OKLAHOMA
State Department
of Health

Delivery via email to: ed@gladeavenueassistedliving.com

June 28, 2023

License Number: AL5512

Nikkita Bowler, Administrator
Glade Avenue South
2480 North Glade Avenue
Bethany, OK 73008

RE: Survey Event ID: UI7D11

Dear Ms. Bowler:

On **June 8, 2023**, 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.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on June 8, 2023.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5512	A. BUILDING: _____ B. WING _____	06/08/2023

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
C 000	INITIAL COMMENTS A relicensure survey was conducted from 06/06/23 through 06/08/23. The following abbreviations will be used throughout this report. approx-approximately cm-centimeters CMA-certified medication aide CNA-certified nursing assistant COPD-chronic obstructive pulmonary disease DCS-Director of Culinary Services ED-Executive Director HWD-Health and Wellness Director LPN-Licensed Practical Nurse LT-left MAR-medication administration record OSDH-Oklahoma State Department of Health PCP-primary care provider RCD-Resident care director tx-treatment w-with +- and	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	C1505		

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C1505	Continued From page 1 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, record review, and interview the center failed to ensure a. monthly weights were obtained and meal replacements (Ensure) were provided as ordered by the physician for two (#1 and #2) of two sampled residents reviewed for weight loss, b. infection control measures were maintained during the provision of peri care for two (#1 and #2) of two sampled residents reviewed for peri care, c. a therapeutic diet was provided as ordered for one (#1) of six sampled residents reviewed for diets, and	C1505		

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C1505	Continued From page 2 d. hair nets were worn by staff members while in the kitchen, and preparing fluids in cups during meal time. The ED identified 10 residents resided in the center. Findings: The facility's "INFECTION PREVENTION PROGRAM" policy, revised 06/19, read in parts, "...Standard precautions include the appropriate methods for...hand hygiene...personal protective equipment..." 1. Resident #1 had diagnoses which included dementia, Alzheimer's disease and depressive disorder. A "Physician Order," dated 03/28/23, read in part, "...WEIGH AND RECORD MONTHLY ON THE 10TH..." MAR's dated April and May 2023 had no documentation a weight had been obtained for Resident #1. The May 2023 MAR, documented the resident was to have Ensure shakes three times a day between meals for weight loss. The MAR, dated 05/31/23 at 7 a.m., and 12 p.m., documented "...On hold until medication is available..." The June 2023 MAR, documented Resident #1 was to have Ensure shake three times a day between meals for weight loss. The MAR documented "...On hold until medication is available..." on the following days: a. On 06/01/23 at 7 a.m., 12 p.m., and 6 p.m., b. On 06/02/23 at 7 a.m., and 12 p.m., and	C1505		

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C1505	Continued From page 3 c. On 06/06/23 at 12 p.m. On 06/07/23 at 8:07 a.m., the RCD and CNA #1 was observed to provide pericare to Resident #1 who was lying in their bed. The RCD was observed to cleanse the pubic area with downward strokes toward the vaginal area then across the pubic area using the same wipe then grabbed a clean brief. The two staff then rolled the resident and the RCD was observed to cleanse the buttocks, place a clean brief, assist to roll, secured the brief, pulled up the residents pants, then adjusted the residents shirt but did not don new gloves. The RCD then positioned the residents chair near the side of the bed and assisted CNA #1 to transfer Resident #1 to the broda chair. The RCD then removed their gloves, washed their hands and left the room. The RCD was not observed to change gloves at any time during the provision of pericare and transfer to the broda chair. On 06/07/23 at 11:44 a.m., the RCD was asked to recall when had they changed their gloves when providing peri care to resident #1. They stated, "When I stepped out of the room." The RCD stated, they had not followed the policy. They were asked if they had changed their gloves after providing peri care and dressing the resident. They stated, "No." On 06/07/23 at 3:42 p.m., LPN #1 was asked if they were aware Resident #1 had not had their Ensure as ordered. They stated, "No." On 06/08/23 at 8:34 a.m., the ED was asked who was responsible to obtain monthly weights. They stated "If it's on the MAR and there is a physician's order it's our responsibility."	C1505		

