requested a hard stop be placed on any resident EMAR missing meds.	
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?	Night shift LPN and Facility RCC's will complete an Audit of the medication carts, MARs and Medication room weekly. While completing this they will be looking for medications that are ordered but out of the facility, that are expired and new orders to ensure the medication has been delivered and is in the medication cart. A log will be kept	

	and reviewed by the DON, RN and ED weekly. A book will be kept on the medication cart to log all medications that are not currently in the facility with steps taken and persons notified. Pharmacy and Nurse consultant to provide routinely audits.		
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.	Pharmacy and nurse consultant provided by pharmacy routinely Consultant report to be reviewed in QA Random cart, mar and med room audits to be done by RN and DON RN, DON or ED to review audit logs weekly		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	7/15/2019		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Reggie Herring OAC 310:663-25-4(F)	Date 8/8/2019		
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: 8/8/2019	
	Facility Name: Glade Avenue South Assisted Living	
	License Number: 5512	
	Survey Event ID: 1w3k11	
		Date Survey Completed: 6/27/2019
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C5015	Based on: It was determined the facility failed to develop and implement a plan of accommodation of a resident whose condition declined and required additional care and services for all activities of daily living	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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?		The Plan of Care and Comprehensive Assessment were immediately updated by the RN to reflect the residents wound care and increased ADL needs as well as diet. Updated Plan of care was placed into the chart and POC binder for review by all staff. Review of this POC completed by all direct care staff. A plan of accommodation was written to address the hospice documentation of a 30% Karnofsky scale score and the physician documentation of resident exceeding hospice care. The dietician recommendation was pulled from the chart and given to dietary staff as well as LPN. The dietary consultant company was terminated and in house CDM will ensure that recommendations are given according to protocol to ensure resident gets those items recommended.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Skin assessments by the RN/LPN will be completed weekly. An in-service was completed on 7/8/2019 by wound care specialist Kari Harman with all direct care staff (CNA, CMA, LPN) to go over Skin observations, repositioning, importance of keeping them clean and dry. Rounds will be supervised Q shift and any skin integrity issues addressed with direct care staff. Repositioning schedule implemented for residents with wounds or at risk. If it is determined that resident has a need meeting d/c criteria then a plan of accommodation will be put into place. Dietary consultant company terminated and in house CDM will ensure dietary recommendations are put into place following appropriate protocol and ensuring that appropriate staff members are given recommendations to follow through.
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?	New wound care assessments implemented for LPN/RN to complete at least weekly for residents with current wounds. This form will have details of wound and healing process. This will be signed off on by RN, LPN, ED, Dietary and HomeHealth or Hospice. Skin assessments by the RN/LPN will be completed weekly. An in-service was completed on 7/8/2019 by wound care specialist Kari Harman with all direct care staff (CNA, CMA, LPN) to go over Skin observations, repositioning, importance of keeping them clean and dry. Rounds will be supervised Q shift. Repositioning schedule implemented for residents with wounds or at risk.		
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.	QA meeting will review each individual resident for any necessary changes that could potentially require them to need a plan of accommodation QA meeting will review each individual resident for any necessary changes that could potentially require them to need a plan of accommodation LPNs will monitor resident care changes routinely and notify RN and ED for possible need for Plan of Accommodation if d/c criteria is met. Enter methods to keep monitoring records:		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	7/8/2019		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Reggie Herring OAC 310:663-25-4(F)		Date 8/8/2019	
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.			

AUG 23 2019
S.I.



