

Deliver Via Email: lburrell@thecommons-umrc.com

August 13, 2020

License Number: NH2407AL

Ms. Ladeana Burrell, Administrator
The Commons
301 South Oakwood Road
Enid, OK 73706

RE: Survey Event ID: XIZR11

Dear Ms. Burrell:

On **February 14, 2020**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on February 14, 2020.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;

- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

**Katie
Stagner**

Digitally signed by Katie Stagner
DN: cn=Katie Stagner,
o=Oklahoma State Department of
Health, ou=Long Term Care,
email=katies@health.ok.gov, c=US
Date: 2020.08.13 08:24:02 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE COMMONS

301 SOUTH OAKWOOD ROAD

ENID. OK 73706

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: NH2407AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2020
NAME OF PROVIDER OR SUPPLIER THE COMMONS		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706		
(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 521	Continued From page 1 assessments available.	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the center failed to ensure a comprehensive assessment was completed for 3 (#2, 5 and #8) of 7 sampled residents who required a completed comprehensive assessment. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #2 Resident #2 was admitted to the center 11/20/18. A comprehensive assessment, identified as an "annual" assessment was dated 06/12/19, almost 7 months after admission. This assessment was dated by the Registered Nurse (RN) DON on 11/18/19. No other assessment was provided. Resident #5 Resident #5 was admitted to the center 06/26/19. The assessment provided was identified as the "14 day" assessment and was dated as being	C 522		

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C 522	Continued From page 2 completed on 10/31/19, over 4 months after admission. This assessment was signed by the RN DON on 11/18/19. Resident #8 Resident #8 was admitted to the center 10/16/19. The resident had a preadmission assessment dated 10/04/19. The comprehensive assessment provided was identified as the "14 day" assessment and was dated 11/11/19, 26 days after admission. This assessment was signed by the Registered Nurse (RN) DON on 11/18/19. On 02/14/2020 at 10:00 a.m., Licensed Practical Nurse (LPN) #1 stated no other assessments were available and she did not know why the assessments were not completed timely.	C 522		
C 531 SS=E	310:663-5-3(a) ASSESSMENT FORM (a) The admission assessment form shall include but not be limited to the following: (1) resident's identification; (2) disease diagnosis/infections; (3) mental health history, and mental retardation or developmental disability; (4) physical functioning which includes the numbers of persons needed to assist with activities of daily living; (5) incontinence; (6) medications; (7) special treatment and procedures; (8) cognitive function; and (9) signatures and dates.	C 531		

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C 531	Continued From page 3 This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure all required components were included in the admission assessment for 2 (#7 and #8) of 5 sampled residents who were admitted to the center since the last survey. This deficient practice had the potential for more than minimal harm at a pattern. Findings: Resident #7 Resident #7 was admitted to the center 02/07/2020. The preadmission assessment, dated 01/27/2020, was incomplete. The areas for mental health history, mental retardation or developmental disabilities, number of persons required to assist with activities of daily living and special treatments were all left blank. Resident #8 Resident #8 was admitted to the center 10/16/19. The preadmission assessment, dated 10/04/19, was incomplete. The areas for disease diagnoses and medically defined conditions, history of infections and prior medical history, medications, confusion under cognitive function and number of persons required for transferring, toileting and ambulation were all blank. On 02/14/2020 at 10:00 a.m., the Licensed Practical Nurse (LPN) stated she did not know why the assessments were not completed.	C 531		

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C 532	Continued From page 4	C 532		
C 532 SS=E	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure all required components were included in the comprehensive assessment for 5 (#1, 3, 4, 6 and #8) of 5 sampled residents who required a comprehensive assessment. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #1 Resident #1 was admitted to the center 12/31/19. The comprehensive assessment, dated 01/14/2020, was incomplete and did not include	C 532		

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C 532	Continued From page 5 ambulatory assistance under physical functional status, mental functional status and history of mood disorder/depression under psychosocial status. Resident #3 Resident #3's comprehensive assessment, dated 06/11/19, was incomplete and did not include mental /cognitive status, mental health history/mental retardation or developmental disabilities under mental functioning status, ambulatory assistance under physical functional status, weight changes under oral/nutritional status, history of mood disorder/depression and history of abnormal behaviors under psychosocial status and, skin turgor, color, texture, appearance and abnormalities under skin condition. Resident #4 Resident #4's most recent comprehensive assessment was dated 02/04/2020. The assessment was incomplete and did not include disease diagnoses and medically defined conditions, history of infections and prior medical history and all current medications. The form documented "See copy" and no copy was attached to the assessment. The assessment also did not include mental health/mental retardation or developmental disabilities under mental functional status, ambulatory assistance under physical functional status, and height and weight change under oral/nutritional status. Resident #6 Resident #6's most recent comprehensive assessment, dated 12/05/19, was incomplete and did not include disease diagnoses and medically	C 532		

