



Oklahoma State Department of Health
Creating a State of Health

December 17, 2019

License Number: AL7405

Ms. Alexandria Sharum, Administrator
Bartlesville Assisted Living
4605 Price Road
Bartlesville, OK 74006

RE: Survey Event ID: 1U1511

Dear Ms. Sharum:

On **November 21, 2019**, 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 November 21, 2019.

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;

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- (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 IDRCordinator@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/lde

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BARTLESVILLE ASSISTED LIVING

**4605 PRICE ROAD
BARTLESVILLE, OK 74006**

(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 A relicensure survey was completed on 11/20/19 and 11/21/19. Census was 40. Deficient practice was cited as follows.	N 000		
N1442 SS=F	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to perform initial competency skills evaluations for 5 (#16, 17, 21, 24, and #26) of 9 sampled CMA's (certified medication aides) prior to performing medication administration. This deficient practice had the widespread potential for more than minimal harm. Findings: On 11/20/19 at 1:30 p.m., during record review the employee files documented no initial validation of skills for CMA #16, #17, #21, #24 and #26 prior to the CMA's performing an initial medication pass. At 2:30 p.m., the administrator was asked if she had any more documentation of initial validation of skills for CMA's, she stated she would look.	N1442		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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N1442	Continued From page 1 On 11/21/19 at 12:00 p.m. the administrator was unable to provide any more documentation of validation of CMA skills.	N1442			
C 000	INITIAL COMMENTS A relicensure survey was completed on 11/20/19 and 11/21/19. Census was 40. Deficient practice was cited as follows.	C 000			
C 301 SS=E	310:663-3-1(a) SERVICE IN ASSISTED LIVING (a) An assisted living center shall not care for any resident needing care in excess of the level that the assisted living center is licensed to provide or capable of providing. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure 3 (#1, 5, and #8) of 9 sampled residents did not exceed the care or services available or the center was capable of providing according to the center's admission/retention/discharge criteria. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #8 Resident #8 admitted to the center on 11/04/19. Her most recent assessment, dated 11/04/19, documented a diagnosis to include diabetes mellitus.	C 301			

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C 301	Continued From page 2 Record review of laboratory results dated, 11/20/19, documented the hemoglobin A1c for resident #8 as 8.2. On 11/20/19 record review of the MAR documented resident #8's FSBS (fingerstick blood sugar) results were over 350mg/dl 17 out of 44 times between 11/06/19 to 11/13/19. There was no documentation showing the center had communicated with the physician according to ordered parameters (call physician for blood sugar 350mg/dl or above). On 11/20/19 record review of the MAR documented resident #8's FSBS (fingerstick blood sugar) results were over 401mg/dl 10 out of 23 times between 11/14/19 to 11/19/19. There was no documentation showing the center had communicated with the physician according to ordered parameters (call physician for blood sugar 401mg/dl or above). On 11/20/19 record review of the MAR documented there were 19 out of a possible 88 FSBS not obtained between 11/06/19 and 11/19/19. On 11/20/19, at 5:01 p.m. the LPN/DON stated there was no documentation showing the physician had been contacted for the out of range blood sugar levels on resident #8 and the LPN/DON stated she did not know why the physician was not notified of the blood sugar results. Resident #5 Resident #5 was admitted to the center 06/26/19 with diagnoses to include diabetes mellitus and Alzheimer's dementia. Admission orders included Metformin 1,000 mg (milligrams) twice	C 301			

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C 301	Continued From page 3 daily by mouth for diabetes mellitus. The resident's service agreement, signed on 06/26/19, documented..."if an admitted Resident's needs cannot be met, the Resident will not be permitted to remain at (name-deleted center)..." On October 22, 2019 the physician wrote an order for the center to obtain the resident's FSBS four times daily and for the resident to receive Novolog Flexpen insulin, dose dependent upon results of FSBS, four times daily. For FSBS results of 130-170, the staff was to give 1 unit of insulin, 171-230, give 2 units, 231-270, give 3 units, 271-349, give 4 units and above 350, notify the physician. On 11/04/19, the physician wrote an order for the resident to receive glipizide 5 mg twice daily for diabetes mellitus. The November MAR documented the center did not obtain the resident's FSBS results and no insulin was administered six times for the month of November, 2019. The November MAR documented the resident received the wrong dose of insulin for the FSBS result 15 times. Four times the FSBS was recorded as 137-200 and the resident got no insulin. Four times her FSBS was 171-196 and she got 1 unit of insulin, once her FSBS result was 268 and 305 and she got 2 units of insulin both times, twice her FSBS result was 161 and one of those times she got 4 units and the other time she got 6 units of insulin. One FSBS result was 146 and she got 2 units of insulin. The FSBS results documented on the November, 2019 MAR ranged from a low of 91 to a high of	C 301		

