



Oklahoma State Department of Health
Creating a State of Health

July 5, 2019

License Number: AL6903

Mr. Dustin Cox, Administrator
Chisholm Trail Assisted Living
625 Chisholm Trail Parkway
Duncan, OK 73533

RE: Survey Event ID: 63ZL11

Dear Mr. Cox:

On **June 25, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on June 25, 2019.

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;

Board of Health

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- (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,



 Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER CHISHOLM TRAIL ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 625 CHISHOLM TRAIL PARKWAY DUNCAN, OK 73533		
(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 On 06/24/19 through 06/25/19 a re-licensure survey was conducted. Census was 62. The following deficient practice was cited.	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 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.	C1505		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER CHISHOLM TRAIL ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 625 CHISHOLM TRAIL PARKWAY DUNCAN, OK 73533		
(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
C1505	Continued From page 2 (milligrams/deciliter). Continue Levemir 30 units BID (twice a day). The physician's orders for resident #2 dated from January 2019 through June 2019 documented Humalog inject 10 units subcutaneously (injection administered underneath the skin) as needed for DM (Diabetes Mellitus) Type 1. Give if FSBS (Finger Stick Blood Sugar) is greater than 150 mg/dl. The additional 10 units of Humalog insulin had not been administered from January 2019 through June 2019. The plan of care for resident #2 identified Diabetes Mellitus Type 1 as a problem. On 06/24/19 at 11:32 a.m., licensed practical nurse (LPN) #4 performed a FSBS for resident #2. Resident #2 FSBS reading was 158 mg/dl (milligrams/deciliters). The routine order for Humalog 10 units was administered. The additional Humalog insulin was not administered for the FSBS reading over 150 mg/dl. A laboratory test for resident #2, dated April 10, 2019, documented an A1C level of 7.8% high (4.2-6.3%) and an estimated average glucose of 177 mg/dl. On 06/25/19 at 2:41 p.m., the center's LPN/Director of Nurses (DON) was asked why resident #2 had not received the additional 10 units of Humalog. The LPN/DON stated she would obtain clarification from the physician for the additional 10 units of Humalog to be administered for a FSBS over 150 mg/dl. The physician's reply was for the staff to administer the additional 10 units of Humalog for a FSBS over 150 mg/dl, because resident #2's A1C (laboratory test to determine average blood sugar	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2019
NAME OF PROVIDER OR SUPPLIER CHISHOLM TRAIL ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 625 CHISHOLM TRAIL PARKWAY DUNCAN, OK 73533		
(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
C1505	Continued From page 3 over time) was still high at 7.8%. On 06/24/19 at 1:30 p.m., resident #2 was asked about her insulin. She stated if her finger stick blood sugar was over 100 she would get insulin and if it was under 100 she would not get insulin. She stated she thought that was right but to check with the nurses, they would know.	C1505		

STATE WORKLOAD REPORT

Provider/Supplier Number
AL6903

Provider/Supplier Name
CHISHOLM TRAIL ASSISTED LIVING

Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30875	06/24/2019	06/25/2019	1.00	0.00	16.00	0.00	4.00	2.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

JUL 08 2019



Oklahoma State Department of Health
Creating a State of Health

July 11, 2019

License Number: AL6903

Mr. Dustin Cox, Administrator
Chisholm Trail Assisted Living
625 Chisholm Trail Parkway
Duncan, OK 73533

RE: Survey Event 63ZL11

Dear Mr. Cox:

On June 25, 2019, 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 **June 27, 2019**.

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,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC.jt

Board of Health

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Interim Commissioner of Health

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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/8/2019

Facility Name: Chisholm Trail Assisted Living

License Number: AL6903

Survey Event ID: 63ZL11

Date Survey Completed: 6/25/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: observation, interview and record review, it was determined the center failed to follow the physician's order for insulin administration

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 ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted: Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted: Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Date 7/8/2019

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.

JUL 12 2019

10012013



Oklahoma State Department of Health
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August 15, 2019

License Number: AL6903

Mr. Dustin Cox, Administrator
Chisholm Trail Assisted Living
625 Chisholm Trail Parkway
Duncan, OK 73533

RE: Survey Event 63ZL12

Dear Mr. Cox:

On **August 7, 2019**, a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 25, 2019 SURVEY**, have now been corrected effective **June 27, 2019**.

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/

Board of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6903	(X2) MULTIPLE CONSTRUCTION A BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED R 08/07/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CHISHOLM TRAIL ASSISTED LIVING

**625 CHISHOLM TRAIL PARKWAY
DUNCAN, OK 73533**

(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 On 08/07/19 a follow-up survey was conducted. Census was 61. All deficient practice was cleared.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE WORKLOAD REPORT
 Provider/Supplier Number
 AL6903

 Provider/Supplier Name
 CHISHOLM TRAIL ASSISTED LIVING

Type of Survey (select all that apply)

2	D			
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 A Complaint Investigation
 B Dumping Investigation
 C Federal Monitoring
 D Follow-up Visit
 M Other

 E Initial Certification
 F Inspection of Care
 G Validation
 H Life Safety Code

 I Recertification
 J Sanctions/Hearing
 K State License
 L CHOW

Extent of Survey (select all that apply)

A				
---	--	--	--	--

 A Routine/Standard Survey (all providers/suppliers)
 B Extended Survey (HHA or Long Term Care Facility)
 C Partial Extended Survey (HHA)
 D Other Survey
SURVEY TEAM AND WORKLOAD DATA

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Team Leader ID								
1. 30875	08/07/2019	08/07/2019	0.50	0.00	3.75	0.00	4.50	1.00
2.								
3.								
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10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours.....

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

 AUG 19 2019 *jm*