OKLAHOMA
State Department
of Health

Delivery via email to: wendy.wilkerson@canoebrookal.com

April 17, 2024

License Number: AL6905

Ms. Wendy Wilkerson, Administrator
Duncan Assisted Living
1095 Chisholm Trail Parkway
Duncan, OK 73533

RE: Survey Event ID: QQMQ11

Dear Ms. Wilkerson:

On **April 10, 2024**, 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 **April 10, 2024**.

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

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

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH

conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to: IDRCoordinator@health.ok.gov
Or **mail** to:

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

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

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

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

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

Respectfully,

Tempal Killman

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

Enclosure

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
	AL6905	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNCAN ASSISTED LIVING	1095 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 A relicensure was conducted from 04/08/24 through 04/10/24. Facility Census: 34 Listed below are the abbreviations used throughout this document: ACMA - Advanced Certified Medication Aide LPN - Licensed Practical Nurse	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure: a. food items were dated and labeled; and b. potentially hazardous foods were discarded after 24 hours for one of two kitchen observations. The Executive Director identified a census of 34. Finding: A "Food Storage" policy, revised 10/25/23, read in part, " ...Staff shall store all foods in safe and sanitary conditions to preserve the condition and quality of the product ...All food will be labeled and dated with an expiration date ...Leftovers will be labeled and dated. Any foods that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours ..."	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6905	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNCAN ASSISTED LIVING	1095 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 391	Continued From page 1 On 04/09/24 at 8:20 a.m., the following items were observed in the three door refrigerator located in the kitchen: a. a circular plastic container with a brown meat substance inside. The label documented "4/7 Roast."; b. seven individual plastic containers of a yellow substance covered with plastic wrap. There was no date or label present; c. three foil covered items wrapped in plastic wrap. One had three foil wrapped items with "T & C" written on it, One had four foil wrapped items with "T & C" written on it, and one had five foiled wrapped items with "HJC" written on it. There were no dates present; and d. a glass jar containing a brown substance with foil over the top with 02/11/24 hand written on the top. On 04/09/24 at 8:20 a.m., Cook # 2 stated they did not know what the foil wrapped items were. On 04/09/24 at 8:25 a.m., Cook #2 opened the foil wrapped items and stated "Ham and cheese sandwiches." They stated they must have been from last night. They stated the others were turkey and cheese. Cook #2 stated there were no dates present. They stated staff were supposed to date and label food items. They were asked how long they kept leftovers. Cook #2 stated, "I'll probably throw away sandwiches today." They stated two days was the leftover policy as long as it wasn't fish, shrimp, or seafood. Cook #2 stated the yellow food items were banana pudding that was served yesterday and would be an option today as well. They stated there was no date or label present. Cook #2 identified the glass jar as containing "Bacon Grease." They stated there was no label so they	C 391		

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	AL6905	A. BUILDING: _____ B. WING _____	04/10/2024

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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
C 391	Continued From page 2 would dump it out. On 04/09/24 at 8:28 a.m., a large covered metal bowl of pasta was observed in the three door refrigerator. Cook #2 stated they came back Monday and were pretty sure it was served "Sunday at Lunch." They stated there was no date or label on it.	C 391		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for one (#3) of eight sampled residents reviewed for assessments. The Executive Director identified a census of 34. Findings: Resident #3 had diagnoses which included type two diabetes mellitus and major depressive disorder.	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6905	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNCAN ASSISTED LIVING	1095 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 522	Continued From page 3 Resident #3 had an annual assessment dated 01/09/23. On 04/10/24 at 10:30 a.m., the Executive Director stated staff completed assessments together. They stated the LPN would fill out certain parts of the assessment, the Executive Director would go in and review the information and sign off on the assessment. The Executive Director stated they would complete an assessment on admission, annually, or when a resident experienced a significant change. They stated the Resident Care Director would know if Resident #3 had an assessment completed newer than the 01/09/23 assessment. On 04/10/24 at 10:40 a.m., the Resident Care Director stated they were going off of the admission month of September, so they did not believe an assessment was due until September 2024. They stated the last assessment for Resident #3 was completed January 2023. They stated they were not aware the requirement was for a comprehensive assessment to be completed every 12 months.	C 522		
C1920 SS=E	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to ensure medications were administered as ordered for one (#5) of five	C1920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6905	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNCAN ASSISTED LIVING	1095 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
C1920	Continued From page 4 sampled residents reviewed for medication administration. The Executive Director identified a census of 34. Findings: A "Medication Administration" policy, resided 05/15, read in part, " ...Medication administration- the provision of prescribed and physician ordered medications by authorized nursing personnel in a manner that assures proper patient and medication identification ...The staff will not administer any medication without an order to do so ..." Resident #5 had diagnoses which included seasonal allergic rhinitis and corneal transplant status. A "Physician Order", dated 02/01/23, documented fluticasone spray 50 mcg two sprays in each nare daily. A "Physician Order", dated 02/01/23, documented sodium chloride solution five percent instill one drop in left eye two times a day related to corneal edema. It documented wait one minute between same drops, and five minutes between different drops. A "Physician Order", dated 02/01/23, documented prednisolone suspension one percent instill one drop in right eye three times a day related to corneal edema. It documented wait one minute between same drops and five minutes between different drops. On 04/09/24 at 7:37 a.m. ACMA #1 was observed preparing Resident #5's medications with	C1920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6905	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNCAN ASSISTED LIVING	1095 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
C1920	Continued From page 5 included: a. fluticasone nasal spray, the label read two sprays each nostril; b. sodium chloride hypertonicity five percent, ACMA #1 stated this was like Clear Eyes and went in both eyes; and c. prednisone one percent, the label read to administer one drop in right eye. On 04/09/24 at 7:40 a.m., ACMA #1 administered medications to Resident #5 which included: a. one spray of fluticasone nasal spray in each nostril; b. one drop of sodium chloride hypertonicity five percent in the right and left eye; and c. one drop of prednisone one percent in the resident's right eye. ACMA #1 did not wait five minutes between the two different eye drops in the resident's right eye. On 04/09/24 at 7:50 a.m., after checking the resident's orders again and stated, ACMA #1 "That was a boo boo." They stated the sodium chloride hypertonicity was only supposed to be administered in the left eye. On 04/09/24 at 7:51 a.m., ACMA #1 stated the medication policy was to punch initial and give. They stated they administered the eye drop in the wrong eye. They stated they would let the Resident Care Director know so they could write it up. ACMA #1 stated the family and physician would be notified. On 04/09/24 at 11:30 a.m., the Resident Care Director stated staff should check the medication and the order to ensure it is the right medication, right dose, right route and right time before administering medications.	C1920		

OKLAHOMA
State Department
of Health

Delivery via email to: wendy.wilkerson@canoebrookal.com

May 23, 2024

License Number: AL6905

Ms. Wendy Wilkerson, Administrator
Duncan Assisted Living
1095 Chisholm Trail Parkway
Duncan, OK 73533

RE: Survey Event QQMQ11

Dear Ms. Wilkerson:

On **April 10, 2024,** agents from our office completed a Licensure survey at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- The proposed actions for correction of **C-0391, C-0522** and **C-1920,** is rejected because the alleged completion date, **April 12, 2024**, does not consider monitoring corrections to ensure the compliance is "achieved and sustained," as required by Oklahoma Administrative Code *(OAC) 310:663-25-4(b)(c).*

Please resubmit a new plan of correction, with amendments, as possible.

Respectfully,

Tempal Killman

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

Enclosure

** INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY **

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
May 7, 2024 at 1:18:36 PM CDT		438	13	Received

05/07/2024 12:09 #726 P.001/013

From:

CANOE BROOK

Canoe Brook Duncan Assisted Living
1095 ~~425~~ Chisholm Trail Parkway
Duncan OK 73533
580-252-3337 | fax: 580-252-3654

fax

TO: Tempal Fillman FROM: Wendy Wilkerson

FAX: 405-900-7683 PAGES:

PHONE: DATE:

RE: Resident: DOB:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments: Plan of Correction
Survey Event ID # QQMQ11