Oklahoma State Department of Health
Creating a State of Health

December 5, 2019

License Number: AL5512

Ms. Regina Herring, Administrator
Glade Avenue South
2480 North Glade Avenue
Bethany, OK 73008

RE: Survey Event ID: 1W3K12

Dear Ms. Herring:

Enclosed is the summary of deficiencies following the revisit of a State Licensure survey conducted at your Assisted Living Center on **November 12, 2019**. These deficiencies remain uncorrected from our original inspection conducted **June 27, 2019**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;

Board of Health

Gary Cox, JD
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(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) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (POC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health

1000 N.E. 10th
Oklahoma City, OK 73117-1299

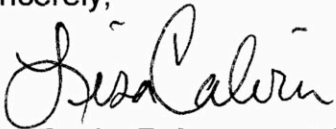
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,


Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5512	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B WING _____	(X3) DATE SURVEY COMPLETED R 11/12/2019
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NAME OF PROVIDER OR SUPPLIER

GLADE AVENUE SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE

**2480 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 follow-up survey was conducted on 11/12/19. Census was 23. The following deficient practice was re-cited.	{C 000}		
{C1505} SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the center failed to have physician ordered medications on the medication cart, available for administration, for 1 (#7) of 4 sampled residents who depended on the centers	{C1505}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5512	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING. _____		(X3) DATE SURVEY COMPLETED R 11/12/2019
NAME OF PROVIDER OR SUPPLIER GLADE AVENUE SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2480 NORTH GLADE AVENUE BETHANY, OK 73008			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{C1505}	Continued From page 1 staff to order and administer their medications. This failed practice had the potential for more than minimal harm, at a pattern. Findings: On 11/12/19 4:00 p.m. during record review, the November physician orders for resident #7 documented Almacone suspension to be given as needed for indigestion, milk of magnesium suspension to be given as needed for constipation, and Robafen liquid to be given as needed for cough. The orders for all three medications originated on 8/29/17. On 11/12/19 at 4:40 p.m. employee #2 was asked to retrieve the medications from the medication cart. The three medications were not located on the medication cart, in the resident's cubby. On 11/12/19 at 4:58 p.m. the LPN/DON was asked if the three physician ordered medications were not in the center. The LPN/DON stated the physician ordered medications are not in the center and the medications should be available in the center for the non-verbal resident #7.	{C1505}			
{C5015} SS=G	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current	{C5015}			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5512	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED R 11/12/2019
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NAME OF PROVIDER OR SUPPLIER

GLADE AVENUE SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE

**2480 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
{C5015}	Continued From page 2 building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to develop and implement a plan of accommodation (POA) for 1 (#7) of 4 sampled residents whose condition declined and the resident required additional care and services for all activities of daily living, transfer assistance and immobility,	{C5015}		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5512	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/12/2019
NAME OF PROVIDER OR SUPPLIER GLADE AVENUE SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2480 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
{C5015}	Continued From page 3 and treatment of wounds. Due to an incomplete, unsigned plan of accommodation it could not be determined specifically what interventions/services were being provided, who would be responsible for providing the interventions/services and who would be monitoring the delivery and response to those services. This failed practice resulted in actual harm, at a pattern. Findings: The last Plan of Care, dated 12/02/18 and updated 03/13/19, identified the resident as requiring total assistance for all activities of daily living. Under "Well Being" on the Plan of Care, the resident was identified with "Acute or life-threatening conditions with some hope for recovery" and the assessment and care plan identified the resident as a "full code." The care plan did not identify interventions on how to communicate with the resident who, according to the assessment, "does not speak." The resident had as needed medication's prescribed but there was no indication how staff would communicate with the resident regarding the resident's need for medication. Even though the resident was identified as a full code, the resident was identified as receiving hospice services, as noted on the significant change assessment dated 06/28/19. On 11/12/19 at 5:15 p.m. the LPN stated the plan of accommodation for the plan of correction, dated 7/8/19, was not signed by the resident's representative. The LPN stated all correspondence by the resident's representative is by mail or by phone and she stated he has not sent the plan of accommodation back signed. Employee #2 stated there was a mail receipt for the contract but not for the plan of accommodation. The resident's representative	{C5015}			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5512	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED R 11/12/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GLADE AVENUE SOUTH

**2480 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
{C5015}	Continued From page 4 was phone and stated he had not received the plan of accommodation or spoken to anyone regarding the plan of accommodation. The LPN also stated the plan of accommodation for the plan of correction, dated 7/08/19, was not signed by the third party provider hospice representative.	{C5015}		

