OKLAHOMA
State Department
of Health

Delivery Via Email: ltruett@oxfordseniorliving.com

August 11, 2020

License Number: AL7239

Ms. Lisa Truett, Administrator
Oxford Glen at Owasso
11113 East 103rd Street North
Owasso, OK 74055

Survey Event ID: ZVEG11

Dear Ms. Truett:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on February 14, 2020. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State Department of Health, ou=Long Term Care, email=katies@health.ok.gov, c=US
Date: 2020.08.11 15:59:03 -05'00'

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

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Oxford Glen of Owasso**
Address: **11113 East 103rd Street North**
City, State, Zip: **Owasso, OK, 74055**
Provider #: **AL7239**
Complaint #: **OK#54699**
Investigation Date(s): **02/14/20**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate staff to meet the needs of the residents according to their contracts/care plans.	**US**
2. The center failed to ensure only qualified staff administered medications.	**US**

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 02/14/2020 at 9:15a.m.

A sample of 9 residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegations.

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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to staffing in an assisted living center was conducted. Residents that require 2 staff member assistance are receiving this assistance as the staffing records for December, January and February were reviewed and identified there were always 2 staff members present in each house for those residents that require two-person assistance. The center's contract was reviewed and it documented a resident that requires two person assist could live at the center. A review of the center's staff schedules for multiple months documented the center's staffing would provide the services the residents required.

An investigation specific to resident to resident abuse and submission of incident reports was also conducted. Based on interviews and record reviews, no residents were reported as being abusive to other residents.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

The staff person identified as administering medications with an expired certification was hired as a certified long term care aide. The individual was also certified as a CMA, which expired 6/30/19. The individual attended a CEU update on 10/23/19, after the CMA certification expired. The Oklahoma Nurse Aide Registry renewed this individuals CMA certification after submitting an application with a copy of a CEU training certificate, on 12/09/19. The CMA's certification was extended and does not expire until 12/31/20.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Lisa McAlister, Survey Manager for

Justina Leach RN/CHFS

Date report completed: 02/18/2020

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
	AL7239	A. BUILDING: _____ B. WING _____	C 02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GLEN AT OWASSO	11113 EAST 103RD STREET NORTH OWASSO, OK 74055

(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
N 000	Initial Comments An abbreviated survey was conducted on 02/14/20, to investigate complaint #OK54699. The census was 48. No deficient practice was cited.	N 000		
C 000	INITIAL COMMENTS An abbreviated survey was conducted on 02/14/20, to investigate complaint #OK54699. The census was 48. No deficient practice was cited.	C 000		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL7239	OXFORD GLEN AT OWASSO

Type of Survey (select all that apply)

3				

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. 32[illegible]	02/14/2020	02/14/2020	0.75	0.00	8.00	0.00	1.25	9.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

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

AUG 19 2020