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C 532	Continued From page 6 defined conditions and history of infections, prior medical history and current medications. The assessment documented "See copy" and no copy was attached to the assessment. The assessment also did not include ambulatory assistance under physical functional status, weight changes under oral/nutritional status, sleep patterns and bathing preference under customary routine and history of mood disorder/depression under psychosocial status. Resident #8 Resident #8's assessment, dated 11/11/19, was incomplete and did not include history of infections and prior medical history, mental health history/mental retardation or developmental disabilities under mental functional status, ambulatory assistance under physical functional status, how many hours of sleep in 24 hours under customary routine. On 02/14/2020 at 10:00 a.m., Licensed Practical Nurse #1 stated she did not know why the assessments were not completed.	C 532		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure all assessments were signed by a Registered Nurse (RN) or the resident's physician for 2 (#4 and #7) of 8 sampled residents who had an assessment	C 542		

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C 542	Continued From page 7 completed. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #4 and #7 assessments were not signed by an RN or the resident's personal physician, only by the LPN #1. On 02/14/2020 at 10:00 a.m., LPN #1 stated she did not know why the assessments were not signed by the RN.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure the comprehensive assessments for 2 (#2 and #3) of 7 sampled residents included a signature to indicate the resident or the resident's representative was interviewed. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #2 and #3's comprehensive assessments did not contain a signature to indicate a personal interview had been conducted between the resident or the resident's	C 543		

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C 543	Continued From page 8 representative and the person who had completed the assessment. On 02/14/2020 at 10:00 a.m., the Licensed Practical Nurse (LPN) stated she did not know why the assessments were not signed by the resident's or the resident's representative.	C 543		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to provide RN supervision and oversight to ensure: a. Non-licensed staff did not obtain blood oxygen levels for 4 (#3, 4, 7 and #8) of 4 sampled residents who had oxygen and/or had breathing treatments/inhalers ordered by a physician and failed to ensure staff stayed with 1 (#8) of 1 sampled resident during a nebulizer breathing	C 911		

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C 911	Continued From page 9 treatment, b. There was a physician's order for oxygen for 1 (#3) of 1 sampled resident who was administered oxygen per nasal cannula, c. Staff followed physician orders for 1 (#1) of 1 unstable diabetic resident and there was a center protocol for 2 (#1 and #3) of 2 sampled diabetic residents who had sliding scale (dosage based on blood sugar result) insulin ordered; and d. Staff placed change of direction stickers on prescription medication bottles and did not alter the dose of prescribe medications by cutting them in half for 1 (#4) of 1 sampled resident who had a medication dosage change order. These deficient practices had the potential for more than minimal harm at a pattern. Findings: a. Oxygen Levels. According to the World Health Organization, a normal healthy person should be able to achieve normal blood oxygen saturation levels of 94% to 99%. For patients with mild respiratory diseases, the blood oxygen levels should be above 90%. Supplementary oxygen should be used if blood oxygen level falls below 90%, which was unacceptable for prolonged period of time. Resident #3 The January 2020 medication administration record (MAR) for resident #3 documented the resident's blood oxygen saturation was to be obtained once on each shift from 01/08/2020 until 01/16/2020 while the resident was being weaned off oxygen. Either a long term care aide (LTCA)	C 911		

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C 911	Continued From page 10 or a certified medication aide (CMA) initialed the MAR they had obtained the resident's blood oxygen saturation 19 times. Resident #4 Resident #4 recently moved into the center with diagnoses to include chronic obstructive pulmonary disease (COPD), coronary artery disease and renal failure. The February 2020 physician orders documented the use of a noninvasive ventilator at night, Brovana 1 vial per nebulizer (breathing) treatment twice daily, Ipratropium-Albuterol one vial per nebulizer four times daily, Budesonide one vial per nebulizer twice daily and continuous oxygen at 2 liters per minute via nasal cannula. The February 2020 MAR documented blood oxygen saturation was obtained by a LTCA or CMA 34 times. The resident's blood oxygen saturation levels ranged from 97% down to 81% and nine times the blood oxygen level was below 90%. There was no documentation a licensed nurse was notified of the low blood oxygen levels. On 02/12/2020 at 9:20 a.m., resident #4 stated he managed the noninvasive ventilator himself and his daughter stated the ventilator was monitored offsite. At 9:45 a.m., LPN #1 stated she was not familiar with noninvasive ventilator. Resident #7 Resident #7 was recently moved into the center with diagnoses to include COPD, chronic respiratory failure with hypoxia (low blood oxygen	C 911		