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C1505	Continued From page 4 2. Resident #2 had diagnoses which included Parkinson's disease, dementia, and depression. A "Recommended Assisted Living Resident Assessment Form," dated 06/10/22, documented Resident #2 needed assistance of one staff for eating and to open packages, and needed assistance of two staff for bathing, dressing, transferring, toileting and received hospice services. A "Physician's Orders," dated 09/29/21, read in parts, "...Mechanical Soft, thin liquids..." A "Physician's Orders," dated 04/25/22, read in parts, "...ENSURE...TAKE 1 BOTTLE BY MOUTH 2 TIMES A DAY FOR SUPPLEMENT..." A "Physician's Orders," dated 04/29/22, read in parts, "...Obtain monthly weight..." Resident #2's MAR for May 2023, documented to administer Ensure two times a day. The MAR, dated 05/31/23, documented Ensure was "...On hold until medication was available..." The MAR did not contain documentation a monthly weight had been obtained. Resident #2 was admitted to the hospital on 06/01/23 until 06/05/23. A Hospital "After Visit Summary" dated 06/05/23 read in part,"...Diet Type: Regular Pureed Nectar Thick Diet..." A facility, "Dietary Communication Form," dated 06/06/23, read in parts, "...Pureed diet...thickened liquids..."	C1505		

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C1505	Continued From page 5 Resident #2's MAR for June 2023, documented to administer Ensure two times a day. The MAR, dated 06/06/23, documented Ensure was "...On hold until medication was available...." On 06/07/23 at 9:37 a.m., CNA #1 was observed assisting Resident #1 with breakfast. Half a piece of bacon, scrambled eggs, oatmeal and a styrofoam cup with a thin clear liquid was observed. CNA #1 gave Resident #2 a drink of water using a straw and the resident coughed. CNA #1 then offered the Resident another drink of water. The Resident coughed after taking a drink through the straw. CNA #1 then left the Residents room. CNA #1 was asked what was in the cup. They stated, water. On 06/07/23 at 11:20 p.m., CNA #1 was asked if any Residents were on a special diet. They stated, they were told [Resident #2] was on a pureed diet after they had fed the Resident. CNA #1 was asked if there were any concerns when they were assisting the Resident with the meal. They stated, "When you walked in [Resident #2] was coughing a little bit towards the end. So I went to [LPN #1] to tell [LPN #1] and [LPN #1] checked on [Resident #2]" On 06/08/23 at 9:40 a.m., CMA #1 was asked who did they report to when medications needed to be ordered. They stated, they report to the RCD. CMA #1 was asked why Resident #2 had not been receiving Ensure. They stated when the Resident went to the hospital, hospice services stopped and the resident has not had any since. They stated they informed the RCD and LPN #1. CMA #1 was asked to review the May 2023 MAR and asked if the resident did not have any Ensure	C1505		

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C1505	Continued From page 6 since 05/31/23. They stated yes, that either Hospice or the family was responsible to provide it and the Resident still did not have any. On 06/08/23 at 10:22 a.m., LPN #1 was asked to explain who the medication aides were to report to when physician ordered medications or Ensure need to be reordered. They stated the medication aides should report to them or the HWD. 3. On 06/07/23 at 8:53 a.m., CNA #1 and the RCD were observed providing incontinent care to Resident #2. The RCD dampened a section of an orange bath towel with water from the bathroom sink and wiped the Resident's mouth with it. They then used the same dampened section of the towel to wipe the Resident's eyes. CNA #1 then placed one of the Resident's pillows on the floor. A scant amount of some brown substance was observed on the Resident's buttocks. CNA #1 and the RCD took turns cleaning the Resident's buttocks. CNA #1 placed the soiled brief on the floor. Neither staff member changed their gloves as they continued to provide clean clothes and a clean brief for Resident #2. CNA #1 was observed patting and holding the Resident's hand with unchanged gloves. Both staff members were observed to transfer the Resident to their wheelchair. After the transfer, CNA # 1 made the Resident's bed and placed the pillow on the floor back unto the bed. The RCD was observed brushing the Resident's hair and patting it down with unchanged gloves. The RCD stated they could not find "the other leg" to Resident #2's wheelchair and transferred Resident #2 to their recliner. CNA #1 and the RCD were not observed to change their gloves at any time during care provision and transfers.	C1505		

