OKLAHOMA
State Department
of Health

Delivery via email to: TMatos@oxfordseniorliving.com

May 6, 2024

License Number: AL7239

Ms. Trish Matos, Regional Director/Administrator
Oxford Glen At Owasso
11113 East 103rd Street North
Owasso, OK 74055

Survey Event ID: 8MCF11

Dear Ms. Matos:

On **April 24, 2024,** 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
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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Oxford Glen at Owasso**
Address: **11113 East 103rd Street North**
City, State, Zip: **Owasso, OK 74055**
Provider #: **AL7239**
Complaint #: **OK00063879**
Investigation Date(s): **04/23/24 through 04/24/24**

ALLEGATION(S)
The facility failed to assess, monitor, and intervene for a resident experiencing pain and who later experienced a fall.

An unannounced on-site investigation was initiated 05/23/2023 at 10:15 a.m.

A sample of three 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:

Residents were observed in their rooms, common areas, and the activity area. Residents were observed for signs of pain and fall interventions. Staff were observed to assist residents and implement fall interventions.

Staff were interviewed regarding pain and fall interventions and policies and procedures. Families were interviewed regarding their loved one's care.

Record review consisted of electronic health records, charts, policies and procedures, incident reports, service plans, hospital records, and staffing schedules.

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: 04/25/2024

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 04/24/2024

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
C 000	INITIAL COMMENTS A complaint investigation (#OK00063879) was conducted on 04/23/24 through 04/24/24. Facility Census: 40 Listed below are abbreviations that will be used throughout this document. CMA - Certified Medication Aide CNA - Certified Nurse Aide c/o - complain of LPN - Licensed Practical Nurse mg - milligram PRN/prn - as needed Pt - patient RCD - Resident Care Director	C 000		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure service plans were updated to reflect the residents' current status related to fall interventions for two (#1 and #2) of three sampled residents who were reviewed for falls. LPN #1 identified 40 residents who resided at the	C 552		

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 04/24/2024

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
C 552	Continued From page 1 facility. Findings: The "Health and Personal Care Services" policy, dated 10/25/23, read in part, "...Health and personal care services will be provided or coordinated based on the residents' need for services as identified by the assessment and specified in the Service Agreement..." 1. Resident #1 had diagnoses which included Alzheimer's disease. The "Service Plan", dated 02/05/24, documented the resident was to receive safety checks once every shift and required reminders to use their walker. The "Service Plan" had not been updated to indicate the resident had falls and the interventions implemented in relation to the falls. ODH form 283-combined initial and final report, incident date 03/19/24, documented Resident #1 had an unwitnessed fall which resulted in a fractured left hip and the resident was sent to hospital. Part C of the incident report documented the resident would be assisted to use walker when trying to get up and walk after physical therapy was completed at another facility. ODH form 283, incident date 03/19/24, documented an update to the ODH form 283, that was previously submitted on 03/20/24, to include interventions of more frequent checks for safety. ODH form 283-final, dated 04/17/24, documented the resident was observed lying on the floor by their bed with their walker close to them, had a bump on the left side of their head and was sent	C 552		

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 04/24/2024

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
C 552	Continued From page 2	C 552		

to the hospital. Part C of the incident report documented the resident had sustained a subarachnoid hemorrhage and interventions implemented were more frequent checks and hospice evaluation.

On 04/23/24 at 12:18 p.m., Resident #1 was observed in their wheelchair in the dining room. Resident #1 was non-interviewable.

On 04/23/24 at 3:19 p.m., CMA #1 stated fall interventions for Resident #1 included keeping the door open for frequent checks, using a night light at bedtime, placing pillows by the edge of the bed for barrier reminders.

On 04/23/24 at 3:24 p.m., CNA #1 stated they checked on Resident #1 every 30 minutes, assisted with toileting every one to two hours, and placed pillows by the edge of their bed for barrier reminders.

