OKLAHOMA
State Department
of Health

Delivery via email to: richard.manganya@northcountyseniorliving.com; PSiriboury@skybluehc.com

April 2, 2025

License Number: AL7218

Mr. Richard Manganya, Administrator
North County Assisted Living
523 North 22nd
Collinsville, OK 74021

Survey Event ID: ZXC811

Dear Mr. Manganya:

On **March 20, 2025,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on 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 will be completed for each violation; and
(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 a 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:

IDR Coordinator
IDRCoordinator@health.ok.gov
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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **North County Assisted Living**
Address: **523 North 22nd**
City, State, Zip: **Collinsville, OK, 74021**
Provider #: **AL 7218**
Complaint #: **OK00075935**
Investigation Date(s): **3/19/2025 through 3/20/2025**

ALLEGATION(S)
Allegations: Family member waited 20 minutes before going out to find a CNA. Was told the system has not worked for some time. The emergency cord and the fire alarm system are in the same control enclosure, they share the same functions. Lack of maintenance to the fire alarm system.

An unannounced on-site investigation was initiated 03/18/2025 at 9:15AM

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

03/18/2025 @ 11:16 Reviewed Fire Marshall Report and took quick tour of facility observing fire Marshall box and call light system. Observed (1) one call light from room 16 (S) answered by CMA #1, within 3 minutes. The fire alarm was not set off.
03/20/2025 @ 11:38AM, pushed call light button in room #15. Answered by CMA #1 within 4 minutes. The fire alarm did not engage.
3/20/2025 @ 11:34 AM, Interviewed three residents based on the concerns relevant to the allegation(s). 3 of 3 residents expressed no concerns.
3/20/2025 @11:48 AM interview CMA #1 regarding the fire alarm system and the call lights being in the same system. They replied: I've worked here over 20 years, and the call light and fire alarm system have not been together in one system.
3/20/2025 @ 5:17PM, interviewed DON and asked it the call lights and fire alarm system are in the same control box? They replied: "Absolutely not!"
Interviewed the Administrator, 3/19/2025 @ 4:19PM and they replied, "No the Fire Marshall would never allow it."

OKLAHOMA
State Department
of Health

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7218	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH COUNTY ASSISTED LIVING	523 NORTH 22ND COLLINSVILLE, OK 74021

(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
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C 000	INITIAL COMMENTS A relicensure survey was conducted from 03/18/25 through 03/20/25. Complaint investigations (#OK00066489 and #OK00075935) were conducted in conjunction with the survey. No deficiencies were cited. Facility Census: 25 Listed below are abbreviations that will be used throughout this document. DON - director of nursing QAPI - quality assurance performance improvement	C 000		
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.	C 522		

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C 522	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a comprehensive assessment was completed within 14 days after admission for 1 (#1) of 8 residents sampled for comprehensive assessments. The DON identified 25 residents resided at the facility. Findings: Resident #1 was admitted with diagnoses which included atherosclerotic heart disease, primary osteoarthritis right hip, mild cognitive impairment, and depression. Review of the clinical record showed no comprehensive assessment following admission on 02/27/25. On 03/20/25 at 5:40 p.m., the DON stated they were not able to locate the comprehensive assessment.	C 522		
C1110 SS=F	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes.	C1110		

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C1110	Continued From page 2	C1110		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to establish a quality assurance committee that met at least quarterly.

The DON identified 25 residents resided at the facility.

Findings:

A policy titled "Operational Policy and Procedure Manual," dated November 2022, read in part, "The quality assurance and performance committee reviews policies and procedure and makes revisions as necessary."

A binder labeled "QAPI," dated 03/26/24, read in part, "No QAPI meeting held previous quarter."

There was no documentation the QAPI committee met quarterly on 6/26/24, 9/26/24, or 12/26/24.

On 03/20/25 at 5:00 p.m., the DON was asked if there was documentation the quality assurance committee met after 03/26/2024.

On 03/20/25 at 5:00 p.m., the DON stated, "No, If it isn't documented it isn't done."

Oklahoma State Department of Health

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OKLAHOMA
State Department
of Health

Delivery via email to: richard.manganya@northcountyseniorliving.com; PSiriboury@skybluehc.com

April 8, 2025

License Number: AL7218
Survey Event ID: ZXC811

Mr. Richard Manganya, Administrator
North County Assisted Living
523 North 22nd
Collinsville, OK 74021

Dear Mr. Manganya:

On **March 20, 2025**, agents from our office concluded an investigation at your facility. You were advised of the findings of that investigation in our notice of **April 2, 2025**.

The original notification sent to your facility did not include a copy of one of the two investigative reports generated based on the complaints investigated during your complaint survey. The excluded investigative report is being provided for your records. Deficiencies identified during the investigation are not affected by this update and a new plan of correction is not required. No additional action on your part is required at this time.

If we can be of any further assistance, please contact us at 405-426-8200.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **North County Assisted Living**
Address: **523 North 22nd**
City, State, Zip: **Collinsville, OK, 74021**
Provider #: **AL 7218**
Complaint #: **OK00075935**
Investigation Date(s): **3/18/2025 through 3/20/2025**

ALLEGATION(S)
Meals not served according to the menus.
Failed to maintain homelike environment
Failed to meet the needs of the residents.
Sufficient staffing, dietary housekeeping and activities, to provide services according to the residents' contract.