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C1505	Continued From page 7 On 06/07/23 at 11:23 a.m., CNA #1 was asked to provide the steps in provision of peri care. They stated they would inform the Resident, provide the peri care, change gloves if soiled, then dispose of their gloves when done. CNA #1 was asked if they had changed their gloves at any time during provision of peri care for Resident #2. They stated "It would have been better if I had taken my gloves off for that." On 06/07/23 at 11:38 a.m., the RCD was asked to provide the steps in provision of peri care. They stated they should change gloves when providing peri care and/or incontinent care. They stated, "If not dirty, you're still supposed to change gloves." They stated they changed their gloves sometimes when providing incontinent care. On 06/07/23 at 11:46 a.m., the RCD was asked if they should have used the same towel to clean Resident #2's mouth and eyes. The RCD stated they should not have cleaned Resident #2's mouth and eyes with the same towel. The RCD was asked if they changed their gloves when providing peri care and/or incontinent care for Resident #2. They stated they did not change gloves during Resident #2's peri care. They stated these actions were against facility policy. 4. On 06/06/23 at 8:44 a.m., a paper sign was observed posted at the kitchen entrance. The sign read, "NOTICE HAIR NET REQUIRED BEYOND THIS POINT." The pocket on the sign to hold hair nets was empty. On 06/06/23 at 8:44 a.m., LPN #1 was observed in the kitchen, during breakfast, with no hair net on. LPN #1 was also observed serving breakfast to a Resident in the dining room.	C1505		

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C1505	Continued From page 8 On 06/06/23 at 8:59 a.m., CNA #2 was observed putting hair nets in the pocket on the sign. They stated when hair nets were needed, staff would go to "the North building" to get them. On 06/07/23 at 8:22 a.m., CNA #1 was observed in the kitchen with no hair net on. They were observed to have poured one cup of milk and one cup of orange juice. On 06/07/23 at 8:50 a.m., the DCS was observed in the kitchen with no hair net on. On 06/07/23 at 12:28 p.m., the DCS was observed in the kitchen with no hair net on. On 06/07/23 at 12:31 p.m., CNA #1 and CMA #1 were observed in the kitchen with no hair net on. On 06/07/23 at 3:52 p.m., the ED was asked about the facility's policy on wearing hair nets. They stated hair nets were required whenever staff was in the kitchen. They stated anyone in the kitchen must have a hair net on. On 06/08/23 at 9:11 a.m., the DCS stated staff members always wore hair nets during serving times in the kitchen. They stated it was against facility policy if dietary staff did not wear hair nets in the kitchen. They stated as of Wednesday, 06/07/23, only dietary staff was required to wear hair nets in the kitchen. On 06/08/23 at 9:37 a.m., CMA #1 was asked what the policy was on wearing hair nets while in the kitchen. They stated they did not know of a facility policy on wearing hair nets. They stated they did not receive any training on use of gloves and wearing hair nets when handling food.	C1505		

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C1507	Continued From page 9	C1507		
C1507 SS=D	310:663-15-1 & 63 OS 1-1918(B)(7) RESIDENT RIGHTS - Reasonable Accommodation 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)(7) (7) Every resident shall have the right to reside and to receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to accommodate a resident with communication deficits related to aphasia for one (#4) of six sampled resident reviewed for accommodation of needs. The ED identified 10 residents who resided in the center.	C1507		