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C 911	Continued From page 11 levels), centrilobular emphysema and solitary pulmonary nodule. The physician orders documented Spiriva inhaler 18 micrograms (mcg) one time daily, Albuterol inhaler two puffs as needed every four hours for wheezing/shortness of breath, Brovana inhaler twice daily, Budesonide twice daily, Ipratropium 0.5 milligrams (mg)-Albuterol 3 mg every six hours for wheezing and continuous oxygen at 3 liters per minute via nasal cannula. Staff on each shift were to maintain blood oxygen levels above 89%. The February 2020 MAR documented, LTCAs and CMAs had obtained the resident's blood oxygen levels 17 times. Resident #8 The February 2020 physician orders documented, Ipratropium-Albuterol every six hours for wheezing. The resident did not have an order to self-administer any medications. On 02/14/2020 the resident was observed alone in her room administering a breathing treatment. A few minutes later, during the breathing treatment, certified medication aide with advanced training in respiratory medications (CMA-R)/employee #2 entered the residents room to clean and put away the breathing treatment equipment for the resident, then left. The resident stated the center's staff prepared the equipment for her breathing treatments, handed the mouthpiece to her then left and came back when the treatment was finished. The resident's January 2020 MAR documented a LTCA or CMA obtained the resident's blood oxygen levels four times.	C 911		

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C 911	Continued From page 12 On 02/14/2020 at 11:00 a.m., LPN #1 stated LTCAs and CMAs always obtained blood oxygen levels when they obtained other vital signs. LPN #1 stated she was not aware LTCAs and CMAs could not obtain oxygen saturation levels which were beyond their scope of practice and not a skill taught in the long term care nurse aide curriculum. b. Physicians Orders. Resident #3 On 02/11/2020 at 10:25 p.m. the LPN relayed during a verbal report that resident #3 used oxygen at night. The resident's record was reviewed. No physician order for oxygen was documented. On 02/14/2020 at 9:00 a.m., resident #3 was interviewed in her room. An oxygen concentrator was observed in her room. The resident stated she had been using oxygen since she came back from the hospital in November 2019. At 9:45 a.m., LPN #1 stated the resident had been using oxygen since December 2019. All the center's printed orders (including February 2020) physician orders documented, "Cancel all previous orders" printed at the top. LPN #1 stated the only oxygen order resident #3 had was dated January 2020 and there was no current order for the oxygen. c. Diabetic Residents - Sliding Scales. Resident #1 Resident #1 moved into the center 12/31/19 with	C 911		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER THE COMMONS		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706		
(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 911	Continued From page 13 a diagnosis of insulin dependent diabetes mellitus and an order for sliding scale insulin. The order documented the resident's FSBS (finger stick blood sugar) was to be obtained three times daily and included instructions to follow hypoglycemic protocol for a blood sugar result of less than 70. The admission order also documented the resident was to receive glucose 4 gm (grams) chewable tablet one daily as needed for diabetes and glucose gel 40% 1 applicator full daily as needed (no diagnosis or indication of when to administer was documented). The February 2020 physician orders documented, glucose 40% gel 1 applicator full by mouth daily as needed (no diagnosis or indication was documented) and glucose 4 gm chewable 1 tablet as needed for diabetes. The orders also documented to follow hypoglycemic protocol for FSBS results below 70. The January 2020 MAR documented the resident's FSBS results to be 62 January 1st and 63 January 24th. The January 2020 MAR documented neither the glucose chewable tablet nor the glucose gel had been administered to the resident on January 1st or January 24th when the resident's FSBS result was below 70 mg/dl. On February 5th, the resident's FSBS result was 53 mg/dl and on February 10th the FSBS result was 62 mg/dl. The February, 2020 MAR documented neither the glucose chewable tablet nor the glucose gel had been administered to the resident on February 5th nor February 10th when the FSBS result was below 70 mg/dl.	C 911		

