OKLAHOMA
State Department
of Health

Delivery Via Email: bdaniel@mrhcok.com

August 12, 2020

License Number: AL6101

Ms. Bethany Daniel, Administrator
Van Buren House Assisted Living
1500 East Van Buren
McAlester, OK 74501

RE: Survey Event ID: W86O11

Dear Ms. Daniel:

On **March 12, 2020**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on March 12, 2020.

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

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

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

(1) Address how corrective action will be accomplished for affected residents;

(2) Address how other residents with the potential to be affected will be identified;

(3) Address measures or systemic changes to ensure the deficiency will not recur;

(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;

(5) Include dates when corrective action and monitoring will be completed for each violation;

(6) Be signed by the administrator.

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

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

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

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

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

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State Department of Health, ou=Long Term Care, email=katies@health.ok.gov, c=US
Date: 2020.08.12 08:26:47 -05'00'

Katie Stagner, Enforcement 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
	AL6101	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAN BUREN HOUSE ASSISTED LIVING	1500 EAST VAN BUREN MCALESTER, OK 74501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 03/10/20 through 03/12/20. Current census was 43. The following deficiencies were cited.	C 000		
C 391 SS=F	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, it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regards to floor maintained and in good repair and single-use of gloves. These failed practices had the widespread potential for more than minimal harm for all 43 residents who received their nutrition from the kitchen. Findings: On 03/11/20, a kitchen sanitation tour was conducted and the following was observed: 310:257-11-3. Floors, walls, and ceilings ...except for antislip floor coverings, or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable. At 10:38 a.m., the tile covered floor in the paper storage room, next to the warewashing area, was observed to have five broken and missing pieces of tiles. One piece of tile, at the entrance left side was almost completely missing, with only a small piece of the tile left in place. The cement floor	C 391		

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C 391	Continued From page 2	C 391		

dining room while she wore the same gloves she had worn to go in and out of the kitchen into the dining room. After she hung up the telephone, dietary employee #3 then retrieved a tray and prepared it with food and drink, to be delivered as a room tray, while wearing the same gloves.

Dietary employee #5 wore blue gloves as he loaded used equipment into a large warewashing machine, unloaded it at the end of the cleaning/sanitizing cycle, and then walked across the kitchen and into a walk-in refrigerator, came out and walked back to the warewasher, all while wearing the same gloves. He did not change gloves or wash his hands between tasks.

Dietary employee #4 wore the same blue gloves as she served residents in the dining room, came in and out of the kitchen to get milk out of a refrigerator, retrieved items out of the paper storage room, placed used items near the warewashing machine, while wearing the same gloves for all the different tasks.

At 11:54 a.m., the dietary supervisor placed his bare hands on his hips as he talked, pulled up his pants with both hands, then went over and picked up a pair of gloves. When informed of touching his clothes, the dietary supervisor asked, "Did I do that?" He then placed the gloves on his hands.

At 12:01 p.m., the dietary supervisor wore the same gloves as he served the lunch meal plates and touched paper menus, to turn them over on top of the serving table.

At 12:07 p.m., dietary employees #2, 3 and #4 continued to wear the same gloves throughout the meal service, going out into the dining room

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C 391	Continued From page 3 and back into the kitchen. At 12:09 p.m., dietary employee #3 stated she kept butter in her pockets because they could not leave it on the tables. She patted her right pocket with her gloved hand and continued to serve filled plates to the residents in the dining room. At 12:12 p.m. the dietary supervisor walked over to a beeping convection oven and opened the doors, then back to the steam table and continued to serve food onto plates with the same gloves he had on all of the meal service. At 12:15 p.m., dietary employee #2 spilled ranch dressing on a preparation table, grabbed some paper towels from a nearby sink, wiped up the spilled dressing, walked over to a 30 gallon trash can, lifted the lid and threw away the soiled paper towels, then returned to serve ranch dressing into two more small plastic cups. She stated she did not change gloves because she was in a hurry. She picked up a bowl of salad and a cup of ranch dressing and left the kitchen, with the same gloves on her hands. At 12:15 p.m., the dietary supervisor continued to touch each paper menu to turn it over and then touched the plates on the surface touched by the food. When asked about touching the menus, he asked, "What about them?" He then stated most of the residents filled out their own menus with their food preferences, or the nurses helped with the ones that could not do their own menus. He further stated everybody in the center touched the menus, the residents, the nurses, and every cook went through them. He stated every menu was touched twice a meal, to see how much food to cook/prepare and then to serve the meal (at least 42 times a week in the kitchen alone). The	C 391		

