OKLAHOMA
State Department
of Health

Delivery via email to: Sslemp@StoreyOaks.com

October 19, 2021

License Number: AL5536

Mr. Scott Slemp, Administrator
Storey Oaks
8300 North May Avenue
Oklahoma City, OK 73120

Survey Event ID: W39811

Dear Mr. Slemp:

On **October 12, 2021,** 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.

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of Health

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

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State Department
of Health

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

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

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

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

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.10.19 10:45:12 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Storey Oaks Assisted Living**
Address: **8300 N May Avenue**
City, State, Zip: **Oklahoma City, OK 73120**
Provider #: **AL5536**
Complaint #: **OK 00057828**
Investigation Date(s): **10-11-21 to 10-12-21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate supervision to prevent falls and failed to document falls.	**S**
2. The center failed to honor contracts related to laundry and housekeeping	**US**

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 10/11/2021 at 10:10 a.m.

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

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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag F1912 and F1951 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility failing to honor contracts related to laundry and housekeeping was conducted.

Observations were made of sampled resident rooms and common areas within the facility. There was no trash or soiled sheets/bedding observed in the resident rooms or common areas. The housekeepers were observed going room to room cleaning the resident rooms and common areas during the survey. Cleaning was observed in rooms and common areas of the facility including trash collection and bags replacement, bedding changes and surfaces wiped and disinfected during the housekeeping process.

Facility records were reviewed. Records documented laundry and housecleaning schedules and completions.

Interviews were conducted with residents and resident representatives. There were no concerns voiced related to housecleaning and laundry being completed according to contracts.

Interviews were conducted with staff from various departments. They were knowledgeable and informative about schedules and completion of housekeeping and laundry.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #2. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Jennifer Major RN Digitally signed by Jennifer Major RN
Date: 2021.10.14 08:30:42 -05'00'

Jennifer Major RN

Date report completed: 10/13/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOREY OAKS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 complaint investigatiom (complaint #OK00057828) was conducted on 10/11/21 and 10/12/21. The following is a list of abbeviations used throughout this document: cm - centimeters CT - computed tomography DON - Director of Nurses EMSA - emergency medical services authority ER - emergency room LPN - licensed practical nurse MAR - medication administration record mg - milligrams OSDH - Oklahoma State Department of Health RCD - resident care director	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and	C1505		

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C1505	Continued From page 1 treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure accuracy of transcribed medications was completed upon admit for one (#1) of four sampled residents reviewed for accidents. This failed practice had the isolated potential for more than minimal harm. The Resident Care Director identified 38 residents resided in the facility. Findings: A physician's order from the facility that resident#1 was recently discharged from, dated 10/06/21, documented Lorazepam 2 mg every six hours as needed for agitation/exit seeking. Resident #1 was admitted to the facility on 10/07/21 with diagnoses which included anxiety.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1505	Continued From page 2 A physician's order, dated 10/09/21, documented Lorazepam 2 mg every six hours. The order was discontinued on 10/11/21. The MAR, dated 10/2021, documented resident #1 had received Lorazepam 2 mg six out of nine ordered doses from 10/09/21 at 12:00 p.m. through 10/11/21 at 12:00 p.m., with the last dose given on 10/11/21 at 12:00 p.m. On 10/11/21 at 1:45 p.m., resident #1 was observed with eyes closed. She did not respond when spoken to by the surveyor. The Resident Care Director (RCD) tried to arouse the resident, who was sitting in a straight back chair in a common area with her head hanging down between her knees. The RCD stated the resident was not acting like herself. She stated, "She is on a large dose of Lorazepam two mg every six hours, maybe she is a little out of it." Resident #1 was aroused upon sternal rub and mumbled garbled words. Vitals were taken and the resident was moved to her room. From 2:45 p.m. until 3:45 p.m., resident #1 was observed to be in the front common area with her eyes closed and her head resting on the arm of a straight back chair. At 4:00 p.m., the RCD informed staff to call EMSA to have resident #1 assessed for altered mental status. On 10/12/21 at 10:57 a.m., LPN #1 stated the Lorazepam had not been transcribed accurately. She stated the orders from the discharge paperwork received from the previous facility documented Lorazepam 2 mg every six hours as needed. She stated she had signed the admission medication list, but had failed to verify	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 3 the doses another nurse had transcribed.	C1505		
C1912 SS=E	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement.	C1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	10/12/2021

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C1912	Continued From page 4	C1912		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the center failed to report a fall to the Oklahoma State Department of Health for one (#4) of four sampled residents reviewed for falls. This failed practice had the isolated potential for more than minimal harm.

The Resident Care Director identified 38 residents at risk for falls.

Findings:

Resident #4 had diagnoses which included dementia.

The clinical record was reviewed. There was no documentation regarding a fall on 08/21/21.

A hospital ER note, dated 08/21/21, documented the resident had acquired a 1 cm, superficial laceration to the left eyebrow which required steri strips to be applied and had occurred due to a fall out of the bed at the long term care facility. A CT scan of the head was obtained and findings documented there was no acute intracranial abnormality.