STATE WORKLOAD REPORT

 Provider/Supplier Number
 AL5512

 Provider/Supplier Name
 GLADE AVENUE SOUTH

Type of Survey (select all that apply)

2	D			
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1.  42023	11/12/2019	11/12/2019	0.50	0.00	5.00	0.00	0.75	0.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

 DEC 09 2019 



Oklahoma State Department of Health
Creating a State of Health

December 18, 2019

License Number: AL5512

Ms. Regina Herring, Administrator
Glade Avenue South
2480 North Glade Avenue
Bethany, OK 73008

RE: Survey Event 1W3K12

Dear Ms. Herring:

On November 12, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. 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 **November 30, 2019**.

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) 271-6868.

Sincerely,

Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/5/2019

Facility Name: Glade Avenue South

License Number: 5512

Survey Event ID: Click here to enter Survey Event ID from cover letter and STATE FORM.

Date Survey Completed: 11/12/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: 1505

Based on: Based on observation, interview and record review it was determined the center failed to have physicians ordered medications on the medication cart, available for administration

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All medications not currently in the center were ordered from the pharmacy and stated to the center immediately. A cart, mar and medroom audit was completed by the ED and LPN the following day. All unused PRN medications have been discontinued per physicians order and all medications meeting re-order status were ordered

An LPN will actively participate in a medication pass at least 3 days a week. While doing so they will review orders and medication inventory. The ED, DON and RCC will complete cart, medroom and mar audits routinely. An order schedule has been implemented for all medication ordering. A missed medication log was implemented that will be kept on medication cart. It will show all missed medication/medication not in center, reason why, action taken and resolution. Log will be reviewed by the LPN daily. Pharmacy consultant will complete an in-service on medication ordering policy and procedure

An LPN will actively participate in a medication pass at least 3 days a week. While doing so they will review orders and medication inventory. The ED, DON and RCC will complete cart, medroom and mar audits routinely. A order schedule has been implemented for all medication ordering. A missed medication log was implemented that will be kept on medication cart. It will show all missed medication/medication not in center, reason why, action taken and resolution. Log will be reviewed by the LPN daily. Pharmacy consultant will complete an in-service on medication ordering policy and procedure. Medication log will be reviewed daily in morning meeting, bi-monthly in LPN meeting and quarterly in the QA meeting

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.		Medication log will be kept on medication cart Log will be reviewed daily by LPN and in morning meeting Log will be reviewed quarterly in QA Log will be reviewed monthly by RN	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		11/30/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Reggie Herring OAC 310:663-25-4(F)		Date 12/11/2019	
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.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/11/2019

Facility Name: Glade Avenue South

License Number: 5512

Survey Event ID: 1w3k12

Date Survey Completed: 11/12/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: 5015

Based on: Observation, interview and record review, it was determined the center failed to develop and implement a plan of accommodation for 1 (#7) or 4 sampled residents whose condition declined and the resident requires additional care and services for all activities of daily living, transfer assistance and immobility and treatment of wounds

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The Plan of Accommodation completed by the Administrator and implemented on 8/3/2019 was immediately sent to the POA via certified mail. The POA was notified by phone on the evening of 11/12/2019 while the state survey was present that this would be arriving by mail and needed to be reviewed, signed and returned to the facility as soon as possible. The ED and DON called the 3rd party provider (Mission Hospice) and reviewed the plan of accommodation with Mary the residents Hospice nurse. The reviewed form was faxed to the hospice with attention Mary to be signed

All Plan of Accommodations will be sent via certified mail to all POA's out of the state if they are unable to be present at the facility when completed. All Plan of Accommodations will be executed with the third party provider (if any) and signed by them.

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All Plan of Accommodations will be reviewed Monthly by the ED, RN or DON

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.		All Plan of accommodations will be reviewed by RN and Admin before implemented All Plan of Accommodations will be reviewed in QA All Plan of Accommodations will be kept in the Plan of Accommodation book at the nurses station and reviewed by all staff routinely for any changes	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		11/30/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Reggie Herring OAC 310:663-25-4(F)		Date 12/11/2019	
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