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C 911	Continued From page 14 At 1:30 p.m., CMA-IA,GM (certified medication aide with advanced training in insulin administration and glucose monitoring)/employee #2 stated she thought resident #1 was to be administered glucose if her FSBS result was below 50. There was no documentation to support this intervention. Both CMA-IA,GM/employee #1 and CMA-IA,GM/employee #2 stated when a resident had a FSBS that was low, they did what they thought was the right thing to do and what they were taught in CMA training. CMA-IA,GM/employee #1 stated she would give a resident with a low blood sugar some orange juice and some peanut butter, then would do another FSBS in 30 to 45 minutes and repeat the process if necessary. Both of the CMA's stated there was no written protocol in place for diabetic care. Throughout the entire interview, neither one of the CMA's mentioned they would notify the licensed nurse. At 3:00 p.m., LPN #1 looked at the MARs and said the resident did not get the glucose as ordered. She also stated she did not know resident #1's blood sugar had ever been low. d. Medication Change Stickers. Resident #4 On 02/12/2020, resident #4's prescription medication bottles in the medication cart were observed. The resident had a bottle of Amlodipine Besylate 5 mg. There was no change of direction label on the bottle and the tablets were cut in half. The prescription label on the bottle read to take 1 tablet by mouth daily. The	C 911		

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C 911	Continued From page 15 bottle cap had 1/2 tab hand written. The February, 2020 physician orders documented Amlodipine Besylate 2.5 mg. 1 tablet every Tuesday and Thursday. The February, 2020 MAR had the same directions as the order. The resident also had a prescription bottle of Amiodarone 100 mg in the medication cart. The prescription label directions stated take one tablet daily. 1/2 tab was handwritten on the bottle cap and the tablets were cut in half. There was no change of direction sticker on the bottle. The current order documented 1/2 tab (50 mg) daily. The February, 2020 MAR had the same directions as the order. There was also a prescription bottle of Carvedilol 6.25 mg. The directions stated take one twice daily. 1/2 tab was handwritten on the bottle cap and the tablets were cut in half. There was no change of direction sticker on the bottle. The current order documented Carvedilol 3.125 mg one tablet by mouth daily. The February, 2020 MAR had the same directions as the order. There was also a bottle of Lasix in the medication cart. The label read for resident #4 to take 80 mg two tablets twice daily. There was a change of direction sticker on the prescription bottle. The prescription was filled on 02/05/2020. There was an order in the resident's record, dated 02/03/2020 for the resident to take 40 mg of Lasix daily, two days before the bottle was filled. And finally there was a bottle of Ropinirole 1 mg in the medication cart for resident #4. The prescription label on the bottle documented the resident was to take one tablet three times daily. 1/2 tab was handwritten on the bottle cap and the pills were cut in two. There was no change of	C 911		

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C 911	Continued From page 16 direction sticker on the bottle and the February, 2020 MAR had the same directions as the order. The physician orders for resident #4 were reviewed. There was a physician order on 01/23/2020 to change the dosage of the Carvedilol to 3.125 mg twice daily and the Amidarone to 50 mg daily. At 10:30 a.m., CMA/employee #2 said the CMAs had to cut resident #4's pills in half because the pharmacy would not send the correct dosage and the family said they did not have the time to do it. At 11:00 a.m., the RN stated the CMAs should not be cutting pills in half and she provided a policy that documented change of direction stickers should be used when indicated, and that only RN's should cut tablets in half and only in an emergency.	C 911		
C1110 SS=F	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes.	C1110		

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C1110	Continued From page 17 This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to maintain a Quality Assurance (QA) committee who met at least quarterly. This failed practice had the widespread potential for more than minimal harm for all 27 residents. Findings: On 02/12/2020 the centers records were reviewed. The only QA meeting records provided were dated January 2020. At 2:40 p.m., LPN #1 stated the only QA meeting records available were from January 2020. She also stated no QA meetings had been held in 2019.	C1110		
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 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	C1505		

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C1505	Continued From page 18 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 interview and record review, it was determined the center failed to ensure glucose was administered as ordered by the physician for 1 (#1) of 1 unstable diabetic who had a physician ordered protocol for hypoglycemia (low blood sugar). This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #1 was admitted to the center 12/31/19 with a diagnosis of insulin dependent diabetes mellitus and a physician order for sliding scale (dose dependent upon blood sugar result) insulin. The order documented the resident's FSBS (finger stick blood sugar) was to be obtained three times daily and included instructions to follow hypoglycemic protocol for a blood sugar result of less than 70. The admission orders documented the resident was to receive glucose 4 grams (gm) chewable tablet one daily as needed for diabetes and glucose gel 40% 1	C1505		

