OKLAHOMA
State Department
of Health

Delivery via email to: apickett@arborhouseliving.com

November 15, 2023

License Number: AL5530

Andrea Pickett, Administrator
Arbor House Assisted Living Of Midwest City
9240 East Reno Avenue
Midwest City, OK 73110

Survey Event ID: 8SVC11

Dear Ms. Pickett:

On **November 9, 2023,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on 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 will be completed for each violation; and
(6) Be signed by the administrator.

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

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

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

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

The IDR request must be submitted within 10 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.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Arbor House Assisted Living of Midwest City**
Address: **9240 East Reno Avenue**
City, State, Zip: **Midwest City, OK, 73110**
Provider #: **AL5530**
Complaint #: **OK00060532**
Investigation Dates: **11/08/23 through 11/09/23**

ALLEGATION(S)

The facility failed to ensure medications were administered according to physicians' orders.

An unannounced on-site investigation was initiated 11/08/2023 at 9:05 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls were observed for qualified staff. Medication Pass was observed.

Resident records were reviewed including assessments, care plans, physician orders, nursing notes, resident contracts, and medication administration records. Facility policy and procedures were reviewed. Grievance records were reviewed.

Residents were interviewed related to the provision of medication administration.

Staff members were interviewed regarding the facility policy for medication administration.

The attached Statement of Deficiencies, Form 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: 11/13/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Arbor House Assisted Living of Midwest City**
Address: **9240 East Reno Avenue**
City, State, Zip: **Midwest, OK, 73110**
Provider #: **AL5530**
Complaint #: **OK00060897**
Investigation Date(s): **11/08/23 through 11/09/23**

ALLEGATION

The center failed to ensure qualified staff to provide care for residents.

An unannounced on-site investigation was initiated 11/08/2023 at 9:05 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls were observed for qualified staff. Residents were observed being assisted with activities of daily living. Medication Pass was observed.

Resident records were reviewed including assessments, care plans, physician orders, nursing notes, resident contracts, and medication administration records. Facility policy and procedures were reviewed. Grievance records were reviewed. Employee files were reviewed.

Residents were interviewed related to the provision of qualified staff.

Staff members were interviewed regarding the facility policy for ensuring qualified staff were providing care to the residents.

The attached Statement of Deficiencies, Form 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: 11/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5530	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING OF MIDWEST CITY	9240 EAST RENO AVENUE MIDWEST CITY, OK 73110

(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 Complain investigations (OK00060532 and OK00060897) were conducted on 11/08/23 through 11/09/23. The following abbreviations will be used throughout this document: CMA- certified medication aide DON- director of nursing MAR- medication administration record MG- milligram ML- milliliters RCC- Resident Care Coordinator	C 000		
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on record review and interview, the center failed to administer medication according to the physician's order for one (#4) of three sampled residents reviewed for medication administration. The administrator identified 53 residents resided in the center. Findings: Resident #4 was admitted on 02/18/18 with diagnoses of dementia and Alzheimer's.	C1921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5530	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING OF MIDWEST CITY	9240 EAST RENO AVENUE MIDWEST CITY, OK 73110

(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
C1921	Continued From page 1 A physician's order, dated 12/22/22, documented morphine 20 mg/ml to give 0.5 ml every four hours sublingual routine for pain. A review of the 12/22 MAR documented Resident #4 received one dose of the routine morphine on 12/24/22 at 8:00 a.m. A review of the 12/22 MAR documented morphine 20 mg/ml to give 0.5 ml every four hours sublingual routine for pain was discontinued on 12/24/22 at 10:58 a.m. On 11/09/23 at 3:05 p.m., the DON stated Resident #4 expired on 12/27/22. On 11/09/22 at 3:07 p.m., the DON stated there was no physician order to discontinue the routine morphine scheduled for every four hours. On 11/09/23 at 3:10 p.m., the DON reviewed the 12/22 MAR. They stated the routine morphine was given once on 12/24/22 at 8:00 a.m. On 11/09/23 at 3:11 p.m., the DON stated based on the 12/22 MAR, no morphine was administered on 12/26/23 and prior to the resident expiring.	C1921		
C1923 SS=D	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.	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5530	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING OF MIDWEST CITY	9240 EAST RENO AVENUE MIDWEST CITY, OK 73110

(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 2 (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 prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to ensure timely medication administration for one (#1) of three sampled residents reviewed for medication administration. The Administrator identified 53 residents resided in the center. Findings: Resident #1 had diagnoses which included depression and anxiety. A physician's order, dated 09/22/23, documented fluoxetine 40 mg take one capsule daily. The medication was scheduled to be administered at 8:00 a.m. On 11/08/23 at 10:18 a.m., during the medication pass observations, CMA #1 stated Resident #1's fluoxetine was not available. They stated once reordered; the medication would arrive the same day at night.	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5530	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING OF MIDWEST CITY	9240 EAST RENO AVENUE MIDWEST CITY, OK 73110

