Oklahoma State Department of Health
Creating a State of Health

March 9, 2020

License Number: AL7201

Ms. Anita Beatt, Administrator
Aberdeen Heights Assisted Living Community
7220 South Yale
Tulsa, OK 74136

RE: Survey Event ID: JQ4O11

Dear Ms. Beatt:

On **February 27, 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 **February 27, 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

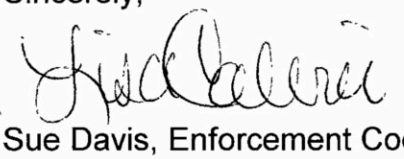
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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,



for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc
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
	AL7201	A BUILDING _____ B WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEIGHTS ASSISTED LIVING COMI	7220 SOUTH YALE TULSA, OK 74136

(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 02/25/20 through 02/27/20. Current census was 82. The following deficiencies were cited.	C 000		
C1324 SS=E	310:663-13-2(4) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (4) discharge criteria; This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure resident service contracts contained a clear statement of discharge criteria for 3 (#1, 3, and #6) of 3 sampled residents who moved into the center since the previous re-licensure survey. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 02/27/20 at 12:05 p.m., a review of the resident agreements for residents #1, 3, and #6 revealed their agreements did not contain a clear statement of the center's discharge criteria. At 2:26 p.m., the administrator stated the current contracts were revised on 05/31/19, and did not contain the required discharge criteria.	C1324		
C1330 SS=E	310:663-13-2(10) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (10) a provision in the event that a resident's condition merits transfer, the transfer shall be initiated within five (5) working days and progress	C1330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1330	Continued From page 1 on the transfers shall be noted in the resident's record. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure resident service contracts contained a clear statement of a provision in the event that a residents' condition merited transfer, the transfer shall be initiated within five (5) working days and progress on the transfer shall be noted in the resident's record for 3 (#1, 3, and #6) of 3 sampled residents who moved into the center since the previous re-licensure survey. This failed practice had the potential for more than minimal harm at a pattern. Findings. On 02/27/20 at 12:05 p.m., a review of the resident agreements for residents #1, 3, and #6 revealed their agreements did not contain a clear statement of a provision in the event the resident's condition merited transfer shall be initiated within five (5) days. At 2:26 p.m., the administrator stated the resident contracts were revised on 05/31/19, and did not contain the required provision for transfer within five (5) days.	C1330		
C1500 SS=E	63 OS 1-890.3(A)(8) RESIDENT RIGHTS - Rx/Fees/Blister Packs 63 OS 1-890.3(A)(8) A. The State Board of Health shall promulgate rules necessary to implement the provisions of the Continuum of Care and Assisted Living Act. Such rules shall include, but shall not be limited to.....	C1500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1500	Continued From page 2 .....(8) Enumeration of resident rights and responsibilities to be observed by each facility and its staff. Such resident rights shall include the freedom of choice regarding any personal attending physicians and all other providers of medical services and supplies without a financial penalty or fee charged by the assisted living center. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure the residents' contracts did not contain a statement of pharmacy packaging fees for 3 (#1, 3, and #6) of 3 sampled residents who moved into the center since the previous re-licensure survey. This failed practice had the potential for more than minimal harm at a pattern. Findings:	C1500		

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	AL7201	A BUILDING _____ B WING _____	02/27/2020

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C1500	Continued From page 3 On 02/27/20 at 12:05 p.m., the service contracts for residents #1, 3, and #6 documented, "...If your pharmacy does not use preferred unit-dose packaging, you will be assessed a monthly fee to cover administrative and operational costs associated with the use of a non-preferred medication packaging..." At 2:26 p.m., the administrator reviewed and confirmed the residents' contracts contained a statement the residents' could be assessed a monthly packing fee if the medications were not in unit-dose packages.	C1500		
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	C1505		

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C1505	Continued From page 4 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, interview, and record review, it was determined the center failed to ensure medications were administered as ordered by the physician for 3 (#9, 11, and #12) of 10 sampled residents who received employee administered medications. This failed practice had the potential for more than minimal harm at pattern. Findings: Resident #11 Resident #11 had an order for Fluticasone Propionate Nasal Suspension (used to treat allergies) 50 micrograms for allergies one spray into nose two times per day on Monday, Wednesday, and Friday at 9:00 a.m. and 8:00 p.m. On 02/26/20 (Wednesday) at 9:19 a.m., medication administration technician (MAT)/employee # 3 administered resident #11's morning medications. MAT/employee #3 did not administer the Fluticasone Propionate nasal suspension, but documented she had administered it to resident #11 on the electronic medication administration record. At 12:15 p.m., MAT/employee #3 stated she thought she had the Fluticasone nasal suspension in her hand. She then stated she did not administer the Fluticasone. Resident #9	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7201	A BUILDING _____ B WING _____	02/27/2020