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C1505	Continued From page 19 applicator full daily as needed (no diagnosis or indication was documented). On January 24th the resident's FSBS was recorded as 63 and on January 1st the FSBS was recorded as 62. The January 2020 medication administration record (MAR) documented the resident was to have glucose 4 mg (milligrams) chewable tablet 1 daily as needed for FSBS below...the MAR did not document the result below which the glucose was to be administered. The same MAR also documented immediately below the glucose chewable order, Glucose gel 40% one applicator full by mouth daily as needed for FSBS result below...The MAR again, did not document the result below which the gel was to be administered. The January 2020 MAR documented neither the glucose chewable tablet nor the glucose gel had been administered to the resident on January 24 th or 1st when her FSBS result was below 70. On February 5th the resident's FSBS result was 53 and on February 10th the FSBS result was 62. The February 2020 physician order documented, glucose 40% gel 1 applicator full by mouth daily as needed (no diagnosis or indication was documented) and glucose 4 gm chewable 1 tablet as needed for diabetes, but did not explain when to give or by who. Another physician order documented to follow hypoglycemic protocol for FSBS results below 70. The February 2020 MAR documented the resident was to receive glucose 40% gel 1 applicator full by mouth daily as needed (no	C1505		

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C1505	Continued From page 20 diagnosis or indication was documented) and glucose 4 gm chewable 1 tablet as needed for diabetes. The February 2020 MAR documented neither the glucose chewable tablet nor the glucose gel had been administered to the resident on February 5th or 10th when her FSBS result was below 70. On 02/12/2020 at 1:30 p.m., certified medication aide with advanced training in insulin administration and glucose monitoring (CMA-IA,GM)/employee #2 stated she thought resident #1 was to be administered glucose if her FSBS result was below 50. Both CMA-IA,GM/employee #1 and CMA-IA,GM/employee #2 stated when a resident had a low FSBS (neither described a low blood sugar), they did what they thought was the right thing to do and what they were taught in CMA training. CMA-IA,GM/employee #1 stated if there was no specific physician's order, she would give a resident with a low blood sugar some orange juice and some peanut butter, then do another FSBS in 30 to 45 minutes and repeat the process if necessary. Both of them stated there was no written protocol to follow for low blood sugar. Neither one of them stated they would notify the licensed nurse. At 3:00 p.m., LPN (licensed practical nurse) #1 reviewed the MARs and stated the resident did not get the glucose as ordered. She also stated she did not know resident #1's blood sugar had ever been low.	C1505		
C1920 SS=F	310:663-19-2(a) MEDICATION ADMINISTRATION	C1920		

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C1920	Continued From page 21 (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to develop and implement medication policies and procedures to ensure the safe administration of medications for all 27 residents who had physician ordered medications. This failed practice had the widespread potential for more than minimal harm. Findings: On 02/12/2020 at 12:00 p.m., the Registered Nurse (RN) provided a single policy which addressed change of direction stickers and splitting pills in half. She stated the center had no other medication policies or procedures. At 1:25 p.m., certified medication aide with advanced training in insulin administration and glucose monitoring (CMA-IA,GM)/employee #1 and CMA-IA,GM/employee #2 both stated there was no policy or protocol in place to follow when a diabetic resident had high or low blood sugar.	C1920		
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.	C1923		

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C1923	Continued From page 22 (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 interview and record review, it was determined the center failed to ensure insulin injection sites were documented accurately for 2 (#1 and #3) of 2 sampled residents who received insulin injections by staff. This failed practice had the potential for more than minimal harm at a pattern. Findings: The January 2020 medication administration record (MAR) was reviewed for residents #1 and #3. The MARs were handwritten and very difficult to read. There were not enough spaces for the staff to document injection sites. On 02/13/2020 at 10:15 a.m., the Registered Nurse (RN) and Licensed Practical Nurse (LPN) #1 reviewed resident #1 and #3's record and stated the MARs were not written out correctly and there were not enough spaces for the staff to document injection sites, so several injection sites were not documented.	C1923		