An unannounced on-site investigation was initiated 03/18/2025 at 9:15AM

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:
A tour of the facility was conducted upon entrance into the center. Residents were observed in private and in common areas. Residents were observed dining. Staff were observed interacting with residents. Records reviewed included: Residents health records, resident contracts, facility reported incidents, and grievances, and menus. Residents and staff were asked questions regarding staffing, dietary, housekeeping and activities.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/20/2025

OKLAHOMA
State Department
of Health

Delivery via email to: cassie.mayfield@northcountyseniorliving.com

April 29, 2025

License Number: AL7218

Ms. Samantha Gillespie, Administrator
North County Assisted Living
523 North 22nd
Collinsville, OK 74021

RE: Survey Event ZXC811

Dear Ms. Gillespie:

On **March 20, 2025,** agents from our office completed an Assisted Living Center survey at your facility. 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 Plan of Correction dates exceed 60 days post survey.**

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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Oklahoma State Department of Health

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

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C1110	Continued From page 2	C1110		

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The DON identified 25 residents resided at the facility.

Findings:

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OKLAHOMA
State Department
of Health

Delivery via email to: ddonley@skybluehc.com; katy.hall@northcountyassistedlivingok.com

April 30, 2025

License Number: AL7218

Ms. Dinah Donley, Administrator
North County Assisted Living
523 North 22nd
Collinsville, OK 74021

Survey Event ID: ZXC811

Dear Ms. Donley:

On **March 20, 2025,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your 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 **May 19, 2025**.

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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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NORTH COUNTY ASSISTED LIVING	523 NORTH 22ND COLLINSVILLE, OK 74021

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D 000	INITIAL COMMENTS A relicensure survey was conducted from 03/18/25 through 03/20/25. Complaint investigations (#OK00066489 and #OK00075935) were conducted in conjunction with the survey. No deficiencies were cited. Facility Census: 25	D 000	C 522 Assessment timeframe 1. Corrective action taken for the identified problem: Complete a comprehensive assessment for Resident #1 and perform a complete audit of assessments for all residents.	
C 000	INITIAL COMMENTS A relicensure survey was conducted from 03/18/25 through 03/20/25. Complaint investigations (#OK00066489 and #OK00075935) were conducted in conjunction with the survey. No deficiencies were cited. Facility Census: 25 Listed below are abbreviations that will be used throughout this document. DON - director of nursing QAPI - quality assurance performance improvement	C 000	2. Residents potential to be affected: The deficient practice has the potential to impact all residents at North County Assisted Living 3. Systemic policies put in place: DON or designee will perform audits of residents for appropriate completion of assessments one time a week for the next four weeks or until in substantial compliance with the regulatory requirements on May 19, 2025. 4. How the facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not reoccur: Administrator or designee will perform once weekly audits for the next four weeks or until substantial compliance is met. Any deficient practices will be reported to the QA committee.	
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.	C 522		

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
	AL7218	A. BUILDING: _____ B. WING _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH COUNTY ASSISTED LIVING	523 NORTH 22ND COLLINSVILLE, OK 74021

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C 522	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a comprehensive assessment was completed within 14 days after admission for 1 (#1) of 8 residents sampled for comprehensive assessments. The DON identified 25 residents resided at the facility. Findings: Resident #1 was admitted with diagnoses which included atherosclerotic heart disease, primary osteoarthritis right hip, mild cognitive impairment, and depression. Review of the clinical record showed no comprehensive assessment following admission on 02/27/25. On 03/20/25 at 5:40 p.m., the DON stated they were not able to locate the comprehensive assessment.	C 522	C 1110 Quality Assurance Committee 1. Corrective action taken for the identified problem: Complete the QAPI committee meetings monthly and will audit quarterly. 2. Residents potential for being affected : The deficient practice has the potential for having impact on all residents at North County Assisted Living. 3. Systematic changes put in place: DON or designee will perform audits of QAPI meeting and documentation of such quarterly for the next two quarters or until meeting substantial compliance with the regulatory requirements on May 19 , 20 25 . 4. How the facility will monitor the corrective actions to ensure the deficient practice is corrected and will not reoccur: Administrator or designee will perform quarterly audit for the next two quarters or until susbstatial compliance is met. Any deficient practices will be reported to the QAPI committee	
C1110 SS=F	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes.	C1110		

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	AL7218	A. BUILDING: _____ B. WING _____	C 03/20/2025

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C1110	Continued From page 2	C1110		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to establish a quality assurance committee that met at least quarterly.

The DON identified 25 residents resided at the facility.

Findings:

A policy titled "Operational Policy and Procedure Manual," dated November 2022, read in part, "The quality assurance and performance committee reviews policies and procedure and makes revisions as necessary."

A binder labeled "QAPI," dated 03/26/24, read in part, "No QAPI meeting held previous quarter."

There was no documentation the QAPI committee met quarterly on 6/26/24, 9/26/24, or 12/26/24.

On 03/20/25 at 5:00 p.m., the DON was asked if there was documentation the quality assurance committee met after 03/26/2024.

On 03/20/25 at 5:00 p.m., the DON stated, "No, If it isn't documented it isn't done."

Oklahoma State Department of Health

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	AL7218	A. BUILDING: _____ B. WING _____	C 03/20/2025

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OKLAHOMA
State Department of Health

Delivery via email to: ddonley@skybluehc.com; katy.hall@northcountyassistedlivingok.com

May 30, 2025

License Number: AL7218
Survey Event ID: ZXC812

Ms. Dinah Donley, Administrator
North County Assisted Living
523 North 22nd
Collinsville, OK 74021

Dear Ms. Donley:

On **May 27, 2025**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **March 20, 2025,** have now been corrected and your facility is in compliance with licensure standards effective **May 19, 2025**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, 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
	AL7218	A. BUILDING: _____ B. WING _____	R-C 05/27/2025

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{D 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 05/27/25. The facility was in substantial compliance.	{D 000}		
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 05/27/25. 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