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C1505	Continued From page 5 Resident #9 had a diagnosis of diabetes and had an order for Glipizide (used to treat high blood sugar) 5 milligrams (mg) to be administered before meals at 7:00 a.m and 4:00 p.m. On 02/26/20 at 1:00 p.m., certified medication aide (CMA)/employee #1 administered resident #9 Glipizide 5 mg. CMA/employee #1 stated the resident had already eaten lunch. This medication was administered at the wrong time. Resident #12 Resident #12 had an order for Carvedilol (used to treat high blood pressure) 6.25 mg two times per day before meals at 9:00 a.m. and 5:00 p.m., and to hold if the pulse was below 60 or systolic blood pressure below 125. On 02/27/20 at 9:35 a.m., CMA/employee #2 obtained resident #12's blood pressure and then administered the resident's medications including the Carvedilol CMA/employee #2 did not obtain the resident's pulse prior to administering Carvedilol as ordered. CMA/employee #2 stated the resident had already eaten breakfast before she administered the Carvedilol. At 10:02 a.m., CMA/employee #2 stated she should have administered the Carvedilol before the resident ate and should have obtained resident #12's pulse prior to administration of the Carvedilol. At 3:36 p.m., licensed practical nurse (LPN) #1 stated the Carvedilol was not administered correctly according to the physician's orders. The LPN stated her employees had already informed her of the medication errors which occurred	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7201	A. BUILDING _____ B. WING _____	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEIGHTS ASSISTED LIVING COMI	7220 SOUTH YALE TULSA, OK 74136

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C1505	Continued From page 6 during the medication pass observations.	C1505		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL7201	ABERDEEN HEIGHTS ASSISTED LIVING COMMUNITY

Type of Survey (select all that apply)

2								

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

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

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. ~~V~~25837	02/25/2020	02/27/2020	0.25	0.00	20.00	0.00	6.00	1.00
2. ~~V~~36191	02/25/2020	02/27/2020	1.00	0.00	22.00	0.00	5.25	4.50
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**

MAR 10 2020 jm

Oklahoma State Department of Health
Creating a State of Health

March 19, 2020

License Number: AL7201

Ms. Anita Beatt, Administrator
Aberdeen Heights Assisted Living Community
7220 South Yale
Tulsa, OK 74136

RE: Survey Event JQ4O11

Dear Ms. Beatt:

On February 27, 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 28, 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,

Sue Davis
Long Term Care Enforcement Coordinator
Oklahoma State Department of Health

SD/tk

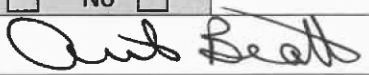
Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/16/2020** **Facility Name:** Aberdeen Heights Assisted Living **License Number:** AL7201 **Survey Event ID:** JQ4011 **Date Survey Completed: 2/27/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1324	Based on: Interview and record review, it was determined the center failed to ensure resident service contracts contained a clear statement of discharge criteria for 3 (#1, 3, and #6) of 3 sampled residents who moved into the center since the previous re-licensure survey. This failed practice had the potential for more than minimal harm at a pattern.

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?	A clear statement of discharge criteria has been added into the resident service contract. The resident service contract with the 5/31/2019 date for 3 (#1, 3, and #6) of 3 sampled residents will be replaced and the new revised agreement will be signed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident who signed the resident service contract with the revised 5/31/2019 date would 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?	A revised resident service contract will replace all resident service contracts with the revised date of 5/31/2019.
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 business director will ensure that the resident service contract has the revised date of 3/09/2020 before it is given to the resident to sign. The Administrator will check the resident service contract for the correct revision date before meeting with the resident to sign. A list of all resident service contracts with the revision date of 3/09/2020 will be reviewed and verified at the quarterly QA meeting. The verified list of resident service contracts will be kept in the QA binder in the administrators office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/28/2020
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature **Anita Beatt** 	**Date 3/18/2020**

OAC 310:663-25-4(F)

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: 3/16/2020** **Facility Name:** Aberdeen Heights Assisted Living **License Number:** AL 7201 **Survey Event ID:** JQ4011 **Date Survey Completed: 2/27/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1330 SS=E	Based on: Interview and record review, it was determined the center failed to ensure resident service contracts contained a clear statement of a provision in the event that a residents' condition merited transfer, the transfer shall be initiated within five (5) working days and progress on the transfer shall be noted in the resident's record for 3 (#1, 3 and #6) of 3 sampled residents who moved into the center since the previous re-licensure survey. This failed practice had the potential for more than minimal harm at a pattern.

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?	A revised resident service contract containing the clear statement of a provision in the event the resident's condition merited transfer shall be initiated within five (5) days, will replace the current resident service contract (revised 5/31/2019) for 3 (#1, 3, and #6) of 3 sampled residents. The new resident service contract will be signed and entered into the resident file.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident who signed the resident service contract with the revised 5/31/2019 date would 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?	A revised resident service contract will replace all resident service contracts with the revised date of 5/31/2019.
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 centers business director will ensure that the resident service contract has the revised date of 3/09/2020 date before it is given to the administrator. The centers Administator will check the resident service contract for the correct revision date before meeting with the resident to sign. A list of all resident service contracts with the revision date of 3/09/2020 will be reviewed and verified at the quarterly QA meeting. The verified list of revised resident service contracts will be kept in a binder in the Administrators office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/28/2020

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Anita Beatt** OAC 310:663-25-4(F)			**Date 3/18/2020**
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.
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: 3/16/2020** **Facility Name:** Aberdeen Heights Assisted Living **License Number:** AL7201 **Survey Event ID:** JQ4011 **Date Survey Completed: 2/27/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1500 SS=E	Based on: Interview and record review, it was determined the center failed to ensure the residents' contracts did not contain a statement of pharmacy packaging fees for 3 (#1, 3, and #6) of 3 sampled residents who moved into the center since the previous re-licensure survey. This failed practice had the potential for more than minimal harm at a pattern.

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?	The sentence in Exhibit P. under Pharmacy Services that reads, "if your pharmacy does not use preferred unit-dose packaging, you will be assessed a monthly fee to cover administrative and operational costs associated with the use of a non-preferred medication packaging" has been removed. For the 3 (#1, 3, and #6) of 3 sampled residents, a new resident service contract revised 3/9/2020 will be signed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident who signed the resident service contract with the revised date of 5/31/2019 would 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?	A resident service contract with a revised date of 3/09/2020 will replace all resident service contracts with the revised date of 5/31/2019
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 community business director will ensure that the resident service contract has the revised date Of 3/09/2020 before it is given to the administrator. The administrator will check the resident service contract for the correct revision date before meeting with the resident to sign. A list of all resident service contracts with the revision date of 3/09/2020 will be reviewed and verified at the quarterly QA meeting. The verified list of resident service contracts will be kept in the QA binder in the administrators office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/28/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Anita Beatt** OAC 310:663-25-4(F)			**Date 3/18/2020**
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.
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: 3/16/2020** **Facility Name:** Aberdeen Heights Assisted Living **License Number:** AL7201 **Survey Event ID:** JQ4011 **Date Survey Completed: 2/27/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Observation, interview and record review, it was determined the center failed to ensure medications were administered as ordered by the physician for 3 (#9, 11, and # 12) of 10 sampled residents who received employee administered medications. This failed practice had the potential for more than minimal harm at pattern.

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?	Employee # 1,2 and 3 who were responsible for the deficient practice have received additional training from the LPN/DON on Medication Administration. A review of the specific medication error for employee #1, 2, and 3 was conducted on February 28, 2020. Any future med errors will be reported to the LPN and Administrator.
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 who receive medication administration 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?	A mandatory inservice on Medication Administration was conducted by the Regional RN. All employees responsible for medication administration were required to attend. This inservice was held on March 4th, 2020. A mandatory inservice conducted by the centers pharmacy consultant will be held on March 26,2020 to review the pharmacy policy on medication administration.
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.	Monthly med pass observations will be conducted by the LPN/DON or LPN/ ADON and will be completed by the 28th of each month. The centers RN Consultant will review the monthly med pass observations. A review of the monthly med pass observation will be included in the quarterly QA. The monthly medpass observations will be kept in a binder in the LPN/ DON office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/28/2020
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature **Anita Beatt**	**Date 3/18/2020**

OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor:** Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department
of Health

Delivery via email to: Abeatt@aberdeenheights.com

December 11, 2020

License Number: AL7201

Ms. Anita Beatt, Administrator
Aberdeen Heights Assisted Living Community
7220 South Yale
Tulsa, OK 74136

RE: Survey Event JQ4O12

Dear Ms. Beatt:

On **November 16, 2020,** a desk audit revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **February 27, 2020,** have now been corrected effective **March 28, 2020.**

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

Sincerely,

Users, Lisa D Calvin
Digitally signed by Users, Lisa D Calvin
Date: 2020.12.11 15:30:41 -06'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

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
	AL7201	A. BUILDING: _____ B. WING _____	R 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN HEIGHTS ASSISTED LIVING COMMUNITY	7220 SOUTH YALE TULSA, OK 74136

(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 desk audit was completed on 11/16/2020. Credible evidence of correction was submitted for all deficiencies.	{C 000}		

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