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C1507	Continued From page 10 Findings: Resident # 4's diagnoses included aphasia following cerebral infarction, depression, epileptic seizures, bacteremia, constipation, nutritional deficiency, muscle weakness, and COPD. A "Recommended Assisted Living Resident Assessment Form," dated 05/24/22, read in parts, "...Mental/Cognitive Functional Status...Alert...Oriented x 2...Confused at Times...Has difficultry (sic) w/speech but able to make needs known...Ability to communicate...Interviewable:..No...If No describe: post stroke asphasia (sic)...Usual mood: Calm...can become frustrated when unable to communicate..." Resident #4's "Plan of Care," dated 05/24/22, read in parts, "...Be patient and take time to listen to...due to the language barrier since...seizure..." On 06/06/23 at 9:41 a.m., Resident #4 was observed in their room, lying in bed covered with a blanket, watching television. They were unable to answer questions. On 06/06/23 at 12:30 p.m., Resident #4 was observed in the dining room at lunch. Resident #4 was observed pointing to their cup filled with tea, stating "babies, babies" to CMA #1. CMA #1 responded they did not understand what Resident #4 was saying and walked away. On 06/06/23 at 2:25 p.m., a family member was asked about Resident #4's care. They stated they could not say much about the Resident's daily care because the facility did not respond to the phone calls they had made and the text messages they had sent. They stated that	C1507		

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(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
C1507	Continued From page 11	C1507		

whenever they "FaceTimed" with the Resident, the Resident looked "disheveled and dirty."

On 06/07/23 at 12:31 p.m., Resident #4 was observed in the dining room at lunch. They went towards the kitchen and attempted to communicate with the staff members there. CMA #1, and CNA#1 were in the kitchen. When CMA#1 saw Resident #4 approaching the kitchen, they stated loudly "You can't come in the kitchen so back up" and waved the Resident off. The Resident then turned around and went back to their table.

On 06/07/23 at 1:43 p.m., CNA #1 was asked how staff communicated with Resident #4. They stated they just guessed and tried to figure out what the Resident wanted. They stated Resident #4 could answer yes or no to questions.

On 06/07/23 at 3:08 p.m., Resident #4 was observed in their room, sitting in a wheelchair. When asked questions, they repeatedly stated "babies, babies" and could not provide any further information.

On 06/07/23 at 3:50 p.m., LPN #1 was asked how staff communicated with Resident #4. They stated staff was used to how the Resident talked and just kept guessing until they understood the Resident.

On 06/07/23 at 3:52 p.m., the ED stated the facility had no other means of communicating with Resident #4. They stated the Resident had not requested any devices to aid with communication. They also stated, "most of our staff" were patient with the Resident.

On 06/08/23 at 9:37 a.m., CMA #1 was asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5512	A. BUILDING: _____ B. WING _____	06/08/2023

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
C1507	Continued From page 12 how staff communicated with Resident #4. They stated they just kept guessing what Resident #4 was trying to say and that they did not understand what the Resident was trying to say at times. When asked how the Resident requested as needed medications, they stated they did not know how the Resident would do so. They stated they had never given the Resident any as needed medications before.	C1507		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515	C1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5512	A. BUILDING: _____ B. WING _____	06/08/2023

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C1912	Continued From page 13 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on record review and interview the center failed to a. investigate and submit an incident report to the OSDH for an unknown injury (bruising to inner thighs) for one (#1), and b. investigate an unknown injury (laceration) for one (#2) of two sampled residents reviewed for unknown injuries. The ED identified 10 residents resided in the center. Findings: An "Internal Incident Reports and State Reports" policy, revised 07/2019, read in parts, "...Injury and unusual incidents will be reported in compliance with state regulatory requirements...All incidents related to physical abuse, neglect, sexual assault, or exploitation are reported to the ombudsman, state licensing agency, and in the case of assault (physical or	C1912		