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C 391	Continued From page 4 dietary manager stated he touched the menus with the same gloves he wore to serve the meal because that was the way they had been doing it.	C 391		

OKLAHOMA
State Department
of Health

Delivery Via Email: bethany_d@mrhcok.com

August 17, 2020

License Number: AL6101

Ms. Bethany Daniel, Administrator
Van Buren House Assisted Living
1500 East Van Buren
McAlester, OK 74501

RE: Survey Event W86O11

Dear Ms. Daniel:

On **March 12, 2020**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **March 21, 2020**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,
Katie
Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State Department of Health, ou=Long Term Care, email=katies@health.ok.gov, c=US
Date: 2020.08.17 14:15:53 -05'00'

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/12/2020** **Facility Name:** Van Buren House Assisted Living **License Number:** AL6101 **Survey Event ID:** W86O11 **Date Survey Completed: 3/12/2020**
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: observation and interview, it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regards to floor maintained and in good repair and single-use of gloves.
ASSISTED LIVING CENTER'S PLAN OF CORRECTION	
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).	
REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	310:257-11-3: Replacement of tile in the paper storage room completed on 3/21/2020. 310:257-5-34: Dietary Department meeting held on 3/18/20 with 100% attendance. Education provided on hand hygiene and glove usage. 3/25/20 Additional education on hand hygiene and glove usage provided to all dietary staff members.
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Completed actions listed above with #1.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	310:257-11-3: Education provided to dietary staff members to immediately report any repair needs to maintenance reporting system and facility Administrator. Enviroment of care rounds are completed monthly by maintenance. Maintenance enters findings into maintenance work order program to ensure completion or repair of task. Annual Environment of Care rounds completed by MRHC team and reported into work order program as necessary. 310:257-5-34: Van Buren House Infection Prevention Nurse provides biweekly Infection Prevention surveillance with all staff, including surveillance of hand hygiene and glove/PPE usage.
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.	Van Buren House Infection Prevention Nurse provides biweekly Infection Prevention surveillance with all staff and provides education as needed to ensure Infection Prevention practices are met. Infection Prevention Nurse shall keep records of IP surveillance and document education when provided Infection Prevention Nurse shall report findings to facility Administrator as needed and provide an update of IP

	surveillance and findings during quarterly QA meetings. Additional education will be given if trends occur IP Surveillance records will be maintained by the Infection Prevention Nurse. Environment of Care Round records will be maintained by Maintenance
5. On what date will corrective action be completed?	3/21/2020
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required	**Date** Enter date of signature 8/17/2020

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 391	Continued From page 3 and back into the kitchen. At 12:09 p.m., dietary employee #3 stated she kept butter in her pockets because they could not leave it on the tables. She patted her right pocket with her gloved hand and continued to serve filled plates to the residents in the dining room. At 12:12 p.m. the dietary supervisor walked over to a beeping convection oven and opened the doors, then back to the steam table and continued to serve food onto plates with the same gloves he had on all of the meal service. At 12:15 p.m., dietary employee #2 spilled ranch dressing on a preparation table, grabbed some paper towels from a nearby sink, wiped up the spilled dressing, walked over to a 30 gallon trash can, lifted the lid and threw away the soiled paper towels, then returned to serve ranch dressing into two more small plastic cups. She stated she did not change gloves because she was in a hurry. She picked up a bowl of salad and a cup of ranch dressing and left the kitchen, with the same gloves on her hands. At 12:15 p.m., the dietary supervisor continued to touch each paper menu to turn it over and then touched the plates on the surface touched by the food. When asked about touching the menus, he asked, "What about them?" He then stated most of the residents filled out their own menus with their food preferences, or the nurses helped with the ones that could not do their own menus. He further stated everybody in the center touched the menus, the residents, the nurses, and every cook went through them. He stated every menu was touched twice a meal, to see how much food to cook/prepare and then to serve the meal (at least 42 times a week in the kitchen alone). The	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6101	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAN BUREN HOUSE ASSISTED LIVING	1500 EAST VAN BUREN MCALESTER, OK 74501

(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 391	Continued From page 4 dietary manager stated he touched the menus with the same gloves he wore to serve the meal because that was the way they had been doing it.	C 391		