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 4/29/2024
Facility Name: Canoe Brook Duncan Assisted Living
License Number: AL6905
Survey Event ID: QQMQ11
Date Survey Completed: 4/10/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391 310:663-3-8	Based on: observation, record review, and interview, the center failed to ensure: a) food items were dated and labeled; and b) potentially hazardous foods were discarded after 24 hours for one of two kitchen observations.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Dietary Manager (DM) disposed all hazardous food items on 04/09/2024. On 4/12/2024 the dietary staff were inserviced on the Food Storage Policy, new monitoring log report and skills checklist to ensure all the food were dated, labeled and all hazardous leftovers are discarded after 24 hours. This inservice will be part of the orientation process for all new hired dietary employees. DM will ensure the monthly logs are completed. The DM will provide copy to Executive Director to review monthly. The QA committee will review the log reports quarterly. Any discrepancies will be address immediately.

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?	Dietary Manager disposed all hazardous food items on 4/09/2024. On 4/12/2024 all dietary staff inserviced on "Food Storage Policy" was 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 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?	Daily monitoring of Food Storage and hazardous leftovers discarded will be documented on log report. The log report will be reviewed monthly by the Dietary Manager and Executive Director.
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.	The Executive Director will ensure the monthly logs are completed and turned into the QA committee. The QA committee will reviewed and discuss the monthly food storage and waste log quarterly. Any discrepancies will be address immediately. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/12/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Wendy Williamson **Date 4/29/2024**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only
Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. **Facility in Compliance by:** Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/29/2024** **Facility Name:** Canoe Brook Duncan Assisted Living **License Number:** AL6905 **Survey Event ID:** QQMQ11 **Date Survey Completed: 4/10/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522 310:663-5-2	Based on: Record review and interview, failed to ensure comprehensive assessments were completed every 12 months for one (#3) of eight sampled residents reviewed for assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The Resident Care Director (RCD) and Register Nurse (RN) completed the comprehensive assessment on 4/11/2024 for resident #3. On 4/12/2024 the RCD audited all residents comprehensive assessments and made a log report for all the residents. The RCD provided to the Executive Director the log report with the due dates for each resident comprehensive assessment monthly. The Executive Director reviewed the log report on 4/12/2024 and will review monthly reports. The QA committee will review the log reports quarterly, and any discrepancies will be address immediately.

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?	RCD and RN completed the comprehensive assessment for #3 on 04/11/2024.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	On 4/12/2024 the RCD audited all resident charts to ensure the comprehensive assessments were completed every 12 months and made a log report. The RCD will complete the log report monthly.
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 RCD provided the log report to the Executive Director. On 4/12/2024 the Executive Director reviewed the log report to ensure all assessments are completed every 12 months and will review monthly reports.
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.	The QA meeting will review and discussed the monthly log reports quarterly, and on-going. Any discrepancies will be addressed immediately. QA to Review quarterly Log reports QA
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/12/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 4/29/2024**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/26/2024** **Facility Name:** Canoe Brook Duncan Assisted Living **License Number:** AL6905 **Survey Event ID:** QQMQ11 **Date Survey Completed: 4/10/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1920 310:663-19-2	Based on: observation, record review and interview, failed to ensure medications were administered as ordered for one (#5) of five sampled residents reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: On 04/09/24 training provided to ACMA (#1) by the RCD on medication administration policy and procedure for administering nasal sprays and eye drops. Also, a skills checklist completed for Acma (#1). On 4/12/2024 all certified medication aides inserviced/trained on medication administration policies/procedures and completed a skills checklist evaluation. Certified medication aides skills checklist will be completed with each new hire and annually. Monthly random medication administration audits will be completed by the RCD and reported to Executive Director. The QA committee will evaluate the effectiveness of correction actions by identifying inconsistencies, and making recommendations every quarter. Any discrepancies will be addressed immediately.

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?	On 4/9/2024 training provided to ACMA (#1) by RCD on Medication Administration Policy and Procedure for administering Nasal Sprays and Eye drops. On 4/12/2024 all Certified Medication aides inserviced on Medication Administration Policy/Procedure and completed a skill checklist evaulation.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	On 4/12/2024 all Certified Medication Aides were inserviced on Medication Administration Policy/Procedure and completed a skill checklist evaluation.
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?	Certified Medication Aides Skills Performance checklist will be completed with each new hire and annually. Monthly random medication administration audits will be completed by the RCD. The monthly audit findings will be reported to Executive Director.
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.	The QA committee will evaluate the effectiveness of corrective actions by identifying inconsistencies, and making recommendations every quarter. Any discrepancies will be addressed immediately. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		4/12/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date 4/29/2024**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

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State Department
of Health

Delivery via email to: wendy.wilkerson@canoebrookal.com

June 6, 2024

License Number: AL6905

Ms. Wendy Wilkerson, Administrator
Duncan Assisted Living
1095 Chisholm Trail Parkway
Duncan, OK 73533

RE: Survey Event QQMQ11

Dear Ms. Wilkerson:

On **April 10, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 12, 2024.**

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

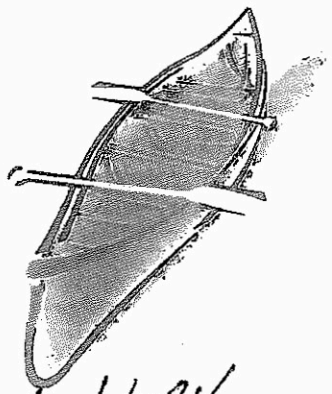
Respectfully,

Tempal Killman

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

Enclosure

Duncan Assisted Living
A Canoe Brook Community
1095 [redacted] Chisholm Trail Parkway
Duncan, OK 73533
(ph) 580-252-3337
(fax) 580-252-3654



To: Tempa Kilman From: Wendy Wilkerson RN LCSW

Fax: 405-900-7083 Pages:

Date:

Phone:

CC:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Thank You

Comments: Plan of Correction
Survey Event ID# QQMQ11
Addendum - 6/3/24 - WWilkerson RN

OKLAHOMA
State Department
of Health

Delivery via email to: wendy.wilkerson@canoebrookal.com

May 23, 2024

License Number: AL6905

Ms. Wendy Wilkerson, Administrator
Duncan Assisted Living
1095 Chisholm Trail Parkway
Duncan, OK 73533

RE: Survey Event QQMQ11

Dear Ms. Wilkerson:

On **April 10, 2024,** agents from our office completed a Licensure survey at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- The proposed actions for correction of **C-0391, C-0522** and **C-1920,** is rejected because the alleged completion date, **April 12, 2024**, does not consider monitoring corrections to ensure the compliance is "achieved and sustained," as required by Oklahoma Administrative Code *(OAC) 310:663-25-4(b)(c).*

Please resubmit a new plan of correction, with amendments, as possible.

Respectfully,

Tempal Killman

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

Enclosure

Completion date
addendum - 6/12/2024
W Wilkerson RN/ED

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/29/2024** **Facility Name:** Canoe Brook Duncan Assisted Living **License Number:** AL6905 **Survey Event ID:** QQMQ11 **Date Survey Completed: 4/10/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391 310:663-3-8	Based on: observation, record review, and interview, the center failed to ensure: a) food items were dated and labeled; and b) potentially hazardous foods were discarded after 24 hours for one of two kitchen observations.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Dietary Manager (DM) disposed all hazardous food items on 04/09/2024. On 4/12/2024 the dietary staff were inserviced on the Food Storage Policy, new monitoring log report and skills checklist to ensure all the food were dated, labeled and all hazardous leftovers are discarded after 24 hours. This inservice will be part of the orientation process for all new hired dietary employees. DM will ensure the monthly logs are completed. The DM will provide copy to Executive Director to review monthly. The QA committee will review the log reports quarterly. Any discrepancies will be address immediately.

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?	Dietary Manager disposed all hazardous food items on 4/09/2024. On 4/12/2024 all dietary staff inserviced on "Food Storage Policy" was 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 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?	Daily monitoring of Food Storage and hazardous leftovers discarded will be documented on log report. The log report will be reviewed monthly by the Dietary Manager and Executive Director.
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.	The Executive Director will ensure the monthly logs are completed and turned into the QA committee. The QA committee will reviewed and discuss the monthly food storage and waste log quarterly. Any discrepancies will be address immediately. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/12/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 4/29/2024**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	6/3/2024	**Submitted by**	Wendy Wilkerson RN/Executive Director