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C 301	Continued From page 4 314. On 11/21/19 at 1:00 p.m., the LPN/DON stated she did not know why the wrong doses of insulin were given or why the resident's FSBS and insulin had not been done as ordered. At 2:00 p.m., RN (registered nurse) #1 and the LPN/DON were asked who administered insulin for the residents. The RN stated LPNs and CMAs, who had Department approved advanced training in insulin administration, when a licensed nurse was not available. Resident #1 Resident #1 was admitted to the center on 10/22/18 with diagnoses to include insulin dependent diabetes mellitus, acute kidney disease, high blood pressure and heart failure. FSBS (fingerstick blood sugars) were ordered on 03/28/19 to be obtained at 8:00 a.m., 12:00 p.m., 8:00 p.m. and 3:00 a.m. Resident #1's hemoglobin A1C was 9.6 on 09/19/19. Resident #1's treatment record for fingerstick blood sugars had no results documented in September for 13 of 90 times, 8 of 150 times in October and 5 of 100 times in November. Resident #1 had an order to administer Humalog Insulin 5 units before meals everyday. No doses were documented administered for four times in September, three times in October and one time in November. At 11:55 a.m., the LPN/DON was asked why the documentation for September, October and November showed 18 daily weights were missing. The LPN/DON did not provide any documentation the resident was weighed on these days.	C 301			

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C 301	Continued From page 5 A physician's order on 10/22/2018, documented metoprolol tartrate 50 mg (milligrams) one tablet twice daily. The staff was to check the resident's blood pressure (B/P) and pulse and hold if the systolic (top number) was less than 105 and the diastolic (bottom number) was less than 50 or pulse was below 50. On 11/21/19 at 12:50 p.m., resident #1's blood pressure results were reviewed for the months of September, October, and November with the LPN/DON. She was asked why the staff had administered the blood pressure medication when the blood pressure results were outside the parameters that were ordered by the physician. She stated the blood pressure medications should not have been given. October 2019 MAR documented blood pressure medication was given 6 times when resident #1's blood pressure was out of parameters. October 4 130/47 October 13 104/70 October 21 130/40 October 24 110/40 October 25 119/43 October 31 119/38 November 2019 MAR documented blood pressure medication was given 7 times when resident #1's blood pressure was out of parameters. November 1 84/44 November 3 103/52 November 4 116/32 November 5 112/32 November 16 100/55	C 301		

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C 301	Continued From page 6 November 17 103/61 November 19 102/58	C 301		
C 954 SS=F	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure 24 (#3-8, 10-23, 25, 26, 28 and #30) of 37 direct care staff had evidence of training in first aid and Cardiopulmonary Resuscitation (CPR). This failed practice had the widespread potential for more than minimal harm. Findings: On 11/20/19 at 2:30p.m., the administrator was asked is she had any documentation of staff receiving training on CPR and first aid in the last year. On 11/21/19 at 12:00 p.m., the administrator was unable to provide documentation of the 24 employees being trained in CPR and first aid.	C 954		
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	C1505		

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C1505	Continued From page 7 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, it was determined the center failed to ensure physicians' orders were followed: A) For 2 (#5 and #8) of 2 sampled residents who had a physician's order for staff to obtain the resident's FSBS (finger stick blood sugar) results and for sliding scale insulin based on the results of the FSBS and, B) for 3 (#1, 4 and #9) of 3 sampled residents who had physician ordered blood pressure and pulse parameters for the administration of medication. These failed practices had the potential for more than minimal harm at at-pattern. Findings:	C1505		

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C1505	Continued From page 8 Resident #4 Resident #4 was admitted to the center 07/15/19 with diagnoses to include congestive heart failure and atrial fibrillation. The resident had a physician's order upon admission for digoxin 0.125 mg (milligrams) daily at 7:00 a.m. and for the staff to check the resident's pulse prior to administering the digoxin. The September, October and November, 2019 MARs (medication administration record) all documented the staff was to obtain the resident's pulse prior to administering the digoxin, but did not document any pulses. On 11/21/19 at 1:20 p.m., both RN (registered nurse) #1 and LPN/DON (licensed practical nurse/director of nurses) stated the pulses were not documented. They both went on to say the resident's pulses were just being taken weekly and not daily. Resident #5 Resident #5 was admitted to the center 06/26/19 with diagnoses to include diabetes mellitus and Alzheimer's dementia. Admission orders included Metformin 1,000 mg (milligrams) twice daily by mouth for diabetes mellitus. On October 22, 2019 the physician wrote an order for the center to obtain the resident's FSBS four times daily and for the resident to receive Novolog Flexpen insulin, dose dependent upon results of FSBS, four times daily. For FSBS results of 130-170, the staff was to give 1 unit of insulin, 171-230, give 2 units, 231-270, give 3 units, 271-349, give 4 units and above 350, notify the physician.	C1505		