(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 3 On 11/08/23 at 10:22 a.m., the RCC stated they were responsible for reordering medications and once ordered the medications arrived the same day at night. On 11/08/23 at 10:28 a.m., Resident #1 asked CMA #1 if the medication in the cup were the same amount they take daily. CMA #1 stated. "Yes". On 11/08/23 at 10:31 a.m., CMA #1 stated Resident #1 had the right to know their Fluoxetine 40 mg was not available. They stated they were instructed not to make residents aware of missing medications until the registered nurse was informed. On 11/08/23 at 11:17 a.m., CMA #1 administered Resident #1's fluoxetine 40 mg. The medication was administered one hour and seventeen minutes past the scheduled time. On 11/08/23 at 1:35 p.m., CMA #1 stated they administered the fluoxetine late. They stated they were to administer medications an hour before and an hour after the scheduled time. On 11/08/23 at 1:47 p.m., the DON stated medications were to be administered an hour before or an hour after scheduled times. They stated the fluoxetine 40 mg was administered late and residents were to be informed about unavailable medications.	C1923		

OKLAHOMA
State Department
of Health

Delivery via email to: andrea.pickett@legendseniorliving.com

November 28, 2023

License Number: AL5530

Ms. Andrea Pickett, Residence Director
Arbor House Assisted Living of Midwest City
9240 East Reno Avenue
Midwest City, OK 73110

Survey Event ID: 8SVC11

Dear Ms. Pickett:

On **November 9, 2023,** 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 **December 16, 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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 11/16/2023
	Facility Name: Arbor House Assisted Living of Midwest City
	License Number: AL5530
	Survey Event ID: 8SVC11
	Date Survey Completed: 11/9/2023

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1921	Based on: record review and interview, the center failed to administer medication according to the physician's order for one (#4) of three sampled residents reviewed for medication administration

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	SAMPLED resident (#4) discharged from community on 12/27/2022.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
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?	The Residence Director, Nursing Team, Certified Medication Aides and Medication Aide Techs will be in-serviced on MEDICATION ADMINISTRATION as outlined in Regulation 310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order. The Residence Director or designee will conduct random audits and monitoring of medication records to ensure accuracy and compliance in accordance with physician orders.
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.	a. The Residence Director or designee will audit a sampling of the medication administration records for accuracy per physician orders in accordance with 310:663-19-2(a)(1) MEDICATION ADMINISTRATION b. Review of the audit (sampling) of medication administration records will be incorporated into the QA meeting and the need for any additional intervention will be put into place. c. A review of the audit (sampling) will be kept with the QA Minutes.

		Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		12/16/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.		**Date 11/27 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: 11/16/2023** **Facility Name:** Arbor House Assisted Living of Midwest City **License Number:** AL5530 **Survey Event ID:** 8SVC11 **Date Survey Completed: 11/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923	Based on: observation, record review and interview, the center failed to ensure timely medication administration for one (#1) of three sampled residents reviewed for medication administration

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	Residence Director or Designee will ensure a review of medication administration record for one (#1) resident as identified on the SoD for timely medication administration as outlined in 310:663-19-2(a)(3) MEDICATION ADMINISTRATION (A) thru (G)
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	ALL residents have the potential to be affected.
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?	The Residence Director, Nursing Team, Certified Medication Aides and Medication Aide Techs will be in-serviced on MEDICATION ADMINISTRATION as outlined in Regulation 310:663-19-310:663-19-2(a)(3) MEDICATION ADMINISTRATION (A) thru (G).
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.	Enter methods to ensure corrections are sustained: a. Residence Director or designee will conduct random audits and monitoring of medication administration records to ensure timely administration of medication in compliance with Chapter 310:661-19-2(a)(3) (A) thru (G). b. Review of the audit will be incorporated into the QA meeting and need for any additional intervention will be put into place. c. Record of the documentation will be kept with the QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/16/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Andrea Peko RD		**Date 11/27/2023**
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

Delivery via email to: andrea.pickett@legendseniorliving.com

February 12, 2024

License Number: AL5530

Andrea Pickett, Administrator
Arbor House Assisted Living Of Midwest City
9240 East Reno Avenue
Midwest City, OK 73110

Survey Event ID: 8SVC12

Dear Ms. Pickett:

On **February 9, 2024,** an offsite/paper complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 9, 2024,** have now been corrected effective **November 27, 2024**

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5530	A. BUILDING: _____ B. WING _____	R 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR HOUSE ASSISTED LIVING OF MIDWES	9240 EAST RENO AVENUE MIDWEST CITY, OK 73110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 02/09/24. The facility was in substantial compliance.	{C 000}		