On 04/24/24 at 2:56 p.m., LPN #1 reviewed the service plan for Resident #1 and stated the fall interventions were not documented. LPN #1 stated the service plan should have been updated immediately after the Resident fell.

2. Resident #2 had diagnoses which included dementia.

The "Service Plan", dated 09/12/23, documented the resident was to receive safety checks every two to three hours and was independent with mobility. The "Service Plan" did not document the resident had fallen or interventions related to the fall.

ODH form 283-combined initial and final, incident date 03/29/24, documented Resident #2 was

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 04/24/2024

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
C 552	Continued From page 3 walking without their walker in their room and fell. The incident report documented the resident complained of shoulder pain and was sent to the hospital. Part C documented the resident had fractured their left humerus, the hospital applied a sling, and the intervention related to the fall was to ensure proper footwear when ambulating. On 04/23/24 at 12:13 p.m., Resident #2 was observed in the common area in their wheel chair. Resident #2 was non-interviewable. On 04/23/24 at 3:19 p.m., CMA #1 stated fall interventions for Resident #2 included keeping the bathroom light on, keeping the door to the bedroom open, assist with toileting, and they had to wear the arm sling for two weeks. On 04/23/24 at 3:24 p.m., CNA #1 stated fall interventions for Resident #2 included encourage wheel chair use while they utilized the arm sling, keep the bedroom door open, and the bathroom light was to be on all the time. On 04/24/24 at 3:29 p.m., LPN #1 reviewed the clinical record for Resident #2 and stated the incident report documented the fall intervention was to ensure proper footwear but the service plan needed to be updated related to the fall and fall interventions.	C 552		
C1505 SS=D	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	C1505		

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 04/24/2024

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
C1505	Continued From page 4 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assess, monitor, and intervene in a timely manner for pain and after a fall for one (#1) of three sampled residents who were reviewed for pain and falls. LPN #1 identified 40 residents who resided in the	C1505		

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 04/24/2024

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
C1505	Continued From page 5 facility. Findings: The "Fall Prevention and Management" policy, dated 10/25/23, read in parts, "...If the resident has had an injury, RCD will notify the physician and follow his or her orders. Depending on the severity of the injury, RCD or designee will call 911; notify responsible parties and Executive Director. Resident will be assessed by Emergency Personnel and transferred if indicated to the Emergency Room for evaluation..." Resident #1 had diagnoses which included Alzheimer's disease. The "Medication Administration Record", dated 03/01/24 through 03/31/24, documented Resident #1 had been administered acetaminophen 1000 mg on 03/19/24 at 1:34 a.m. with a documented pain level of six. The "Medication Administration Record" documented the medication was ineffective. The "Progress Note", dated 03/19/24 at 1:34 a.m., documented Resident #1 had been administered acetaminophen 1000 mg for pain. The note read in part, "...Pt c/o pain and crying out yelling that [their] left leg is killing [them]..." The "Progress Note", dated 03/19/24 at 6:31 a.m., read in part, "...Follow-up Pain Scale was: 7 PRN Administration was: Ineffective still yelling out in pain..." The "Medication Administration Record", dated 03/01/24 through 03/31/24, documented Resident #1 was administered acetaminophen 1000 mg on 03/19/24 at 8:42 a.m. with a documented pain	C1505		

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 04/24/2024

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
C1505	Continued From page 6	C1505		

level of seven. The "Medication Administration Record" documented the medication was ineffective.

The "Progress Note", dated 03/19/24 at 8:42 a.m., documented Resident #1 had been administered acetaminophen 1000 mg for pain. The note read in part, "...Gave prn for left leg pain..."

The "Progress Note", dated 03/19/24 at 11:14 a.m., documented staff had reported Resident #1 had been found on the floor. The note documented Resident #1 had complained of pain with movement of the left hip and left shoulder, was unable to stand, and bruising was noted to the left shoulder. The note documented the physician had been notified, ordered an x-ray of the hip and shoulder, and a portable x-ray company had been notified of the ordered x-rays.