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C1912	Continued From page 14 sexual), to law enforcement per state regulations..." A "Resident Protection and Abuse Prevention" policy, revised 03/2020, read in parts,"...The Executive Director/Designee will initiate and direct investigations for abuse allegations and ensure residents are maintained in a safe environment...The abuse allegation is immediately reported to the Executive Director/Designee...Executive Director/Designee ensures the investigation is prompt and confidential via private interviews with resident, witnesses and employee..." 1. Resident #1 had diagnoses which included dementia, Alzheimer's disease and depressive disorder. A "Radiology Interpretation" report, dated 04/25/23, read in parts, "...LEFT LT X-RAY EXAM OF FEMUR...Unremarkable x-ray examination of the femur..." An "Incident/Accident Report," dated 04/26/23 at 9:40 p.m., read in part, was changing resident and found bruising on inner thighs left inner thigh bruising is swollen..." The diagram documented the location of injury as bruising to the right thigh, and bruising and swelling to the left thigh. A "Nurse's Note," dated 04/26/23 at 1:00 p.m., read in parts, "...DHW notified on 4-25-23 @ 2141 [9:41 p.m.] about resident having fresh bruising + swelling to [left] inner thigh...Hospice notified along w/family and PCP. No new orders this time..." On 06/06/23 at at 3:15 p.m., the ED was asked what was done, they stated they were unsure.	C1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1912	Continued From page 15 They were asked if an investigation and incident report had been completed. They stated they were unsure, and was not aware of the incident. No further documentation was provided by the center an investigation had been completed related to the bruising. 2. Resident #2 had diagnoses which included Parkinson's disease, dementia, and depression. A "Recommended Assisted Living Resident Assessment Form," dated 06/10/22, documented Resident #2 needed assistance of two staff for bathing, dressing, transferring, and toileting. A "Nurses's Notes," dated 01/04/23, read in parts, "...CNA alerted this nurse res was bleeding. Res observed sitting up in wheelchair blood noted on...pant leg. Removed pant leg laceration noted approx 12 cm in length...Res sent to [hospital] for eval and tx..." A final OSDH "INCIDENT REPORT FORM," dated 01/04/23, read in parts, "...Certain Injuries...CNA reported Laceration to lower left leg to floor nurse...Resident returned to community with 18 staples to Left lower leg..." Part C did not contain any documentation an investigation had been started to identify the cause of the laceration. On 06/08/23 at 3:15 p.m., the ED was asked if an investigation had been completed related to Resident #2's laceration. They stated, they were not aware if the incident had been investigated. No further documentation was provided by the center an investigation had been completed related to the laceration.	C1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OKLAHOMA
State Department
of Health

Delivery via email to: ed@gladeavenueassistedliving.com

July 24, 2023

License Number: AL5512

Ms Nikkita Bowler, Executive Director
Glade Avenue South
2480 North Glade Avenue
Bethany, OK 73008

RE: Survey Event UI7D11

Dear Ms. Bowler:

On **June 8, 2023**, 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 **August 8, 2023**.

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, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/10/2023** **Facility Name:** Glade Avenue Assisted Living **License Number:** AL5512 **Survey Event ID:** UI7D11 **Date Survey Completed: 6/8/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Observation, record review, and interview A. Monthly weights were obtained and meal replacements (Ensure) were provided as ordered by a physician. B. infection control measures were maintained during the provision of peri care. C. a therapeutic diet was provided as ordered. D. hair nets were worn by staff members while in the kitchen and preparing fluids in cups during meal times.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Staff was in-serviced on 6/23/2023 on wearing hair nets while in the kitchen and preparing fluids in cups during meal service Staff was in-serviced on 6/23/2023 on proper peri-care procedures. Staff will be in-serviced on a therapeutic diet per the physician's order on 7/14/2023. Staff will be in-serviced on 7/14/2023 on obtaining monthly weights and meal replacements per the physician's order
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding. Staff training was completed on 6/23/2023 and will continue. To provide education on obtaining monthly weights, ordering meal replacements as ordered by a physician, infection control measures while performing peri-care and wearing hair nets while in the kitchen, and preparing fluids in cups during meal times.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	A. Director of Health and Wellness or designee will train staff on obtaining weights. B. Director of Health and Wellness or designee will review orders to ensure meal replacements are provided as ordered by the Physician. C. Director of Health and Wellness and or designee and Directory of Culinary Services will coordinate the provision of therapeutic diets as ordered by the Physician.