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C1505	Continued From page 9 The November MAR documented the resident's FSBS results were not recorded and no insulin was documented as given to the resident six times for the month of November, 2019. The November MAR documented the resident received the wrong dose of insulin for the FSBS result 15 times. Four times the FSBS was recorded as 137-200 and the resident got no insulin. Four times her FSBS was 171-196 and she got 1 unit of insulin, once her FSBS result was 268 and 305 and she got 2 units of insulin both times, twice her FSBS result was 161 and one of those times she got 4 units and the other time she got 6 units of insulin. One FSBS result was 146 and she got 2 units of insulin. On 11/21/19 at 1:00 p.m., the LPN/DON stated she did not know why the wrong doses of insulin were given or why the resident's FSBS and insulin had not been done as ordered. Resident #1 Resident #1 was admitted to the center on 10/22/18 with diagnoses to include insulin dependent diabetes mellitus, acute kidney failure, high blood pressure and heart failure. A physician's order on 10/22/2018, documented metoprolol tartrate 50 mg (milligrams) one tablet twice daily. The staff was to check the resident's blood pressure (B/P) and pulse and hold if the systolic (top number) was less than 105 and the diastolic (bottom number) was less than 50 or pulse was below 50. On 11/21/19 at 12:50 p.m., resident #1's blood pressure results were reviewed for the months of September, October, and November with the LPN/DON. She was asked why the staff had	C1505			

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C1505	Continued From page 10 administered the blood pressure medication when the blood pressure results were outside the parameters that were ordered by the physician. She stated the blood pressure medications should not have been given. October 2019 MAR documented blood pressure medication was given 6 times when resident #1's blood pressure was out of parameters. October 4 130/47 October 13 104/70 October 21 130/40 October 24 110/40 October 25 119/43 October 31 119/38 November 2019 MAR documented blood pressure medication was given 7 times when resident #1's blood pressure was out of parameters. November 1 84/44 November 3 103/52 November 4 116/32 November 5 112/32 November 16 100/55 November 17 103/61 November 19 102/58 Resident #8 Resident #8 admitted to the center on 11/04/19. Her most recent assessment, dated 11/04/19, documented a diagnosis to include diabetes mellitus. Record review of laboratory results dated, 11/20/19, documented the hemoglobin A1c for resident #8 as 8.2.	C1505		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 11 On 11/20/19 record review of the MAR documented resident #8's FSBS (fingerstick blood sugar) results were over 350mg/dl 17 out of 44 times between 11/06/19 to 11/13/19. There was no documentation showing the center had communicated with the physician according to ordered parameters (call physician for blood sugar 350mg/dl or above). On 11/20/19 record review of the MAR documented resident #8's FSBS (fingerstick blood sugar) results were over 401mg/dl 10 out of 23 times between 11/14/19 to 11/19/19. There was no documentation showing the center had communicated with the physician according to ordered parameters (call physician for blood sugar 401mg/dl or above). On 11/20/19 record review of the MAR documented there were 19 out of a possible 88 FSBS not obtained between 11/06/19 and 11/19/19. On 11/20/19, at 5:01 p.m. the LPN/DON stated there was no documentation showing the physician had been contacted for the out of range blood sugar levels on resident #8. The LPN/DON stated she did not know why the physician was not notified of the blood sugar results. Resident #9 The physician's orders, dated 04/26/19, documented diagnoses to include diabetes mellitus and heart disease. On 11/20/19, record review was conducted, the blood pressure and heart rate were not documented previous to medication	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74006		
(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 12 administration of sotalol for resident #9 100 out of 100 times between 10/01/19 and 11/19/19. On 11/21/19, at 2:20 p.m., the LPN/DON stated there was no documentation of blood pressure and heart rate for resident #9 with the administration of the medication sotalol but there should have been and stated she did not know why. The LPN/DON stated she should have made sure the blood pressure and heart rate was recorded to ensure the medication was given per physician's orders.	C1505		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, it was	C1923		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74006		
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C1923	Continued From page 13 determined the center failed to ensure insulin injection sites were documented for 4 (#1, 5, 8, and #9) of 4 sampled residents who were administered insulin per the center's staff. This failed practice had the potential for more than minimal harm at a pattern. Findings: The resident records documented residents #1, 5, 8 and #9 all had physician's orders for insulin to be injected per the center's staff. The medication administration records (MAR) for the residents were reviewed and none of the MARs included insulin injection sites. On 11/21/19 at 3:20 p.m., the licensed practical nurse/director of nurses and registered nurse #1 both stated the insulin injection sites were not documented.	C1923		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to document services provided for 5 (#1, 4, 5, 8 and #9) of 5 sampled residents for daily weights, fingerstick blood sugars, blood pressure monitoring, heart	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74006		
(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
C1951	Continued From page 14 rate monitoring, and insulin administration. This deficient practice had the potential for more than minimal harm at a pattern. Findings: Resident #1 Resident #1 was admitted to the center on 10/22/18 with diagnoses to include insulin dependent diabetes mellitus, acute kidney disease, high blood pressure and heart failure. FSBS (fingerstick blood sugars) were ordered on 03/28/19 to be obtained at 8:00 a.m., 12:00 p.m., 8:00 p.m. and 3:00 a.m. Resident #1's treatment record for fingerstick blood sugars had no results documented in September for 13 of 90 times, 8 of 150 times in October and 5 of 100 times in November. Resident #1 had an order to administer Humalog Insulin 5 units before meals everyday. No doses were documented administered for four times in September, three times in October and one time in November. On 11/21/19 at 11:40 a.m., the LPN/DON (Licensed Practical Nurse/ Director of Nurses) was asked if there were any parameters for elevated FSBS's to report to the physician, and about the missing FSBS documentation. The LPN/DON stated there were no parameters, and that the insulin was given. At 11:55 a.m., the LPN/DON was asked why the documentation for September, October and November showed 18 daily weights were missing. The LPN/DON stated they keep a book on the scales, but did not provide any documentation the resident was weighed on these days.	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74006		
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C1951	Continued From page 15 Resident #2 Resident #2 was admitted to the center on 08/20/19 with diagnosis of atrial fibrillation. On 08/20/19 a physician ordered Digoxin tablet 0.125 milligram tablet by mouth once daily, hold if pulse is less than 60 beats per minute. Record review of the (medication administration record) MAR documented no pulse results recorded for the months of October and November 2019. Resident #5 Resident #5 was admitted to the center 06/26/19 with diagnoses to include diabetes mellitus and Alzheimer's dementia. On October 22, 2019 the physician wrote an order for the center to obtain the resident's FSBS four times daily and for the resident to receive Novolog Flexpen insulin, dose dependent upon results of FSBS, four times daily. The November MAR had six blank spaces where the resident's FSBS results and insulin dose should have been documented. On 11/21/19 at 1:00 p.m., the LPN/DON (licensed practical nurse/director of nurses) stated she did not know why the MAR was blank where the FSBS results and insulin dose should have been documented. Resident #8 Resident #8 admitted to the center on 11/04/19. Her most recent assessment, dated 11/04/19, documented a diagnosis to include diabetes	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74006		
(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
C1951	Continued From page 16 mellitus. On 11/20/19 record review of the MAR documented resident #8's FSBS (fingerstick blood sugar) results were over 350mg/dl 17 out of 44 times between 11/06/19 to 11/13/19. There was no documentation showing the center had communicated with the physician according to ordered parameters (call physician for blood sugar 350mg/dl or above). On 11/20/19 record review of the MAR documented resident #8's FSBS (fingerstick blood sugar) results were over 401mg/dl 10 out of 23 times between 11/14/19 to 11/19/19. There was no documentation showing the center had communicated with the physician according to ordered parameters (call physician for blood sugar 401mg/dl or above). On 11/20/19 record review of the MAR documented there were 19 out of a possible 88 FSBS not obtained between 11/06/19 and 11/19/19. On 11/20/19, at 5:01 p.m. the LPN/DON stated there was no documentation showing the physician had been contacted for the out of range blood sugar levels on resident #8. The LPN/DON stated she did not know why the physician was not notified of the blood sugar results. Resident #9 The physician's orders, dated 04/26/19, documented diagnoses to include diabetes mellitus and heart disease. On 11/20/19, record review was conducted, the blood pressure and heart rate were not	C1951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
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C1951	Continued From page 17 documented previous to medication administration of sotalol for resident #9 100 out of 100 times between 10/01/19 and 11/19/19. On 11/21/19, at 2:20 p.m., the LPN/DON stated there was no documentation of blood pressure and heart rate for resident #9 with the administration of the medication sotalol and there should have been and stated she did not know why. The LPN/DON stated she should have made sure the blood pressure and heart rate was recorded to ensure the medication was given per physician's orders.	C1951		
C6000 SS=F	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If	C6000		

Oklahoma State Department of Health

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C6000	Continued From page 18 that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services.	C6000		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
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C6000	Continued From page 19 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a fingerprint based national criminal background check was completed for 8 (#4, 9, 12, 15, 17, 19, 22 and #29) of 58 sampled staff members. This failed practice had the widespread potential for more than minimal harm for all 40 residents who resided in the center. Findings: On 11/20/19 at 2:30 p.m., the administrator was asked if she had any more documentation for verification of fingerprint based criminal background checks for direct care staff, she stated she would look. On 11/21/19 at 12:00 p.m. the administrator was unable to provide any more documentation of national criminal background checks.	C6000		

STATE WORKLOAD REPORT

Provider/Supplier Number AL7405	Provider/Supplier Name BARTLESVILLE ASSISTED LIVING
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Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- 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. 41872	11/20/2019	11/21/2019	0.50	0.00	11.25	0.00	6.00	8.00
2. 36967	11/20/2019	11/21/2019	0.25	0.00	11.25	0.00	6.00	9.00
3. 42023	11/20/2019	11/21/2019	0.00	0.00	11.25	0.00	5.00	8.00
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

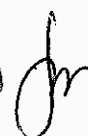
Total SA Supervisory Review Hours..... 0.00

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

DEC 19 2019 



Oklahoma State Department of Health
Creating a State of Health

January 6, 2020

License Number: AL7405

Ms. Alexandria Sharum, Administrator
Bartlesville Assisted Living
4605 Price Road
Bartlesville, OK 74006

RE: Survey Event 1U1511

Dear Ms. Sharum:

On November 21, 2019, 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 **December 6, 2019**.

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 V. Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

Board of Health

Gary Cox, JD
Commissioner of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BARTLESVILLE ASSISTED LIVING

**4605 PRICE ROAD
BARTLESVILLE, OK 74006**

(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 A relicensure survey was completed on 11/20/19 and 11/21/19. Census was 40. Deficient practice was cited as follows.	N 000		
N1442 SS=F	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to perform initial competency skills evaluations for 5 (#16, 17, 21, 24, and #26) of 9 sampled CMA's (certified medication aides) prior to performing medication administration. This deficient practice had the widespread potential for more than minimal harm. Findings: On 11/20/19 at 1:30 p.m., during record review the employee files documented no initial validation of skills for CMA #16, #17, #21, #24 and #26 prior to the CMA's performing an initial medication pass. At 2:30 p.m., the administrator was asked if she had any more documentation of initial validation of skills for CMA's, she stated she would look.	N1442		

Refer to POC
Template, Survey Event ID
1U1511, N1442

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74006			
(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	
N1442	Continued From page 1 On 11/21/19 at 12:00 p.m. the administrator was unable to provide any more documentation of validation of CMA skills.	N1442			
C 000	INITIAL COMMENTS A relicensure survey was completed on 11/20/19 and 11/21/19. Census was 40. Deficient practice was cited as follows.	C 000			
C 301 SS=E	310:663-3-1(a) SERVICE IN ASSISTED LIVING (a) An assisted living center shall not care for any resident needing care in excess of the level that the assisted living center is licensed to provide or capable of providing. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure 3 (#1, 5, and #8) of 9 sampled residents did not exceed the care or services available or the center was capable of providing according to the center's admission/retention/discharge criteria. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #8 Resident #8 admitted to the center on 11/04/19. Her most recent assessment, dated 11/04/19, documented a diagnosis to include diabetes mellitus.	C 301	Refer to POC Template, Survey went 10/25/19, ID Prefix tag C302		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
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NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74005
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 301	Continued From page 2 Record review of laboratory results dated, 11/20/19, documented the hemoglobin A1c for resident #8 as 8.2. On 11/20/19 record review of the MAR documented resident #8's FSBS (fingerstick blood sugar) results were over 350mg/dl 17 out of 44 times between 11/06/19 to 11/13/19. There was no documentation showing the center had communicated with the physician according to ordered parameters (call physician for blood sugar 350mg/dl or above). On 11/20/19 record review of the MAR documented resident #8's FSBS (fingerstick blood sugar) results were over 401mg/dl 10 out of 23 times between 11/14/19 to 11/19/19. There was no documentation showing the center had communicated with the physician according to ordered parameters (call physician for blood sugar 401mg/dl or above). On 11/20/19 record review of the MAR documented there were 19 out of a possible 88 FSBS not obtained between 11/06/19 and 11/19/19. On 11/20/19, at 5:01 p.m. the LPN/DON stated there was no documentation showing the physician had been contacted for the out of range blood sugar levels on resident #8 and the LPN/DON stated she did not know why the physician was not notified of the blood sugar results. Resident #5 Resident #5 was admitted to the center 06/26/19 with diagnoses to include diabetes mellitus and Alzheimer's dementia. Admission orders included Metformin 1,000 mg (milligrams) twice	C 301		

	New CMA communication sheet implemented that tracks held medications, corresponding vitals, and which nurse was notified.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		An immediate review of MARs/TARs on all residents occurred and orders were reviewed and new orders were received for parameters on medication.
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?		Routine audits to be completed by RN/Admin/Regional Director to ensure proper procedures are being completed and implementation is effective.
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.		Audits will be reviewed by RN/Admin/Regional director upon completion to ensure that corrective measures have been sufficient. The pharmacist will be requested to attend QA. Those audits will be brought to the QA committee for review. Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		12/6/2019
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Alexandria Sharum OAC 310-663-25-4(F)		Date 12/27/2019
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.		
Addendum Date	Enter a date of addendum.	Submitted by Enter name of person submitting addendum.
Items Below Are For OSDH Use Only		
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor		
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.		
Facility in Compliance by: Click here to enter a date.		



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/27/2019

Facility Name: Bartlesville Assisted Living

License Number: AL7405

Survey Event ID: 1U1511

Date Survey Completed: 11/21/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923

Based on: Based on record review and interview, it was determined the center failed to ensure insulin injection sites were documented for 4 (#1, 5, 8 and 9) of 4 sampled residents who were administered insulin per the center's staff. 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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Alexandria Sharum

OAC 310:663-25-4(F)

Date 12/27/2019

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.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Pharmacy charting software added injection site as a part of the mandatory charting for insulin administration.

LPN's were trained by RN on 12-6-19 and again by Pharmacy representative on the appropriate use of computer software for charting purposes on 12-19-19.

Routine audits are to be completed by RN/Regional Director/Administrator/Executive Director to ensure that insulin injection sites are on TARs upon admission and remain there with all new med changes.

Routine audits, to be monitored by RN and Regional Director, and will be monitored at QA quarterly

Audits will be monitored by QA committee quarterly for effectiveness.

A tracking form will be used and submitted to RN/Admin/Regional Director to ensure that the injection sites are present on all residents receiving injections.

Enter methods to incorporate into QA system:

Records will continue to be monitored quarterly at QA, and weekly by RN and Regional Director

Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
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Facility in Compliance by: Click here to enter a date.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/27/2019

Facility Name: Bartlesville Assisted Living

License Number: AL7405

Survey Event ID: 1U1511

Date Survey Completed: 11/21/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1951

Based on: Based on interview and record review it was determined the center failed to document services provided for 5 (#1,4, 5, 8 and #9) of 5 sampled residents for daily weights, fingersticks, blood sugars, blood pressure monitoring, heart rate monitoring, and insulin administration. This deficient practice had the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The assisted living

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 11-27-19, RN educated DON/LPN on the importance of documenting in 'real time', when to notify physicians/practitioners if FSBS or any vital sign was not within range of the set parameters that had been ordered; and why these parameters were important to patient health.

All resident's medications were reviewed by RN and new DON to ensure that all necessary vitals, and corresponding physician parameters for documentation were implemented for chart and on pharmacy software.

Weekly and/or random checks are preformed by RN, Administrator, and/or Regional Administrator to ensure compliance with all aspects of medication documentation and administration.

Diabetic/treatment cart implemented as the only acceptable form of checking FSBS and administering insulin to ensure accurate documentation in real time.

New leadership position implemented for director of nursing. Random checks preformed, no less than weekly, by RN, Administrator, Regional Administrator and new DON preformed to ensure charting, reporting to physician's, insulin administration, and vital sign charting is being completed per physician's orders.

In-service held by RN for all LPN's and CMA's on 12-06-2019 on the importance of recognizing and reporting all parameters that are out of range; the importance of documenting all medications and vital signs in real time; high risk medications and the importance of receiving

		them on time, the importance of withholding these medications if vital signs are not within the parameters ordered by the physician.
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 MARs/TARs have been reviewed by RN and LPN/DON to ensure that parameters have been ordered by the physician. These audits will continue on a routine basis to ensure existing residents and new residents have orders in place with parameters and are being documented.
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?		Routine audits of MARs/TARs to be completed and presented to the QA committee, if issues are noted during audit they will be turned into the DON for an immediate fix. Pharmacist to review meds quarterly to ensure proper vitals are being monitored before/after administration, and parameters are in place. Recommendations will be presented at time of pharmacy visit for immediate attention.
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.		Audits will be sent to RN, Regional Director, Admin weekly for review. Audits will also be reviewed by QA committee quarterly. Request the attendance of the pharmacist to attend QA to review the audits. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: A tracking form will be utilized for quick review of audit. And will be presented to QA Committee quarterly. RN/Regional Director and Administrator will review them upon receipt.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		12/6/2019
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Alexandria Sharum OAC 310:663-25-4(F)		Date 12/27/2019
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.
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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor		
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/27/2019

Facility Name: Bartlesville Assisted Living

License Number: AL7405

Survey Event ID: 1U1511

Date Survey Completed: 11/21/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C6000

Based on: Based on interview and record review, it was determined the center failed to ensure a fingerprint based national criminal background check was completed for 8 (#4, 9, 12, 15, 17, 19, 22, and #29) of 58 sampled staff members. This failed practice had the widespread potential for more than minimal harm for all 40 residents who resided in the center.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The assisted living was not left with a list of sampled staff upon exit. The assisted living was aware of 2 staff who had been fingerprinted but Identogo, OK Screen, and the assisted living center had been in communication regarding the two as there had been issues with the fingerprinting itself. Communication was provided to surveyors and situation was explained.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

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.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Alexandria Sharum

OAC 310:663-25-4(F)

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Executive Director and Administrator will follow hiring procedures in which a background check is completed by corporate HR prior to job offer. Background results will be emailed from corporate HR prior to any job offers along with required documents for employee file.

Assisted living will continue background checks and fingerprinting upon hiring and ensure that all required documents are placed in employee binder.

Executive Director will ensure that fingerprints are completed within 14 days of hire as required by OK Screen.

Executive Director and corporate HR ensure that background and fingerprints are completed.

OK Screen is checked by corporate daily

Employee records are checked routinely

Executive director and corporate HR ensure that all records are up to date

12/6/2019

Date 12/27/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74006		
(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 9 The November MAR documented the resident's FSBS results were not recorded and no insulin was documented as given to the resident six times for the month of November, 2019. The November MAR documented the resident received the wrong dose of insulin for the FSBS result 15 times. Four times the FSBS was recorded as 137-200 and the resident got no insulin. Four times her FSBS was 171-196 and she got 1 unit of insulin, once her FSBS result was 268 and 305 and she got 2 units of insulin both times, twice her FSBS result was 161 and one of those times she got 4 units and the other time she got 6 units of insulin. One FSBS result was 146 and she got 2 units of insulin. On 11/21/19 at 1:00 p.m., the LPN/DON stated she did not know why the wrong doses of insulin were given or why the resident's FSBS and insulin had not been done as ordered. Resident #1 Resident #1 was admitted to the center on 10/22/18 with diagnoses to include insulin dependent diabetes mellitus, acute kidney failure, high blood pressure and heart failure. A physician's order on 10/22/2018, documented metoprolol tartrate 50 mg (milligrams) one tablet twice daily. The staff was to check the resident's blood pressure (B/P) and pulse and hold if the systolic (top number) was less than 105 and the diastolic (bottom number) was less than 50 or pulse was below 50. On 11/21/19 at 12:50 p.m., resident #1's blood pressure results were reviewed for the months of September, October, and November with the LPN/DON. She was asked why the staff had	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74005		
(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 10 administered the blood pressure medication when the blood pressure results were outside the parameters that were ordered by the physician. She stated the blood pressure medications should not have been given. October 2019 MAR documented blood pressure medication was given 6 times when resident #1's blood pressure was out of parameters. October 4 130/47 October 13 104/70 October 21 130/40 October 24 110/40 October 25 119/43 October 31 119/38 November 2019 MAR documented blood pressure medication was given 7 times when resident #1's blood pressure was out of parameters. November 1 84/44 November 3 103/52 November 4 116/32 November 5 112/32 November 16 100/55 November 17 103/61 November 19 102/58 Resident #8 Resident #8 admitted to the center on 11/04/19. Her most recent assessment, dated 11/04/19, documented a diagnosis to include diabetes mellitus. Record review of laboratory results dated, 11/20/19, documented the hemoglobin A1c for resident #8 as 8.2.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7406	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74006			
(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 11 On 11/20/19 record review of the MAR documented resident #8's FSBS (fingerstick blood sugar) results were over 350mg/dl 17 out of 44 times between 11/06/19 to 11/13/19. There was no documentation showing the center had communicated with the physician according to ordered parameters (call physician for blood sugar 350mg/dl or above). On 11/20/19 record review of the MAR documented resident #8's FSBS (fingerstick blood sugar) results were over 401mg/dl 10 out of 23 times between 11/14/19 to 11/19/19. There was no documentation showing the center had communicated with the physician according to ordered parameters (call physician for blood sugar 401mg/dl or above). On 11/20/19 record review of the MAR documented there were 19 out of a possible 88 FSBS not obtained between 11/06/19 and 11/19/19. On 11/20/19, at 5:01 p.m. the LPN/DON stated there was no documentation showing the physician had been contacted for the out of range blood sugar levels on resident #8. The LPN/DON stated she did not know why the physician was not notified of the blood sugar results. Resident #9 The physician's orders, dated 04/26/19, documented diagnoses to include diabetes mellitus and heart disease. On 11/20/19, record review was conducted, the blood pressure and heart rate were not documented previous to medication	C1505			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74006		
(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 12 administration of sotalol for resident #9 100 out of 100 times between 10/01/19 and 11/19/19. On 11/21/19, at 2:20 p.m., the LPN/DON stated there was no documentation of blood pressure and heart rate for resident #9 with the administration of the medication sotalol but there should have been and stated she did not know why. The LPN/DON stated she should have made sure the blood pressure and heart rate was recorded to ensure the medication was given per physician's orders.	C1505		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, it was	C1923	Refer to POC template, Survey Report 10 201577, ID Prefix tag C1923	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7406	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74006		
(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
C1923	Continued From page 13 determined the center failed to ensure insulin injection sites were documented for 4 (#1, 5, 8, and #9) of 4 sampled residents who were administered insulin per the center's staff. This failed practice had the potential for more than minimal harm at a pattern. Findings: The resident records documented residents #1, 5, 8 and #9 all had physician's orders for insulin to be injected per the center's staff. The medication administration records (MAR) for the residents were reviewed and none of the MARs included insulin injection sites. On 11/21/19 at 3:20 p.m., the licensed practical nurse/director of nurses and registered nurse #1 both stated the insulin injection sites were not documented.	C1923		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to document services provided for 5 (#1, 4, 5, 8 and #9) of 5 sampled residents for daily weights, fingerstick blood sugars, blood pressure monitoring, heart	C1951	Refer to POC template, Survey Event 10 201911, 10 Prefix tag C1951	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/21/2019
NAME OF PROVIDER OR SUPPLIER BARTLESVILLE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 4605 PRICE ROAD BARTLESVILLE, OK 74006		
(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
C1951	Continued From page 14 rate monitoring, and insulin administration. This deficient practice had the potential for more than minimal harm at a pattern. Findings: Resident #1 Resident #1 was admitted to the center on 10/22/18 with diagnoses to include insulin dependent diabetes mellitus, acute kidney disease, high blood pressure and heart failure. FSBS (fingerstick blood sugars) were ordered on 03/28/19 to be obtained at 8:00 a.m., 12:00 p.m., 8:00 p.m. and 3:00 a.m. Resident #1's treatment record for fingerstick blood sugars had no results documented in September for 13 of 90 times, 8 of 150 times in October and 5 of 100 times in November. Resident #1 had an order to administer Humalog Insulin 5 units before meals everyday. No doses were documented administered for four times in September, three times in October and one time in November. On 11/21/19 at 11:40 a.m., the LPN/DON (Licensed Practical Nurse/ Director of Nurses) was asked if there were any parameters for elevated FSBS's to report to the physician, and about the missing FSBS documentation. The LPN/DON stated there were no parameters, and that the insulin was given. At 11:55 a.m., the LPN/DON was asked why the documentation for September, October and November showed 18 daily weights were missing. The LPN/DON stated they keep a book on the scales, but did not provide any documentation the resident was weighed on these days.	C1951		