A nurse's progress note, dated 08/21/21 at 8:47 a.m., documented LPN #1 received report upon the resident returning to the facility via EMSA transport on a stretcher with a laceration to the left eyebrow.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1912	Continued From page 5 On 10/12/21 at 2:30 p.m., the administrator stated if a resident had a fall and required treatment, he would have reported the incident to the Oklahoma State Department of Health. He was asked if the fall on 08/21/21, which required treatment at a hospital, had been reported to OSDH. He stated no, he did not think he needed to report the fall due to the resident not requiring treatment more than first aid. He stated there was no documentation regarding the fall on 08/21/21. He stated he could not verify the resident had a fall or the circumstances concerning the incident due to the lack of documentation.	C1912		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review, the center failed to document a fall for one (#4) of four sampled residents reviewed for falls. This failed practice had the isolated potential for more than minimal harm. The Resident Care Director identified 38 residents resided in the facility. Findings: Resident #4 had diagnoses which included	C1951		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	10/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1951	Continued From page 6 dementia. The clinical record was reviewed. There was no documentation regarding a fall on 08/21/21. A hospital ER note, dated 08/21/21, documented the resident had acquired a 1 cm, superficial laceration to the left eyebrow which required steri strips to be applied and had occurred due to a fall out of the bed at the long term care facility. A nurse's progress note, dated 08/21/21 at 8:47 a.m., documented LPN #1 received report upon the resident returning to the facility via EMSA transport on a stretcher with a laceration to the left eyebrow. On 10/12/21 at 2:33 p.m., the administrator stated there was no documentation regarding the fall on 08/21/21. He stated he could not verify the resident had a fall or the circumstances concerning the incident due to the lack of documentation.	C1951		

OKLAHOMA
State Department
of Health

Delivery via email to: Sslemp@StoreyOaks.com

October 28, 2021

License Number: AL553

Mr. Scott Slemp, Administrator
Storey Oaks
8300 North May Avenue
Oklahoma City, OK 73120

Survey Event ID: W39811

Dear Mr. Slemp:

On **October 12, 2021,** 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 26, 2021**.

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.

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2021.10.28 15:32:49 -05'00'

Tempal Killman, Administrative Assistant
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: 10/25/2021** **Facility Name:** Storey Oaks **License Number:** AL5536 **Survey Event ID:** W39811 **Date Survey Completed: 10/12/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1951	Based on: This Rule is not met as evidenced by: Based on interview and record review, the center failed to document a fall for one (#4) of four sampled residents reviewed for falls.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This does not admit or acknowledge any deficient practice.

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?	Resident no longer resides at community
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Executive Director will audit open and closed files to see if any other residents were 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?	Executive Director will audit open and closed resident files monthly for 3 months and report findings and make suggestions if needed to QA Committee.
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.	RN/DCS will report findings and suggestions if needed to QA Committee. QA Committee will make recommendations if needed.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/26/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) **Date 10/27/2021**

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: 10/25/2021** **Facility Name:** Storey Oaks **License Number:** AL5536 **Survey Event ID:** W39811 **Date Survey Completed: 10/12/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: This REQUIREMENT is not met as evidenced by:Based on observation, record review, and interview the facility failed to ensure accuracy of transcribed medications was completed upon admit for one (#1) of four sampled residents reviewed for accidents. This failed practice had the isolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This does not admit or acknowledge any deficient practice. Physician and staff were aware and resident ordes were clarified and corrected.

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?	Resident order was corrected prior to State Survey Visit exit.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Resident Physician Orders will be reviewed and compared to Medication Administration Records to see if there are any other affected residents.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	RN/DCS will audit physicians orders and medication administration records monthly for 3 months and report findings and make suggestions if needed to QA Committee.
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.	RN/DCS will report findings and suggestions if needed to QA Committee. QA Committee will make recommendations if needed.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/26/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	**Date 10/27/2021**

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/25/2021** **Facility Name:** Storey Oaks **License Number:** AL5536 **Survey Event ID:** W39811 **Date Survey Completed: 10/12/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1912	Based on: This REQUIREMENT is not met as evidenced by:Based on interview and record review, the center failed to report a fall to the Oklahoma State Department of Health for one (#4) of four sampled residents reviewed for falls

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This does not admit or acknowledge any deficient practice.

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?	RN/DCS will review and audit incident reports to ensure all state reportables have been completed.
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 Incident Reports will be reviewed by the RN/DCS or their designee promptly to ensure anything that needs to be reported to the state will be completed timely going forward.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	RN/DCS will be in-serviced on state reportable incidents. RN/DCS will audit all incident reports and report to QA Committee findings monthly for 3 months.
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.	RN/DCS will report findings and suggestions if needed to QA Committee. QA Committee will make recommendations if needed. Executive Director will in-service RN/DCS on state reportable incident reports and submit in-service to QA Committee.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/26/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	**Date 10/27/2021**

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

OKLAHOMA
State Department
of Health

Delivery via email to: Sslemp@StoreyOaks.com

January 7, 2022

License Number: AL5536

Mr. Scott Slemp, Administrator
Storey Oaks
8300 North May Avenue
Oklahoma City, OK 73120

Survey Event ID: W39812

Dear Mr. Slemp:

On **January 3, 2022,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 12, 2021** have now been corrected effective **December 26, 2021.**

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

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.01.07 08:39:49 -06'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

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
	AL5536	A. BUILDING: _____ B. WING _____	R 01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOREY OAKS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 revisit was conducted 01/03/2022. All deficiencies from the 10/12/2021 survey were cleared.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE