
Delivery via email to: Skye@gladeavenueassistedliving.com

November 7, 2024

License Number: AL5512

Ms. Skye Statum, Administrator
Glade Avenue Assisted Living South
2480 North Glade Avenue
Bethany, OK 73008

RE: Survey Event ID: Y6I711

Dear Ms. Statum:

On **October 24, 2024**, agents from our office concluded a State Licensure survey with complaint investigations 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 **October 24, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action 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 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,

Tempal Killman

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

Enclosure

INVESTIGATIVE REPORT

Facility: Glade Ave S

Address: 2480 N Glade Ave

City, State, Zip: Bethany, OK

Provider #: AL5512

Complaint #: OK00061572

Investigation Date(s): 10/14/24 – 10/17/24 and 10/21/24 – 10/24/24

ALLEGATION(S)

The center failed to ensure medications were administered by qualified staff and failed to have and/or implement an effective pharmacy policy to ensure an accurate count of medications.

The center failed to ensure medications were administered by qualified staff.

The center failed to ensure assistance with ADLs was provided in a timely manner and according to contract and the plan of care.
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The center failed to ensure adequate staff was provided to meet the needs of the residents.

The center failed to ensure a clean, sanitary, and homelike environment.
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The center failed to ensure food was served warm according to resident's preference.
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An unannounced on-site investigation was initiated 10/14/2024 at 2:08 p.m.

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

An investigation related to staff, credentials, policy, ADLs, environment, and food was conducted.

At the time of the survey, individual narcotic count sheets were observed on the medication cart binder. The counts were correct. Staff credentials were verified with the nurse aide registry. Residents were observed receiving incontinent care with adequate staff. There were no mold near, under, or around activity room sink or kitchen sink observed.

At the time of the survey, no resident complained about staff, their medications, incontinent care, or mold.

At the time of the survey, staff stated only CMA's with advanced training in glucose monitoring and insulin would administer insulin. Staff demonstrated their knowledge of individual narcotic count sheets. Staff stated incontinent care was provided every two hours and as needed. Staff were not aware of any mold.

At the time of the survey, no deficient practice was cited in relation to qualified staff, accurate narcotic administration records, ADL's, nursing services, or physical environment.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/04/2024

INVESTIGATIVE REPORT

Facility: Glade Ave S

Address: 2480 N Glade Ave

City, State, Zip: Bethany, OK 73008

Provider #: AL5512

Complaint #: OK00064604

Investigation Date(s): 10/14/24 – 10/17/24 and 10/21/24 – 10/24/24

ALLEGATION(S)

The center failed to ensure adequate nutrition and hydration was provided according to the plan of care and the standard of care.

The center failed to ensure assistance with eating and incontinent care was provided according to the plan of care and the standard of care.
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The center failed to assess, monitor, and intervene for residents who fall.

The center failed to provide adequate staff to meet the needs of the residents.

The center failed to ensure falls were reported to the OSDH according to State Law.

An unannounced on-site investigation was initiated 10/14/2024 at 2:08 p.m.

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

An investigation related to adequate nutrition and hydration, assistance with eating and incontinent care, adequate staff to meet the needs of the residents, assessments, monitoring, and interventions of residents who fell, and falls reported to the Oklahoma State Department of Health.

At the time of the survey, nutritious meals with hydration were observed with residents receiving assistance as required. No untouched meal trays were observed in resident rooms. Incontinent care was observed provided to residents with enough staff to meet the needs of the residents. Progress notes, weights, reportable and not reportable incident reports were reviewed. Reportable events documented doctor and family notification. A full-time registered nurse was observed daily throughout the survey. Residents were observed out of bed, in the lobby, activity room, dining room, and living area throughout the survey.

At the time of the survey, no resident complained about being hungry, the meals, hydration, assistance with eating, incontinent care, or staff providing care.

At the time of the survey, staff stated they provided assistance with eating and incontinent care for residents who required services. Staff stated if a resident fell they would notify their immediate supervisor and follow the chain of command and center's procedure.

At the time of the survey, there was no deficient practice related to quality of care, quality of life, accidents, nursing services, or state licensure.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/04/2024

INVESTIGATIVE REPORT

Facility: Glade Ave S

Address: 2480 N Glade Ave

City, State, Zip: Bethany, OK 73008

Provider #: AL5512

Complaint #: OK00066274

Investigation Date(s): 10/14/24 – 10/17/24 and 10/21/24 – 10/24/24

ALLEGATION(S)

The center failed to maintain the center in a safe, working condition to ensure a safe, clean, and homelike environment.
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An unannounced on-site investigation was initiated 10/14/2024 at 2:08 p.m.

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

An investigation related to the condition of the beauty shop, the activity room, the roof, the ceilings, and water temperatures were conducted.

At the time of the survey, there were no leaking ceilings, no water seeping from underneath the floor or a huge open hole in the floor of the beauty salon or destruction to the activity room observed.

At the time of the survey, no resident complained about leaking ceilings, being moved from their room, water coming up from under the floor or raccoons.

At the time of the survey, the staff stated there were no leaking ceilings or water seeping from underneath the floor or current problems with raccoons.

At the time of the survey, there was no deficient practice related to physical environment.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health

Long Term Care Service

Date report completed: 11/04/2024

INVESTIGATIVE REPORT

Facility: Glade Ave S
Address: 2480 N Glade Ave
City, State, Zip: Bethany, OK 73008
Provider #: AL5512
Complaint #: OK00067433
Investigation Date(s): 10/14/24 – 10/17/24 and 10/21/24 – 10/24/24

ALLEGATION(S)

The center failed to have a disclosure on file with the OSDH to provide care for memory care residents.

An unannounced on-site investigation was initiated 10/14/2024 at 2:08 p.m.

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

An investigation related to a disclosure on file with OSDH to provide care for memory care residents was conducted.

At the time of the survey, residents stated care was provided to people who had memory problems.

At the time of the survey, the staff stated they provided care for memory care residents.

At the time of the survey, there was no deficient practice related to administration.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/04/2024

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 C 10/24/2024
NAME OF PROVIDER OR SUPPLIER GLADE AVENUE ASSISTED LIVING 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 relicensure survey was conducted 10/14/24 through 10/17/24 and 10/21/24 through 10/24/24. Complaint investigations (#OK00061572, OK00064604, OK00066274, and #OK00067433) were conducted in conjunction with the survey. Center Census: 19 The following abbreviations will be used throughout this report. CNA - certified nurses aide DON - director of nursing FSBS - fingerstick blood sugar MAR - medication administration record mcg - microgram mg - milligram ml - milliliter NMDA - N-Methyl-D-aspartate NSAID - nonsteroidal anti-inflammatory drugs RN - registered nurse sub-q - subcutaneous	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to maintain a steam table in good repair and hold temperature for hot hold food at 135 degrees Fahrenheit or above for hall trays.	C 391		

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 391	Continued From page 1 The DON identified 19 residents resided at the center. Findings: On 10/14/24 at 4:53 p.m., Cook #1 stated the burner to the far right of the steam table did not work. On 10/15/24 at 12:09 p.m., Cook #2 stated the fourth burner on the steam table did not work. On 10/15/24 at 12:54 p.m., observed hall plates (Styrofoam plate covered with Styrofoam plate) being placed on a cart for resident room deliveries. On 10/15/24 at 1:06 p.m., the cart was observed empty after hall tray deliveries were made. On 10/15/24 at 1:09 p.m., a test tray (Styrofoam plate covered with Styrofoam plate) was obtained. The pork was 85.1 degrees Fahrenheit, the vegetable mix was 96.6 degrees Fahrenheit, and the mashed potatoes were 99.5 degrees Fahrenheit. On 10/15/24 at 1:20 p.m., CNA #3 stated the hall trays were prepared and delivered the same way each day with a disposable plate covering a disposable plate.	C 391		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall	C 543		

Oklahoma State Department of Health

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C 701	Continued From page 3 This Rule is not met as evidenced by: Based on observation and record review, the center failed to maintain hot water temperatures of at least 115 degrees Fahrenheit for three (#6, 7, and #9) of four sampled residents whose sink temperatures were checked. The DON identified 19 residents resided at the center. Findings: On 10/16/24 at 10:15 a.m., a sink hot water temperature was 103.7 degrees Fahrenheit. Resident #7 stated, "They take showers in there." On 10/16/24 at 10:24 a.m., a sink hot water temperature was 106.3 degrees Fahrenheit. When Resident #9 was asked if the water was warm enough in the shower they shrugged their shoulders. On 10/16/24 at 10:25 a.m., the maintenance director stated the hot water temperatures should be 115 degrees Fahrenheit. On 10/16/24 at 10:28 a.m., the maintenance director stated random hot water temperatures should be taken and documented.	C 701		
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	C1505		

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C1505	Continued From page 4 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 interview and record review, the center failed to administer medications as ordered by the physician for two (#7 and #8) of eight sampled residents whose medication administration was	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 5 reviewed. The DON identified 19 residents resided at the center. Findings: The center's service agreement, documented every resident shall have the right to adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. 1. Resident #7 had diagnoses which include dementia, insomnia, and hypertension. Physician orders, dated 06/24/24, documented Namenda (NMDA antagonist medication) 5 mg one tablet by mouth twice a day for dementia; and Remeron (antidepressant medication) 15 mg one tablet by mouth at bedtime for dementia. A physician order, dated 07/15/24, documented Ambien (hypnotic medication) 5 mg one tablet by mouth every evening for insomnia. A physician order, dated 07/23/24, documented Eliquis (anticoagulant medication) 5 mg one tablet by mouth twice a day for blood thinner. The September 2024 MAR documented initials with circles around them. Eliquis from September 16-18 (6 missed doses), Namenda from September 1-15 (30 missed doses), Remeron from September 1-30 (30 missed doses) and Ambien from September 1-30 (30 missed doses.) The October 2024 MAR documented initials with circles around them. Namenda from October 1-13 (26 missed doses), Remeron October 1-21	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 6 (21 missed doses) and Ambien from October 1-22 (22 missed doses.) 2. Resident #8 had diagnoses to include depression and hypothyroidism. Physician orders, dated 08/24/23, documented Celexa (SSRI) 20 mg one tablet by mouth daily for depression; and Synthroid (hormone medication) 100 mcg one tablet by mouth daily for hypothyroidism. The October 2024 MAR documented initials with circles around them. Celexa from October 15-20 (6 missed doses) and Synthroid from October 16-22 (7 missed doses.) On 10/23/24 at 10:16 a.m., the RN did not know the reason the residents had not been receiving their physician ordered medications.	C1505		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 7 prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on interview and record review, the center failed to accurately document medication not given for two (#10 and #11) of eight sampled residents whose medication administration records were reviewed. The DON identified 19 residents resided at the center. Findings: A center policy, documented to notify the physician/prescriber for persistent refusals and held medications. 1. Resident #10 had diagnoses to include hypertension, depression, and type II diabetes mellitus. Physician orders, dated 12/21/23, documented Lantus (insulin) injectable 100/ml inject 25 units sub-q every morning for type II diabetes; and Lantus injectable 100/ml inject 15 units sub-q every evening for type II diabetes. A physician order, dated 04/30/24, documented Prozac (SSRI) 40 mg one capsule by mouth daily for depression. A physician order, dated 06/08/24, documented Metoprolol (beta blocker) 50 mg one tablet by mouth daily for hypertension.	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 8 The August 2024 MAR had blank spaces, missing finger stick blood sugar readings, and/or insulin not given. The MAR documented the resident did not receive their physician ordered FSBS and/or insulin because it was outside of parameters. The September 2024 MAR had blank spaces, missing finger stick blood sugar readings, and/or insulin not given. The MAR documented the resident did not receive their physician ordered FSBS and/or insulin and anti-depression medication because it was outside of parameters or on hold until medication was available. The October 2024 MAR had blank spaces, missing fingerstick blood sugar readings, and/or insulin not given. The MAR documented the resident did not receive their physician ordered FSBS and/or insulin, their anti-depressant, or their hypertension medication because of being on hold until the medication was available. 2. Resident #11 had diagnoses which include hyperlipidemia, major depressive disorder, seizures, and pain. A physician order, dated 05/03/23, Lamictal (phenyltriazine) 150 mg one tablet by mouth twice daily for epilepsy. Physician orders, dated 07/21/23, documented Lipitor (statin) 80 mg one tablet by mouth at bedtime for hyperlipidemia; Lexapro (SSRI) 20 mg one tablet by mouth daily for major depressive disorder; and Keppra (anticonvulsant medication) 750 mg one tablet by mouth every 12 hours for seizures.	C1923		

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 C 10/24/2024
NAME OF PROVIDER OR SUPPLIER GLADE AVENUE ASSISTED LIVING 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
C1923	Continued From page 9 A physician order, dated 04/23/24, documented Mobic (NSAID) 7.5 mg one tablet by mouth twice daily. A physician order, dated 09/03/24, documented Neurontin (anticonvulsant medication) 300 mg one capsule by mouth three times a day for flaccid hemiplegia. The August 2024 MAR documented the resident did not receive their physician ordered medications because they refused and/or on hold until the medication was available. The September 2024 MAR documented the resident did not receive their physician ordered medications because they refused, the medication was held until available, or out of the community. The October 2024 MAR documented the resident did not receive their physician ordered medications because they refused or held until the medication was available. On 10/23/24 at 12:54 p.m., the RN stated they did not believe the staff were using the correct or accurate reason a medication was held or not given.	C1923			

Delivery via email to: Skye@gladeavenueassistedliving.com

December 11, 2024

License Number: AL5512

Ms. Skye Statum, Executive Director
Glade Avenue Assisted Living South
2480 North Glade Avenue
Bethany, OK 73008

RE: Survey Event **Y6I711**

Dear Ms. Statum:

On **October 24, 2024**, agents from our office completed a Relicensure survey with a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C-391, C-543, C-701, C-1505, C-1923** - The alleged date of completion is outside the sixty (60) days of the dated letter they received.

Please provide a new plan of correction with amendments as soon as possible.

Respectfully,

Tempal Killman

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

Enc



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/2/2024

Facility Name: Glade Assisted Living

License Number: AL5512 SOUTH Building

Survey Event ID: Y61711

Date Survey Completed: 10/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 Food
Storage, Preparation AND
Service

Based on: Observation, record review, and interview center failed to maintain a steam table in good repair and hold temperature for hot hold food at 135 degrees Fahrenheit or above for hall trays.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. Executive Director will train the Dining room Director on Chapter 257 on food stored, prepared, and served. Training will be added to the QA monthly minutes.
2. Kitchen Staff will be trained on completing Work Orders on equipment not working properly. Training added to QA minutes.
3. Kitchen staff will be trained on proper temperatures for serving residents.
4. Facility will ensure halltrays are properly prepared and stored to maintain required temperatures.
5. Facility will repair the steam table and ensure it is in proper working condition. This will be documented by the Maintenance Director and documentation will be added to the Monthly QA meetings.
6. Dining Room Director will perform weekly audits on kitchen steam table to ensure it is properly working.
7. Dining Room Director will perform weekly audits on delivery of halltrays and review food temperatures.
8. Audits will be turned into Executive Director weekly and reviewed by Administrator monthly and added to the QA minutes.

OSDH Response: Element accepted Yes ☐ No ☐

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

Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding. Executive Director will train the Dining Director and Kitchen staff on Chapter 257 food storage, prepared, and proper temperatures.

OSDH Response: Element accepted Yes ☐ No ☐			
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		1. Dining Room Director will maintain weekly audits on food temperatures and monitor delivery of halltrays weekly. 2. Maintenance Director will review Kitchen work orders weekly and report the status of the work orders to the Administrator in the monthly QA minutes. 3. The Audits will be reviewed in the monthly QA by the Administrator.	
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 Dining Room Director will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits will be reviewed by Executive Director and added to the monthly QA meeting. Monitoring of audits will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		1/22/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Skye Statum OAC 310:663-25-4(F)		Date 12/2/2024	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/2/2024

Facility Name: Glade Assisted Living

License Number: AL5512 SOUTH Building

Survey Event ID: Y61711

Date Survey Completed: 10/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C543

Based on: Observation, record review, and interview center failed to include a personal interview between the residents representative and person completing the form.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. Executive Director will re-train the facilities RN(s) on the OSDH regulation 310:663-5-4(b) Conduct of Assessment. Training will be added to the QA monthly minutes. Facility
2. RN will ensure that Resident #1,#2,#7,#8, & #9 will have their current comprehensive assessment reviewed and signed by resident/POA/& or family member.
3. These assessments will be reviewed by Executive Director to audit for resident/family signature. F
4. Facility RN will create an audit of assessments to ensure the personal interview was conducted and resident/family participated in the assessment process.
5. The audit will be reviewed by the Executive Director monthly and added to the QA monthly minutes.

OSDH Response: Element accepted Yes ☐ No ☐

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

Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding. Executive Director will train the RN and or new RN/LPN on the Conduct of Assessment OSDH regulation 310:663-5-4(b).

OSDH Response: Element accepted Yes ☐ No ☐

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

1 Executive Director will train the RN and or new RN's/LPN on the Conduct of assessments based on the OSDH regulation 310:663-5-4(b).
2. Facility RN will create and maintain a master spreadsheet of all residents assessments to ensure the personal interview of resident was conducted during the assessment process.

		3. The spreadsheet of the assessments will be reviewed in the monthly QA.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		ED and/or Director of Nursing will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits of spreadsheet of assessments with resident/family signature will be conducted by Executive Director and reviewed during the QA meeting. Monitoring of audits will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		1/22/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Skye Statum OAC 310:663-25-4(F)		Date 12/2/2024	
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Facility in Compliance by: Click here to enter a date.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/2/2024

Facility Name: Glade Assisted Living

License Number: AL5512 SOUTH Building

Survey Event ID: Y61711

Date Survey Completed: 10/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C701 Hot
Water-Bathing

Based on: Observation, record review, and interview center failed to maintain hot water temperatures of at least 115 degrees Fahrenheit.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. Administrator will train Maintenance Director on Appendix A General Requirements to ensure maintenance Director understands the water temperatures should be maintained at 115 degrees Fahrenheit. Training will be added to the monthly QA meeting.
2. Maintenance Director will adjust hot water temperatures for resident #6,7, & 9 to ensure meet Appendix A General Requirements. The Temperatures will be documented and submitted to the Administrator and added to the monthly QA meeting notes.

OSDH Response: Element accepted Yes ☐ No ☐

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

1. Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding.
2. Maintenance Director will train the maintenance team on Appendix A General Requirements. The Training will be reviewed by Administrator and added to the monthly QA meetings.
3. Maintenance team will perform random weekly hot water temperature checks in residents apartment. Minimal of 5 apartments a week. The checks will be documented, reviewed by Maintenance Director, and water temperatures adjusted as needed to meet Appendix A.
4. The weekly hot water checks will be submitted to the Administrator monthly and reviewed in the monthly QA meetings.

OSDH Response: Element accepted Yes ☐ No ☐		
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	1. Maintenance team will perform random weekly hot water temperature checks in residents apartment. Minimal of 5 apartments a week. The checks will be documented, reviewed by Maintenance Director, and water temperatures adjusted as needed to meet Appendix A. 2. The weekly hot water checks will be submitted to the Administrator monthly and reviewed in the monthly QA meetings. 3. Efforts and Outcomes will be identified and documented in the QA monthly meetings.	
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	ED and/or Maintenance Director will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits will be reviewed by Executive Director and added to the monthly QA meeting. Monitoring of audits will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	1/22/2025	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Skye Statum OAC 310:663-25-4(F)		Date 12/2/2024
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.		
Addendum Date	Enter a date of addendum.	Submitted by Enter name of person submitting addendum.
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Facility in Compliance by: Click here to enter a date.		

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 12/2/2024	
	Facility Name: Glade Assisted Living	
	License Number: AL5512 SOUTH Building	
	Survey Event ID: Y61711	
Date Survey Completed: 10/24/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1505 Resident Rights-Medical Care	Based on: Observation, record review, and interview center failed to administer medications as ordered by physician.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Assisted Living Center's Comments: Submission of this response and plan of correction is NOT legal admission that a deficiency exists or, that this statement of deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or plan of correction. In addition, the preparation and submission of this plan of correction does NOT constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of an conclusions set forth in this allegation by the survey agency.		
REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS	
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	1. DON & or RN/LPN will train the medication staff on "Properly Administering Medication, Documentation, Ordering medications, Medication Error Incident Reports, and reporting to DON/RN when Resident is "out of Stock" of medication. Training will be reviewed by Administrator and added to the QA monthly minutes. 2. DON & or RN/LPN will perform audits on resident #7 & #8 EMAR to ensure all medications are in stock and being administered based on physician orders. Audit will be reviewed by Administrator and added to the QA monthly notes. 3. Random weekly audits of residents EMAR will be performed by DON/or RN/LPN to ensure proper documentation, residents are receiving proper medications as per physician orders and to ensure residents are not "out of stock" of medications. The weekly audits will be reviewed by the DON. Monthly by the Administrator and added to the QA monthly minutes. 4. DON/RN/LPN will complete Medication Error Incident Reports if needed and will review monthly in QA meeting. 5. Audits will be turned into Administrator monthly and reviewed by Administrator and added to the QA minutes.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding.	
OSDH Response: Element accepted Yes ☐ No ☐		

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		1. DON/RN/LPN will perform a monthly QA audit of all medication Errors and document. 2. DON/RN/LPN will track and trend all Medication Error Incident reports and provide the information monthly in the QA meetings. 3. Efforts and Outcomes will be identified and documented in the QA monthly meetings. 4. Additional training will be provided to the medication staff as needed by DON/RN/LPN.	
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 DON/RN will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits will be reviewed by Executive Director and added to the monthly QA meeting. Monitoring of audits will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		1/22/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Skye Statum OAC 310:663-25-4(F)		Date 12/2/2024	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
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Facility in Compliance by: Click here to enter a date.			



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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/2/2024

Facility Name: Glade Assisted Living

License Number: AL5512 SOUTH Building

Survey Event ID: Y61711

Date Survey Completed: 10/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923
Medication Administration

Based on: Observation, record review, and interview center failed to accurately document medication not given.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. DON & or RN/LPN will train the medication staff on "Properly Administering Medication, Documentation, Ordering medications, Medication Error Incident Reports, and reporting to DON/RN when Resident is "out of Stock" of medication. Training will be reviewed by Administrator and added to the QA monthly minutes.
2. DON & or RN/LPN will perform audits on residents #10 and #11) EMAR to ensure all medications are in stock and being properly documented and administered based on physician orders. Audit will be reviewed by Administrator and added to the QA monthly notes.
3. Random weekly audits of residents EMAR will be performed by DON/or RN/LPN to ensure proper documentation, residents are receiving proper medications as per physician orders and to ensure residents are not "out of stock" of medications. The weekly audits will be reviewed by the DON. Monthly by the Administrator and added to the QA monthly minutes.
4. DON/RN/LPN will complete Medication Error Incident Reports if needed and will review monthly in QA meeting.
5. Audits will be turned into Administrator monthly and reviewed by Administrator and added to the QA minutes.

OSDH Response: Element accepted Yes ☐ No ☐

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

Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding.

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		1. DON/RN/LPN will perform a monthly QA audit of all medication Errors and document. 2. DON/RN/LPN will track and trend all Medication Error Incident reports and provide the information monthly in the QA meetings. 3. Efforts and Outcomes will be identified and documented in the QA monthly meetings. 4. Additional training will be provided to the medication staff as needed by DON/RN/LPN.	
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 DON/RN will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits will be reviewed by Executive Director and added to the monthly QA meeting. Monitoring of audits will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		1/22/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Skye Statum OAC 310:663-25-4(F)		Date 12/2/2024	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

Delivery via email to: Skye@gladeavenueassistedliving.com

December 12, 2024

License Number: AL5512

Ms. Skye Statum, Administrator
Glade Avenue Assisted Living South
2480 North Glade Avenue
Bethany, OK 73008

Survey Event ID: Y6I711

Dear Ms. Statum:

On **October 24, 2024**, a Relicensure survey with a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 9, 2025**.

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

Respectfully,

Tempal Killman

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

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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/2/2024

Facility Name: Glade Assisted Living

License Number: AL5512 SOUTH Building

Survey Event ID: Y61711

Date Survey Completed: 10/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 Food
Storage, Preparation AND
Service

Based on: Observation, record review, and interview center failed to maintain a steam table in good repair and hold temperature for hot hold food at 135 degrees Fahrenheit or above for hall trays.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. Executive Director will train the Dining room Director on Chapter 257 on food stored, prepared, and served. Training will be added to the QA monthly minutes.
2. Kitchen Staff will be trained on completing Work Orders on equipment not working properly. Training added to QA minutes.
3. Kitchen staff will be trained on proper temperatures for serving residents.
4. Facility will ensure halltrays are properly prepared and stored to maintain required temperatures.
5. Dining Room Director will perform weekly audits on kitchen steam table to ensure it is properly working.
6. Dining Room Director will perform weekly audits on delivery of halltrays and review food temperatures.
7. Audits will be turned into Executive Director weekly and reviewed by Administrator monthly and added to the QA minutes.

OSDH Response: Element accepted Yes ☐ No ☐

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

Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding. Executive Director will train the Dining Director and Kitchen staff on Chapter 257 food storage, prepared, and proper temperatures.

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		1. Dining Room Director will maintain weekly audits on food temperatures and monitor delivery of halltrays weekly. 2. Maintenance Director will review Kitchen work orders weekly and report the status of the work orders to the Administrator in the monthly QA minutes. 3. The Audits will be reviewed in the monthly QA by the Administrator.	
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 Dining Room Director will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits will be reviewed by Executive Director and added to the monthly QA meeting. Monitoring of audits will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		1/9/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Skye Statum OAC 310:663-25-4(F)		Date 12/2/2024	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/2/2024

Facility Name: Glade Assisted Living

License Number: AL5512 SOUTH Building

Survey Event ID: Y61711

Date Survey Completed: 10/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C543

Based on: Observation, record review, and interview center failed to include a personal interview between the residents representative and person completing the form.

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

1. Executive Director will re-train the facilities RN(s) on the OSDH regulation 310:663-5-4(b) Conduct of Assessment. Training will be added to the QA monthly minutes. Facility
2. RN will ensure that Resident #1,#2,#7,#8, & #9 will have their current comprehensive assessment reviewed and signed by resident/POA/& or family member.
3. These assessments will be reviewed by Executive Director to audit for resident/family signature. F
4. Facility RN will create an audit of assessments to ensure the personal interview was conducted and resident/family participated in the assessment process.
5. The audit will be reviewed by the Executive Director monthly and added to the QA monthly minutes.

Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding. Executive Director will train the RN and or new RN/LPN on the Conduct of Assessment OSDH regulation 310:663-5-4(b).

1 Executive Director will train the RN and or new RN's/LPN on the Conduct of assessments based on the OSDH regulation 310:663-5-4(b).
2. Facility RN will create and maintain a master spreadsheet of all residents assessments to ensure the personal interview of resident was conducted during the assessment process.
3. The spreadsheet of the assessments will be reviewed in the monthly QA.

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		ED and/or Director of Nursing will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits of spreadsheet of assessments with resident/family signature will be conducted by Executive Director and reviewed during the QA meeting. Monitoring of audits will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		1/9/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Skye Statum OAC 310:663-25-4(F)		Date 12/2/2024	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			



Oklahoma State
Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/2/2024

Facility Name: Glade Assisted Living

License Number: AL5512 SOUTH Building

Survey Event ID: Y61711

Date Survey Completed: 10/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C701 Hot
Water-Bathing

Based on: Observation, record review, and interview center failed to maintain hot water temperatures of at least 115 degrees Fahrenheit.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. Administrator will train Maintenance Director on Appendix A General Requirements to ensure maintenance Director understands the water temperatures should be maintained at 115 degrees Fahrenheit. Training will be added to the monthly QA meeting.
2. Maintenance Director will adjust hot water temperatures for resident #6,7, & 9 to ensure meet Appendix A General Requirements. The Temperatures will be documented and submitted to the Administrator and added to the monthly QA meeting notes.