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: 4/29/2024** **Facility Name:** Canoe Brook Duncan Assisted Living **License Number:** AL6905 **Survey Event ID:** QQMQ11 **Date Survey Completed: 4/10/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522 310:663-5-2	Based on: Record review and interview, failed to ensure comprehensive assessments were completed every 12 months for one (#3) of eight sampled residents reviewed for assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The Resident Care Director (RCD) and Register Nurse (RN) completed the comprehensive assessment on 4/11/2024 for resident #3. On 4/12/2024 the RCD audited all residents comprehensive assessments and made a log report for all the residents. The RCD provided to the Executive Director the log report with the due dates for each resident comprehensive assessment monthly. The Executive Director reviewed the log report on 4/12/2024 and will review monthly reports. The QA committee will review the log reports quarterly, and any discrepancies will be address immediately.

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?	RCD and RN completed the comprehensive assessment for #3 on 04/11/2024.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	On 4/12/2024 the RCD audited all resident charts to ensure the comprehensive assessments were completed every 12 months and made a log report. The RCD will complete the log report monthly.
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 RCD provided the log report to the Executive Director. On 4/12/2024 the Executive Director reviewed the log report to ensure all assessments are completed every 12 months and will review monthly reports.
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.	The QA meeting will review and discussed the monthly log reports quarterly, and on-going. Any discrepancies will be addressed immediately. QA to Review quarterly Log reports QA
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/12/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 4/29/2024**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	6/3/2024	**Submitted by**	Wendy Wilkerson RN/Executive Director
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: 4/26/2024** **Facility Name:** Canoe Brook Duncan Assisted Living **License Number:** AL6905 **Survey Event ID:** QQMQ11 **Date Survey Completed: 4/10/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1920 310:663-19-2	Based on: observation, record review and interview, failed to ensure medications were administered as ordered for one (#5) of five sampled residents reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: On 04/09/24 training provided to ACMA (#1) by the RCD on medication administration policy and procedure for administering nasal sprays and eye drops. Also, a skills checklist completed for Acma (#1). On 4/12/2024 all certified medication aides inserviced/trained on medication administration policies/procedures and completed a skills checklist evaluation. Certified medication aides skills checklist will be completed with each new hire and annually. Monthly random medication administration audits will be completed by the RCD and reported to Executive Director. The QA committee will evaluate the effectiveness of correction actions by identifying inconsistencies, and making recommendations every quarter. Any discrepancies will be addressed immediately.

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?	On 4/9/2024 training provided to ACMA (#1) by RCD on Medication Administration Policy and Procedure for administering Nasal Sprays and Eye drops. On 4/12/2024 all Certified Medication aides inserviced on Medication Administration Policy/Procedure and completed a skill checklist evaulation.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	On 4/12/2024 all Certified Medication Aides were inserviced on Medication Administration Policy/Procedure and completed a skill checklist evaluation.
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?	Certified Medication Aides Skills Performance checklist will be completed with each new hire and annually. Monthly random medication administration audits will be completed by the RCD. The monthly audit findings will be reported to Executive Director.
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.	The QA committee will evaluate the effectiveness of corrective actions by identifying inconsistencies, and making recommendations every quarter. Any discrepancies will be addressed immediately. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		6/12/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			**Date 4/29/2024**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	6/3/2024	**Submitted by**	Wendy Wilkerson RN/Executive Director
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: wendy.wilkerson@canoebrookal.com

July 1, 2024

License Number: AL6905

Ms. Wendy Wilkerson, Administrator
Duncan Assisted Living
1095 Chisholm Trail Parkway
Duncan, OK 73533

RE: Survey Event QQMQ12

Dear Ms. Wilkerson:

On **June 28, 2024,** an off-site paper revisit was conducted for your facility by this agency. The findings of that revisit indicate that the deficiencies cited during your survey on **April 10, 2024,** have now been corrected effective **June 12,2024.**

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

Respectfully,

Tempal Killman

Tempal Killman, 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
	AL6905	A. BUILDING: _____ B. WING _____	R 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNCAN ASSISTED LIVING	1095 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 An offsite/paper revisit was conducted on 06/28/24. The facility was in substantial compliance.	{C 000}		

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