The "Progress Note", dated 03/19/24 at 11:19 a.m., documented the physician's office had been notified Resident #1 had fallen "this morning" and a portable x-ray was ordered.

The "Progress Note", dated 03/19/24 at 11:57 a.m., read in part, "...Follow-up Pain Scale was: 7 PRN Administration was: Ineffective resident still c/o pain...waiting on X ray..."

The "Progress Note", dated 03/19/24 at 2:03 p.m., documented the x-ray report documented a left hip fracture and the resident was sent to the hospital.

The "Radiology Interpretation" form, dated 03/19/24, read in part, "...LEFT X-RAY EXAM OF SHOULDER...IMPRESSION: Age-indeterminate humeral fracture by frontal views...LEFT X-RAY

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 04/24/2024

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
C1505	Continued From page 7 HIP WITH PELVIS...IMPRESSION: Acute nondisplaced left femoral intertrochanteric fracture..." ODH form 283-combined initial and final report, dated 03/19/24, read in part, "...Unwitnessed fall: C.N.A. found resident on floor in her bedroom, near the bed. Resident said [they] didn't know how [they] got in on the floor. Resident had an x-ray ordered and portable x-ray results indicated a fractured left hip. Resident sent to hospital via [emergency services]...Part C...Resident still in hospital. Any new orders will be followed, once [they] return to the facility. [They] will also be assisted to use walker when trying to get up and walk. At this time, [they] will complete recovery in the hospital, following hip surgery and go to [company name withheld] rehab, before returning to the facility..." On 04/23/24 at 12:18 p.m., Resident #1 was observed in their wheelchair in the dining room. Resident #1 was non-interviewable. On 04/23/24 at 3:24 p.m., CNA #1 stated Resident #1 had complained of generalized pain on the night shift on 03/19/24 and had received pain medication. They stated Resident #1 had not fallen during their shift from 03/18/24 at 10:00 p.m. to 03/19/24 at 6:00 a.m. On 04/24/24 at 2:56 p.m., the LPN #1 stated they began assisting at the facility after Resident #1 had fallen on 03/19/24. LPN #1 stated they had been informed the resident had fallen on 03/19/24 at approximately 7:30 a.m. They stated they did not know why the physician had not been notified until 11:14 a.m. on 03/19/24 but Resident #1 should not have experienced a delay in treatment for complaints of pain or after the fall.	C1505		

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 04/24/2024

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
C1505	Continued From page 8 On 04/24/24 at 4:30 p.m., the Regional Director of Operations stated they were unsure of the exact time Resident #1 had fallen but had been told it was on the day shift on 03/19/24. They stated Resident #1 should have received prompt treatment in regards to their complaints of pain and after the resident had fallen, in accordance to the facility's protocols and procedures.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: ralsup@oxfordseniorliving.com

May 21, 2024

License Number: AL7239

Mr. Ryan Alsup, Administrator
Oxford Glen At Owasso
11113 East 103rd Street North
Owasso, OK 74055

Survey Event ID: 8MCF11

Dear Mr. Alsup:

On **April 24, 2024,** 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 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 24, 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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
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
	AL7239	A. BUILDING: _____ B. WING _____	C 04/24/2024

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
C 000	INITIAL COMMENTS A complaint investigation (#OK00063879) was conducted on 04/23/24 through 04/24/24. Facility Census: 40 Listed below are abbreviations that will be used throughout this document. CMA - Certified Medication Aide CNA - Certified Nurse Aide c/o - complain of LPN - Licensed Practical Nurse mg - milligram PRN/prn - as needed Pt - patient RCD - Resident Care Director	C 000		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure service plans were updated to reflect the residents' current status related to fall interventions for two (#1 and #2) of three sampled residents who were reviewed for falls. LPN #1 identified 40 residents who resided at the	C 552	Refer to POC Template, Survey Event ID# 8MCF11, ID Prefix Tag C552.	