OSDH Response: Element accepted Yes ☐ No ☐

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

1. Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding.
2. Maintenance Director will train the maintenance team on Appendix A General Requirements. The Training will be reviewed by Administrator and added to the monthly QA meetings.
3. Maintenance team will perform random weekly hot water temperature checks in residents apartment. Minimal of 5 apartments a week. The checks will be documented, reviewed by Maintenance Director, and water temperatures adjusted as needed to meet Appendix A.
4. The weekly hot water checks will be submitted to the Administrator monthly and reviewed in the monthly QA meetings.

OSDH Response: Element accepted Yes ☐ No ☐		
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	1. Maintenance team will perform random weekly hot water temperature checks in residents apartment. Minimal of 5 apartments a week. The checks will be documented, reviewed by Maintenance Director, and water temperatures adjusted as needed to meet Appendix A. 2. The weekly hot water checks will be submitted to the Administrator monthly and reviewed in the monthly QA meetings. 3. Efforts and Outcomes will be identified and documented in the QA monthly meetings.	
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	ED and/or Maintenance Director will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits will be reviewed by Executive Director and added to the monthly QA meeting. Monitoring of audits will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	1/9/2025	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Skye Statum OAC 310:663-25-4(F)		Date 12/2/2024
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.		
Addendum Date	Enter a date of addendum.	Submitted by Enter name of person submitting addendum.
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Facility in Compliance by: Click here to enter a date.		



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OPTIONAL PLAN OF CORRECTION TEMPLATE

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Survey Event ID: Y61711

Date Survey Completed: 10/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505 Resident
Rights-Medical Care

Based on: Observation, record review, and interview center failed to administer medications as ordered by physician.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. DON & or RN/LPN will train the medication staff on "Properly Administering Medication, Documentation, Ordering medications, Medication Error Incident Reports, and reporting to DON/RN when Resident is "out of Stock" of medication. Training will be reviewed by Administrator and added to the QA monthly minutes.

2. DON & or RN/LPN will perform audits on resident #7 & #8 EMAR to ensure all medications are in stock and being administered based on physician orders. Audit will be reviewed by Administrator and added to the QA monthly notes.

3. Random weekly audits of residents EMAR will be performed by DON/or RN/LPN to ensure proper documentation, residents are receiving proper medications as per physician orders and to ensure residents are not "out of stock" of medications. The weekly audits will be reviewed by the DON. Monthly by the Administrator and added to the QA monthly minutes.

4. DON/RN/LPN will complete Medication Error Incident Reports if needed and will review monthly in QA meeting.

5. Audits will be turned into Administrator monthly and reviewed by Administrator and added to the QA minutes.

OSDH Response: Element accepted Yes ☐ No ☐

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

Current residents residing in the community have the potential to be affected by the deficient practices. To date, no resident has experienced a negative outcome pertaining to the listed finding.

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		1. DON/RN/LPN will perform a monthly QA audit of all medication Errors and document. 2. DON/RN/LPN will track and trend all Medication Error Incident reports and provide the information monthly in the QA meetings. 3. Efforts and Outcomes will be identified and documented in the QA monthly meetings. 4. Additional training will be provided to the medication staff as needed by DON/RN/LPN.	
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 DON/RN will be responsible for sustained compliance. ED and/ or designee will maintain documentation of completed in-service in the community in-service binder. Monthly audits will be reviewed by Executive Director and added to the monthly QA meeting. Monitoring of audits will be attached to the QA meeting minutes and maintained by Executive Director to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		1/9/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Skye Statum OAC 310:663-25-4(F)		Date 12/2/2024	
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