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N 000	Initial Comments A re-licensure survey was conducted 02/11/2020 through 02/14/2020. Resident census was 27. The following deficient practices were cited.	N 000		
N1405 SS=E	310:677-13-6 (b) Competency and Practice Standards Each certified medication aide shall: (1) Comply with 63 O.S. Section 1-1950.3 (E) and OAC 310:677-13; (2) Perform within authorized duties; (3) Follow written instructions of a licensed nurse or physician; and (4) Accurately record medications administered, withheld or refused.	N1405		

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

TITLE

(X6) DATE

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N1405	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure certified medication aides (CMAs) performed within authorized duties: a) for 2 (#1 and #3) of 2 sampled residents who had a physician's order for sliding scale insulin; and b) by cutting prescribed medication tablets in half for 1 (#7) of 1 sampled resident who had a physician ordered change of medication dosage. These failed practices had the potential for more than minimal harm at a pattern. Findings: Resident #1 a) Resident #1 was admitted to the center 12/31/19 with a diagnosis of insulin dependent diabetes mellitus and an order for sliding scale (dose dependent upon finger stick blood sugar (FSBS) result) insulin. The order documented the resident's FSBS was to be obtained three times daily and included instruction to follow hypoglycemic protocol for a blood sugar result of less than 70. The admission order also documented the resident was to receive glucose 4 gm (grams) chewable tablet one daily as needed for diabetes and glucose gel 40% 1 applicator full daily as needed (no diagnosis or indication was documented). On 02/12/2020 at 1:30 p.m., certified medication aide with advanced training in insulin administration and glucose	N1405		

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N1405	Continued From page 2 monitoring(CMA-IA,GM)/employee #2 stated she thought resident #1 was to be administered glucose if her FSBS result was below 50. Resident #3 a) Resident #3 had a diagnosis of diabetes mellitus and had an order for FSBS twice daily, Lantus (insulin) 16 units injected at bedtime and sliding scale Novolog (insulin). The resident did not have a physician ordered protocol in place for high or low blood sugar. CMA-IA,GM/employee #2 said there was no physician ordered diabetic protocol or written center protocol, so resident #3 would tell the CMAs how to treat her low blood sugar, and the CMAs did what the resident told them to do. CMA-IA,GM/employee #2 did not say the CMAs would notify the licensed nurse. Both CMA-IA,GM/employee #1 and CMA-IA,GM/employee #2 stated when a resident had a low FSBS (neither described a low blood sugar), they did what they thought was the right thing to do and what they were taught in CMA training. CMA-IA,GM/employee #1 stated if there was no specific physician's order, she would give a resident with a low blood sugar some orange juice and some peanut butter, then do another FSBS in 30 to 45 minutes and repeat the process if necessary. Both of them stated there was no written protocol to follow for low blood sugar. Neither one of them mentioned they would notify the licensed nurse. Resident #4 b) On 02/12/2020, resident #4's prescription medication bottles in the medication cart were	N1405		

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N1405	Continued From page 3 observed. The resident had a bottle of Amlodipine Besylate 5 mg. There was no change of direction label on the bottle and the tablets were cut in half (2.5 mg). The prescription label on the bottle documented to take 1 (5mg) tablet by mouth daily. 1/2 tab (2.5 mg) was hand written on the bottle cap. The February 2020 physician orders and MAR both documented Amlodipine Besylate 2.5 mg, 1 tablet every Tuesday and Thursday. Resident #4 had a prescription bottle of Amiodarone 100 mg in the medication cart. The prescription label directions documented take one (100 mg) tablet daily. There was no change of direction sticker on the bottle. 1/2 tab (50 mg) was handwritten on the bottle cap and the tablets were cut in half. The February 2020 physician order and MAR documented 1/2 tab (50 mg) daily. During record review, resident #4's physician order, dated 01/23/2020, documented to change the dosage of the Amidarone to 50 mg daily. Resident #4 had a prescription bottle of Carvedilol 6.25 mg in the medication cart. The directions documented take one (6.25 mg) twice daily. There was no change of direction sticker on the bottle. 1/2 tab was handwritten on the bottle cap and the tablets were cut in half. The February 2020 physician order and MAR documented Carvedilol 3.125 mg one tablet by mouth daily. During record review, resident #4's physician order, dated 01/23/2020, documented to change the dosage of the Carvedilol to 3.125 mg twice daily.	N1405		