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 04/24/2024

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
C 552	Continued From page 1 facility. Findings: The "Health and Personal Care Services" policy, dated 10/25/23, read in part, "...Health and personal care services will be provided or coordinated based on the residents' need for services as identified by the assessment and specified in the Service Agreement..." 1. Resident #1 had diagnoses which included Alzheimer's disease. The "Service Plan", dated 02/05/24, documented the resident was to receive safety checks once every shift and required reminders to use their walker. The "Service Plan" had not been updated to indicate the resident had falls and the interventions implemented in relation to the falls. ODH form 283-combined initial and final report, incident date 03/19/24, documented Resident #1 had an unwitnessed fall which resulted in a fractured left hip and the resident was sent to hospital. Part C of the incident report documented the resident would be assisted to use walker when trying to get up and walk after physical therapy was completed at another facility. ODH form 283, incident date 03/19/24, documented an update to the ODH form 283, that was previously submitted on 03/20/24, to include interventions of more frequent checks for safety. ODH form 283-final, dated 04/17/24, documented the resident was observed lying on the floor by their bed with their walker close to them, had a bump on the left side of their head and was sent	C 552		

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 04/24/2024

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
C 552	Continued From page 2 to the hospital. Part C of the incident report documented the resident had sustained a subarachnoid hemorrhage and interventions implemented were more frequent checks and hospice evaluation. On 04/23/24 at 12:18 p.m., Resident #1 was observed in their wheelchair in the dining room. Resident #1 was non-interviewable. On 04/23/24 at 3:19 p.m., CMA #1 stated fall interventions for Resident #1 included keeping the door open for frequent checks, using a night light at bedtime, placing pillows by the edge of the bed for barrier reminders. On 04/23/24 at 3:24 p.m., CNA #1 stated they checked on Resident #1 every 30 minutes, assisted with toileting every one to two hours, and placed pillows by the edge of their bed for barrier reminders. On 04/24/24 at 2:56 p.m., LPN #1 reviewed the service plan for Resident #1 and stated the fall interventions were not documented. LPN #1 stated the service plan should have been updated immediately after the Resident fell. 2. Resident #2 had diagnoses which included dementia. The "Service Plan", dated 09/12/23, documented the resident was to receive safety checks every two to three hours and was independent with mobility. The "Service Plan" did not document the resident had fallen or interventions related to the fall. ODH form 283-combined initial and final, incident date 03/29/24, documented Resident #2 was	C 552		

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 04/24/2024

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
C 552	Continued From page 3 walking without their walker in their room and fell. The incident report documented the resident complained of shoulder pain and was sent to the hospital. Part C documented the resident had fractured their left humerus, the hospital applied a sling, and the intervention related to the fall was to ensure proper footwear when ambulating. On 04/23/24 at 12:13 p.m., Resident #2 was observed in the common area in their wheel chair. Resident #2 was non-interviewable. On 04/23/24 at 3:19 p.m., CMA #1 stated fall interventions for Resident #2 included keeping the bathroom light on, keeping the door to the bedroom open, assist with toileting, and they had to wear the arm sling for two weeks. On 04/23/24 at 3:24 p.m., CNA #1 stated fall interventions for Resident #2 included encourage wheel chair use while they utilized the arm sling, keep the bedroom door open, and the bathroom light was to be on all the time. On 04/24/24 at 3:29 p.m., LPN #1 reviewed the clinical record for Resident #2 and stated the incident report documented the fall intervention was to ensure proper footwear but the service plan needed to be updated related to the fall and fall interventions.	C 552		
C1505 SS=D	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	C1505	Refer to POC Template, Survey Event ID# 8MCF11, ID Prefix Tag C1505	

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 04/24/2024

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
C1505	Continued From page 4 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assess, monitor, and intervene in a timely manner for pain and after a fall for one (#1) of three sampled residents who were reviewed for pain and falls. LPN #1 identified 40 residents who resided in the	C1505		

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 04/24/2024

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
C1505	Continued From page 5 facility. Findings: The "Fall Prevention and Management" policy, dated 10/25/23, read in parts, "...If the resident has had an injury, RCD will notify the physician and follow his or her orders. Depending on the severity of the injury, RCD or designee will call 911; notify responsible parties and Executive Director. Resident will be assessed by Emergency Personnel and transferred if indicated to the Emergency Room for evaluation..." Resident #1 had diagnoses which included Alzheimer's disease. The "Medication Administration Record", dated 03/01/24 through 03/31/24, documented Resident #1 had been administered acetaminophen 1000 mg on 03/19/24 at 1:34 a.m. with a documented pain level of six. The "Medication Administration Record" documented the medication was ineffective. The "Progress Note", dated 03/19/24 at 1:34 a.m., documented Resident #1 had been administered acetaminophen 1000 mg for pain. The note read in part, "...Pt c/o pain and crying out yelling that [their] left leg is killing [them]..." The "Progress Note", dated 03/19/24 at 6:31 a.m., read in part, "...Follow-up Pain Scale was: 7 PRN Administration was: Ineffective still yelling out in pain..." The "Medication Administration Record", dated 03/01/24 through 03/31/24, documented Resident #1 was administered acetaminophen 1000 mg on 03/19/24 at 8:42 a.m. with a documented pain	C1505		

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 04/24/2024

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
C1505	Continued From page 6 level of seven. The "Medication Administration Record" documented the medication was ineffective. The "Progress Note", dated 03/19/24 at 8:42 a.m., documented Resident #1 had been administered acetaminophen 1000 mg for pain. The note read in part, "...Gave prn for left leg pain..." The "Progress Note", dated 03/19/24 at 11:14 a.m., documented staff had reported Resident #1 had been found on the floor. The note documented Resident #1 had complained of pain with movement of the left hip and left shoulder, was unable to stand, and bruising was noted to the left shoulder. The note documented the physician had been notified, ordered an x-ray of the hip and shoulder, and a portable x-ray company had been notified of the ordered x-rays. The "Progress Note", dated 03/19/24 at 11:19 a.m., documented the physician's office had been notified Resident #1 had fallen "this morning" and a portable x-ray was ordered. The "Progress Note", dated 03/19/24 at 11:57 a.m., read in part, "...Follow-up Pain Scale was: 7 PRN Administration was: Ineffective resident still c/o pain...waiting on X ray..." The "Progress Note", dated 03/19/24 at 2:03 p.m., documented the x-ray report documented a left hip fracture and the resident was sent to the hospital. The "Radiology Interpretation" form, dated 03/19/24, read in part, "...LEFT X-RAY EXAM OF SHOULDER...IMPRESSION: Age-indeterminate humeral fracture by frontal views...LEFT X-RAY	C1505		

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 04/24/2024

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
C1505	Continued From page 7 HIP WITH PELVIS...IMPRESSION: Acute nondisplaced left femoral intertrochanteric fracture..." ODH form 283-combined initial and final report, dated 03/19/24, read in part, "...Unwitnessed fall: C.N.A. found resident on floor in her bedroom, near the bed. Resident said [they] didn't know how [they] got in on the floor. Resident had an x-ray ordered and portable x-ray results indicated a fractured left hip. Resident sent to hospital via [emergency services]...Part C...Resident still in hospital. Any new orders will be followed, once [they] return to the facility. [They] will also be assisted to use walker when trying to get up and walk. At this time, [they] will complete recovery in the hospital, following hip surgery and go to [company name withheld] rehab, before returning to the facility..." On 04/23/24 at 12:18 p.m., Resident #1 was observed in their wheelchair in the dining room. Resident #1 was non-interviewable. On 04/23/24 at 3:24 p.m., CNA #1 stated Resident #1 had complained of generalized pain on the night shift on 03/19/24 and had received pain medication. They stated Resident #1 had not fallen during their shift from 03/18/24 at 10:00 p.m. to 03/19/24 at 6:00 a.m. On 04/24/24 at 2:56 p.m., the LPN #1 stated they began assisting at the facility after Resident #1 had fallen on 03/19/24. LPN #1 stated they had been informed the resident had fallen on 03/19/24 at approximately 7:30 a.m. They stated they did not know why the physician had not been notified until 11:14 a.m. on 03/19/24 but Resident #1 should not have experienced a delay in treatment for complaints of pain or after the fall.	C1505		

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 04/24/2024

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
C1505	Continued From page 8 On 04/24/24 at 4:30 p.m., the Regional Director of Operations stated they were unsure of the exact time Resident #1 had fallen but had been told it was on the day shift on 03/19/24. They stated Resident #1 should have received prompt treatment in regards to their complaints of pain and after the resident had fallen, in accordance to the facility's protocols and procedures.	C1505		

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/10/2024** **Facility Name:** Oxford Glen Memory Care at Owasso **License Number:** AL 7239 **Survey Event ID:** 8MCF11 **Date Survey Completed: 4/24/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C552	Based on: observation, record review, and interview, the facility failed to ensure service plans were updated to reflect the residents' current status related to fall interventions for two (#1 and #2) of three sampled residents who were reviewed for falls.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by May 24, 2024.

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?	Resident #1 and #2's care plans have been updated to include the fall interventions.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents are identified by any resident residing in the facility that falls.
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?	Falls will be reviewed each business day in morning meeting to ensure proper interventions have been implemented by staff. The Resident Care Director or appropriate designee will update the care plan to reflect the fall intervention. All residents will have their falls reviewed over the past three months and their care plans will be updated to reflect the interventions.
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 or designee will monitor care plans of those sustaining falls twice weekly for four weeks to ensure they have been updated correctly and keep a log such. Monitoring will continue at random thereafter. Results of audit and compliance checks will be reviewed in QA meetings. QA committee will determine if additional interventions or recommendations are needed for compliance. Results of reviews and audits will be reported and recorded in QA minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/24/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Amy D. Klug	**Date** Enter a date of signature. 05/10/2024

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: 5/10/2024** **Facility Name:** Oxford Glen Memory Care at Owasso **License Number:** AL 7239 **Survey Event ID:** 8MCF11 **Date Survey Completed: 4/24/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: record review and interview, the facility failed to assess, monitor, and intervene in a timely manner for pain and after a fall for one (#1) of three sampled residents who were reviewed for pain and falls.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations, the community has taken, or will take, the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by May 24, 2024.

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?	Resident #1 was sent to the hospital and treated for pain and injury.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents are identified as any resident in the facility that sustains a fall, injury or uncontrollable pain.
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?	All staff will be in-serviced about the process to follow when a fall occurs and about signs of pain and the process to follow for uncontrollable pain.
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, Resident Care Director or designee will audit incident reports to ensure action was taken in a timely manner and keep a log of such. We will monitor every fall that occurs through June 7, 2024 and then randomly thereafter. The Executive Director, Resident Care Director or designee will once weekly for four weeks review the medication administration records for five residents who are administered pain medications to ensure proper charting of pain levels and relief and that appropriate action was taken when necessary and keep a log of such. Monitoring will continue at random thereafter. Results of audit and compliance checks will be reviewed in QA meetings. QA committee will determine if additional interventions or recommendations are needed for compliance. Results of reviews and audits will be reported and recorded in QA minutes.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		5/24/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Shyn D. Alley	**Date** Enter a date of signature.	05102024
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: ralsup@oxfordseniorliving.com

June 25, 2024

License Number: AL7239

Ryan Alsup, Administrator
Oxford Glen At Owasso
11113 East 103rd Street North
Owasso, OK 74055

Survey Event ID: 8MCF12

Dear Mr. Alsup:

On **June 25, 2024,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 24, 2024,** have now been corrected effective **May 24, 2024.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
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
	AL7239	A. BUILDING: _____ B. WING _____	R-C 06/25/2024

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
{C 000}	INITIAL COMMENTS On 06/25/24, an offsite/revisit was conducted. The deficiencies from 04/24/24 were cleared.	{C 000}		

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