	D. Director of Culinary Services or designee will monitor staff wearing hairnets while in the kitchen and preparing fluids in cups during meal times.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	ED and/ or the Director of Health and Wellness will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-services that were conducted on 6/23/2023 and 7/14/2023 in the community in-service binder. Tracking and trending of monthly weights, provision of meal replacement (ensure) as ordered, Infection Control measures, and wearing of hair nets will be reported and reviewed during the QA meeting. Montoring of records will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/8/2023
OSDH Response: Element accepted Yes ☐ No ☐	

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

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

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

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/10/2023** **Facility Name:** Glade Avenue Assisted Living **License Number:** AL5512 **Survey Event ID:** UI7D11 **Date Survey Completed: 6/8/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1507	Based on: observation, record review, and interview, the facility failed to accommodate a resident with communication deficits related to aphasia.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Staff will be in-serviced on 7/14/2023 on effective ways to communicate with the resident(#4) with communication deficits related to aphasia.
OSDH Response: Element accepte Ye ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents residing in the community with communication deficits have the potential to be affected by the deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed finding. Staff training will be completed on 7/14/2023, to provide effective communication devices and or methods of effective ways to communicate with residents (#4).
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Director of Health and Wellness or designee will train staff on effective methods to communicate with residents with communication deficits related to aphasia.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	ED and/ or the Director of Health and Wellness will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service that was conducted on 7/14/2023 in the community in-service binder. Tracking and trending of effective communication of resident (#4) will be reported and reviewed during QA meeting. Montoring of record 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?	8/8/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Nikkita Bowler OAC 310:663-25-4(F)			**Date 7/12/2023**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. **Facility in Compliance by:** Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/10/2023** **Facility Name:** Glade Avenue Assisted Living **License Number:** AL5512 **Survey Event ID:** UI7D11 **Date Survey Completed: 6/8/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1912	Based on: record review and interview the center failed to, a. investigate and submit an incident report to the OSDH for an unknown injury (bruising to inner thighs). B. investigate an unknown injury (laceration).

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Staff was in-serviced on 6/7/2023, 6/8/2023, and again on 6/23/2023 on investigating and reporting incidents to the Director of Health and Wellness and Executive Director on unknown injuries and reporting to OSDH.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents residing in the community have the potential to be affected by deficient practices. To date, no residents have experienced a negative outcome pertaining to the listed finding. Staff training was completed on 6/7/2023,6/8/2023 and 6/23/2023. To provide education on reporting and investigating unknown injuries (bruising of inner thigh and laceration).
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	A. Director of Health and Wellness or designee will investigate and report all unknown injuries to OSDH. B. Director of Health and Wellness or designee will investigate all unknown injuries and report to OSDH.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	ED and/or the Director of Health and Wellness will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-services that were conducted on 6/7/2023,6/8/2023 and 6/23/2023 in the community binder. Tracking and trending of unknown injuries report to OSDH and investigation will be reported and reviewed during the QA meeting.

	Monitoring of records will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	8/8/2023		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Nikkita Bowler** OAC 310:663-25-4(F)		**Date 7/12/2023**	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
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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: ed@gladeavenueassistedliving.com

August 30, 2023

License Number: AL5512

Nikkita Bowler, Administrator/E.D.
Glade Avenue South
2480 North Glade Avenue
Bethany, OK 73008

RE: Survey Event UI7D12

Dear Ms. Bowler:

On **August 29, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 8, 2023,** have now been corrected effective **August 8, 2023.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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
	AL5512	A. BUILDING: _____ B. WING _____	R 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLADE AVENUE SOUTH	2480 NORTH GLADE AVENUE BETHANY, OK 73008

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 08/29/23. 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