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N1405	Continued From page 4 Resident #4 had a prescription bottle of Lasix in the medication cart. The label documented take 80 mg two tablets twice daily. There was a change of direction sticker on the prescription bottle. There was a physician's order, dated 02/03/2020 for the resident #4 to take 40 mg of Lasix daily. The prescription was filled on 02/05/2020. Resident #4 had a prescription bottle of Ropinirole 1 mg in the medication cart. The prescription label on the bottle and the February 2020 MAR documented to take one tablet three times daily. 1/2 tab was handwritten on the bottle cap and the pills were cut in half. There was no change of direction sticker on the bottle. At 10:30 a.m., CMA/employee #2 stated the CMAs had to cut resident #4's pills in half because the pharmacy would not send the correct dosage and the family stated they did not have the time to do it. At 11:00 a.m., the RN stated the CMAs should not be cutting pills in half and she provided a policy which documented change of direction stickers should be used when indicated, and only RN's should cut tablets in half and only in an emergency.	N1405		
N1472 SS=E	310:677-13-11 (a)(4)(5)(6)(7) Facility Policies And Procedures (a) If a facility uses certified medication aides, facility policies and procedures shall address: (4) Procedures for responding when a resident experiences a change in condition, demonstrates	N1472		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH2407AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2020
NAME OF PROVIDER OR SUPPLIER THE COMMONS		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706		
(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
N1472	Continued From page 5 side effects or does not respond to the medication regimen as identified in the plan of care; (5) Documentation that must be maintained; (6) Reporting errors to licensed nurses and/or physicians; and (7) Reporting violations of 63 O.S. Section 1-1950.3 (E) and OAC 310:677 to the State Health Department. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the center failed to have policies and procedures in place to address procedures for certified medication aides (CMAs) to follow when a diabetic resident demonstrated episodes of low or high blood sugar for 2 (#1 and #3) of 2 sampled residents who had sliding scale insulin ordered by a physician. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #1 was admitted to the center 12/31/19 with a diagnosis of insulin dependent diabetes mellitus and an order for sliding scale (dose dependent upon blood sugar result) insulin. The order also documented the resident's FSBS (finger stick blood sugar) was to be obtained three times daily. The orders also documented, glucose 40% gel 1 applicator full by mouth daily	N1472		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH2407AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2020
NAME OF PROVIDER OR SUPPLIER THE COMMONS		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706		
(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
N1472	Continued From page 6 as needed (no diagnosis or indication was documented) and glucose 4 gm (grams) chewable 1 tablet as needed for diabetes, but did not explain when to give. In a separate area, the orders documented to follow hypoglycemic protocol for FSBS results below 70. Resident #3 had a diagnosis of diabetes mellitus and had an order for FSBS twice daily, Lantus (insulin) 16 units injected at bedtime and sliding scale Novolog (insulin). The resident did not have a physician ordered protocol in place for high or low blood sugar. On 02/12/2020 at 1:25 p.m., the Registered Nurse (RN) stated there was no written protocol in place for diabetics, but the CMAs should just know to notify the licensed nurse when a resident's blood sugar is high or low. At 1:30 p.m., certified medication aide with advanced training in insulin administration and glucose monitoring (CMA-IA,GM)/employee #2 stated she thought resident #1 was to be administered glucose if the FSBS result was below 50 because the MARs did not document when the low blood sugar protocol became effective, just the orders. Both CMA-IA,GM/employee #1 and CMA-IA,GM/employee #2 both stated there was no written protocol in place for diabetics. They both also stated when a resident had a FSBS that was low, they did what they thought was the right thing to do and what they were taught in CMA training. CMA-IA,GM/employee #1 stated she would give a resident with a low blood sugar some orange juice and some peanut butter, then would do another FSBS in 30 to 45 minutes and repeat the process if necessary.	N1472		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH2407AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2020
NAME OF PROVIDER OR SUPPLIER THE COMMONS		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706		
(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
N1472	Continued From page 7 CMA-IA,GM/employee #2 said there was no physician ordered diabetic protocol or written center protocol, so resident #3 would tell the CMAs how to treat her low blood sugar, and the CMAs did what the resident told them to do. Throughout the entire interview, neither CMA mentioned they would notify the licensed nurse. At 4:15 p.m., the RN provided a written protocol and stated everyone should have been aware of the protocol because it had been in place all along. On 02/14/2020 at 11:50 a.m., the RN stated the diabetic protocol she had provided previously was the protocol for the nursing home side and the assisted living side did not have a written protocol.	N1472		



Delivery Via Email: lburrell@thecommons-umrc.com

September 24, 2020

License Number: NH2407AL

Ms. Ladeana Burrell, Administrator
The Commons
301 South Oakwood Road
Enid, OK 73706

RE: Survey Event XIZR11

Dear Ms. Burrell:

On **February 14, 2020**, a re-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 **August 24, 2020**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma
State Department of Health, ou=Long
Term Care, email=katies@health.ok.gov,
c=US
Date: 2020.09.24 10:59:23 -05'00'

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

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 8/24/2020	
	Facility Name: The Commons-Trinity Assisted Living	
	License Number: NH2407AL	
	Survey Event ID: XIZR11	
Date Survey Completed: 2/14/2020		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: N1405	Based on: This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure certified medication aides (CMAs) performed within authorized duties: a) for 2 (#1 and #3) of 2 sampled residents who had physicians order for sliding scale insulin and b) by cutting prescribed medication in half for 1 (#7) of 1 sampled resident who had a physician ordered change of medication dosage. These failed practices had the potential for more than minimal harm at a pattern.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		All staff were reeducated on policies and procedures regarding medication administration and dosage changes during staff meeting on 2/20/2020. Copies of medication administration policy were given to all employees. Staff also reeducated on notifying nurse of any order discrepancies.
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 have the potential to be affected. All MAR's/TAR's are reviewed and compared to physicians orders to ensure accuracy.
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?		Medications are verified by staff during medication administration to insure accuracy of dosage, and upon receipt of any new medications verification is made that proper dosage is received from pharmacy. A nurse is notified of any discrepancies.
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.		a. Physicians orders are reviewed monthly along with medication administration records. If any discrepancy is found, staff informs charge nurse immediately. b. Any medication errors will be discussed in the quarterly QA meeting. c. Staff educated to notify the nurse if any medications received are in discrepancy with medication orders. Any medication orders changed in MAR/TAR are to be completed by a nurse. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		2/20/2020
OSDH Response: Element accepted Yes ☐ No ☐		

Administrator's Signature LaDeana Burrell OAC 310:663-25-4(F)		Date 8/25/2020	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 8/24/2020		
	Facility Name: The Commons-Trinity Assisted Living		
	License Number: NH2407AL		
	Survey Event ID: XIZR11		
Date Survey Completed: 2/14/2020			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: N1472	Based on: This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the center failed to have policies and procedures in place to address procedures for certified medication aides (CMAs) to follow when a diabetic resident demonstrated episodes of lower high blood sugar for 2 (#1 and #3) of 2s ampled residents who had sliding scale insulin ordered by a physician. This failed practice had the potential for more than minimal harm at a pattern.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS	
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		Policies and procedures given in staff meeting on 2/20/2020. Reviewed hypoglycemic protocol and copies given to all staff members. Also, staff reminded to notify the nurse of any FSBS that would require them to follow the resident's hypoglycemic protocol.	
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 have potential to be affected. All diabetic resident's hypoglycemic protocols were verified.	
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?		MAR's/TAR's are reviewed for accuracy every month by a nurse. Any new admissions will have an individualized hypoglycemic protocol.	
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.		a. MAR's/TAR's are checked every month to verify all insulin orders are correct. b. Any diabetic resident that has protocol changes will be discussed in QA meeting. c. All MAR's/TAR's are checked every month and prn against physicians orders by a nurse to insure accuracy. Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/20/2020	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature LaDeana Burrell OAC 310:663-25-4(F)			Date 8/25/2020
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH2407AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/14/2020
NAME OF PROVIDER OR SUPPLIER THE COMMONS		STREET ADDRESS, CITY, STATE, ZIP CODE 301 SOUTH OAKWOOD ROAD ENID, OK 73706		
(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 re-licensure survey was conducted 02/11/2020 through 02/14/2020. Resident census was 27. The following deficient practices were cited.	N 000	"Refer to POC Template, Survey Event ID# XIZR11, ID Prefix Tag N1405 "	
N1405 SS=E	310:677-13-6 (b) Competency and Practice Standards Each certified medication aide shall: (1) Comply with 63 O.S. Section 1-1950.3 (E) and OAC 310:677-13; (2) Perform within authorized duties; (3) Follow written instructions of a licensed nurse or physician; and (4) Accurately record medications administered, withheld or refused.	N1405	"Refer to POC Template, Survey Event ID# XIZR11, ID Prefix Tag N1472"	

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE