OKLAHOMA
State Department
of Health

Delivery via email to: Jbarker@thecommons-umrc.com; MBrinker@thecommons-umrc.com

June 19, 2023

License Number: NH2407AL

Ms. Jennifer Barker, Administrator
The Commons
301 South Oakwood Road
Enid, OK 73706

RE: Survey Event ID: 5WZ211

Dear Ms. Barker:

On **June 1, 2023**, 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 June 1, 2023.

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) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2407AL	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COMMONS	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 000	INITIAL COMMENTS A re-licensure survey was conducted on 06/01/23. Listed below are abbreviations that will be used throughout this document: CPR - cardiopulmonary resuscitation CMA - certified medication aide COPD - chronic obstructive pulmonary disease DON - director of nursing gm - gram MARs - medication administration record mcg - micrograms mg - milligrams RN - registered nurse	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure dietary staff changed their gloves and washed their hands to prevent cross-contamination for two (dietary cook #1 and dietary cook #2) of two staff observed during the lunch meal preparation. The charge nurse identified 18 residents resided in the facility and received services from the kitchen. Findings: A "Disposable Glove Use" policy, revised 01/2020, read in part, "Disposable, non-latex	C 391		

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C 391	Continued From page 1 gloves must be worn at the following times...When handling read-to-eat foods...when serving food or assembling patient meals...Disposable gloves must be changed and hands washed when the gloves are dirty...when moving from one task to another, such as moving from handling dirty dishes to handling clean dishes...hands must be washed with soap and water before putting on or after use of gloves for food plating..." On 06/01/23 at 11:10 a.m., dietary cook #1 was observed wearing gloves and holding a plate with a bun and a hamburger patty on it. Dietary cook #1 used the same gloved hands and picked up shredded lettuce, tomato slices, and pickles, and placed them on the plate. Dietary cook #1 used the same gloves hands and grabbed the dirty handle of a fryer basket to pull it out of the grease. They took the plate and covered it with plastic wrap, placed a cover on the plate, opened a warming cart, and placed it in the cart. Dietary cook #1 was observed to pick up another plate with a bun and hamburger patty on it, and used the same gloved hands to pick up lettuce, tomato slices, pickles, and placed them on the plate. They were observed to cover the plate with plastic wrap, placed a cover on the plate, and placed it in the warming cart. On 06/01/23 at 11:12 a.m., dietary cook #2 was observed wearing gloves and picked up a plate with a bun and hamburger patty on it. They used the same gloved hands to pick up lettuce, tomato slices, pickles, and placed them on the plate. Dietary cook #2 was observed to pick up french fries out of the fryer basket with the same gloved hands. Dietary cook #2 was observed to cover the plate with plastic wrap, placed a lid on it, and	C 391		

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C 391	Continued From page 2	C 391		

put it in the warming cart.

On 06/01/23 at 11:13 a.m., dietary cook #1 was observed to walk to the walk-in freezer, opened the freezer door, picked up a bag of frozen shrimp, and closed the freezer door with the same gloves on. Dietary cook #1 then used the same gloved hands to pull three dirty fryer baskets out of the grease. Dietary cook #1 was observed to open the bag of frozen shrimp, placed the same gloved hand inside the bag, pulled out a handful of shrimp, placed it in a fryer basket, and lowered the basket into the grease. Dietary cook #1 was observed separating one slice of cheese from a bulk stack of cheese, and placed it on a hamburger patty on the grill, with the same gloved hands.

On 06/01/23 at 11:14 a.m., dietary cook #2 was observed separating two slices of cheese from a pre-sliced, stack of cheese, not individually wrapped, took two slices of bread from a loaf of bread, placed the bread onto the grill, and placed a slice of cheese on each piece of bread using the same gloved hands.

On 06/01/23 at 11:17 a.m., dietary cook #1 was observed to use the dirty handle of a fryer basket to pull it out of the grease using the same gloved hands. They picked up a plate and placed lettuce, tomato slices, and pickles on the plate with the same gloved hands. The dietary cook used the handle of the fryer basked to pull the basket out of the grease and dumped the shrimp onto the plate. They covered the plate with plastic and put a cover on it using the same gloved hands.

Dietary aide #1 was observed taking frozen tater tots out of a bag with the same gloved hands,

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C 391	Continued From page 3	C 391		

placed them into a fryer basket, and used the handle to lower it into the grease. Dietary cook #1 picked up another plate, used tongs to take two corn dogs out of a fryer basket, used the same gloved hands to take french fries out of a fryer basked, placed them onto the plate, and covered it with plastic.

On 06/01/23 at 11:21 a.m., dietary cook #1 used the same gloved hands to take a handful of frozen, breaded shrimp out of a box, placed it in a fryer basket, and used the handle of the fryer basket to lower the basket into the grease. They used the handle of a fryer basket to lift the fryer basket out of the grease at 11:24 a.m.

On 06/01/23 at 11:25 a.m., dietary cook #1 used the same gloved hands to pick up the fried breaded shrimp and some onion rings from fryer baskets, placed them on a plate, wrapped it with plastic, and covered it with a plate cover.

Dietary cook #1 and #2 were not observed changing gloves between ready to eat foods, and dirty fryer handles, freezer door handles, tongs, plate covers, and frozen food items. Dietary cook #1 and #2 were observed using the same gloved hands while touching everything during the lunch meal service.

On 06/01/23 at 11:26 a.m., dietary cook #1 was asked what the policy was for wearing gloves. They stated they used gloves for ready to eat foods and changed them if they were dirty to prevent cross-contamination.

On 06/01/23 at 11:33 a.m., the director of dining services was asked what the policy was for staff wearing gloves. They stated staff were to wear gloves when handling ready to eat foods and

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C 391	Continued From page 4 were to change them when touching different items so they weren't cross contaminating. The director of dining services was informed of the above observations. They stated dietary cook #1 was pretty new.	C 391		
C 911 SS=D	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, record review, and interview, the facility failed to ensure an RN conducted a self administration of medication assessment for one (#1) of one sampled resident reviewed for self administration of medication. The DON identified 10 residents had physician orders for self administration.	C 911		

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C 911	Continued From page 5 Findings: A "Self-Administration of Medications" policy, dated 08/09/22, documented the licensed nurse will assess the resident's physical, cognitive, and functional ability to self-administer by completing a facility-approved assessment. Resident #1 had diagnoses which included COPD. A "Physician's Order," dated 04/25/23, documented to administer albuterol sulfate nebulizer treatments four times daily. A list of residents who have orders to self-administer medications did not have Resident #1 on it. On 06/01/23 at 9:23 a.m., CMA #7 was observed exiting Resident #1's room. Resident #1 was observed sitting in a recliner and had a nebulizer mask on and a treatment was in progress. On 06/01/23 at 9:30 a.m., CMA #7 entered Resident #1's room and sat down until the treatment was completed. On 06/01/23 at 12:45 p.m., the charge nurse was asked what the policy was for administering nebulizer treatments in a residents' room. They stated staff would stay with them the entire treatment.	C 911		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.	C 954		

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C 954	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff received CPR training for one (CMA #4) of five sampled staff reviewed for CPR training. The "Assisted Living Resident Condition and Care Overview" report, dated 06/01/23, documented 18 residents Findings: CMA #4's date of hire was 12/25/22. There was no documentation the CMA #4's employee file of CPR training. On 06/01/23 at 3:00 p.m., the DON was asked for CPR training for CMA #4. On 06/10/23 at 3:10 p.m., the DON stated, "I don't think [CMA #4] has one."	C 954		
C1922 SS=E	310:663-19-2(a)(2) MEDICATION ADMINISTRATION (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour prior to administration.	C1922		

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C1922	Continued From page 7	C1922		

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure staff observed medications being swallowed for four (#4, 5, 6, and #8) of sampled residents observed during medication administration pass.

The "Assisted Living Resident Condition and Care Overview" report, dated 06/01/23, documented 18 residents.

Findings:

An "Administration of Medication" policy, dated 08/08/22, documented staff were to remain with the resident during medication administration to ensure that the medicine is swallowed.

1. Resident #6 had the following physician orders:
a. aspirin 81 mg,
b. propranolol 80 mg,
c. vitamin B-12,
d. folbic, and
e. Buspar 5 mg.

On 06/01/23 at 7:45 a.m., CMA #7 was observed to prepare the above medication for Resident #6. CMA #7 placed the medications on the dining table where Resident #6 was sitting. CMA #7 went back to the medication cart without watching Resident #6 take their medications.

2. Resident #4 had the following physician orders:
a. subnet 25-100,
b. Norvasc 5 mg,
c. Lasix 40 mg,
d. protonix 40 mg,

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C1922	Continued From page 8 e. vitamin D 2000 U, f. Eliquis 5 mg, g. Metformin 1000 mg, and h. Tylenol 500 mg. On 06/01/23 at 7:50 a.m., CMA #7 was observed to prepare the above medications for Resident #4. CMA #7 handed Resident #4 the cup of medications, then walked back to the medication cart. CMA #7 did not observe Resident #4 swallow their medications. 3. Resident #5 had the following physician orders: a. probiotic, b. Meloxicam 7.5 mg, c. memantine 21 mg, d. Myrbetriq 50 mg, e. calcium 500 mg + D, f. vitamin B 1000 mcg, g. vitamin D3 5000 U, h. methanamine 1 gm, and i. proamatine 2.5 mg. On 06/01/23 at 7:55 a.m., CMA #7 was observed to prepare the above medications for Resident #5. CMA #7 handed Resident #5 the cup of medications, then walked back to the medication cart. CMA #7 did not observe Resident #5 swallow their medications. 4. Resident #8 had the following physician orders: a. amiodarone 200 mg, b. clearlax powder, c. multivitamin, d. calcium 600 mg + D, and e. Eliquis 2.5 mg. On 06/01/23 at 8:20 a.m., CMA #6 was observed to prepare the above medications for Resident #8. CMA #6 sat Resident #8's cup of medication	C1922		

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C1922	Continued From page 9 on the dining table, poured the clearlax into Resident #8's water, stirred it, then walked away. CMA #6 did not observed Resident #8 swallowing their medications. On 06/01/23 at 10:49 a.m., CMA #6 was asked what the policy was for administering medications. They stated they were to punch out the medications, initial on the MARs, then give the medications. CMA #6 was asked what the policy was for observing residents taking their medications. They stated they watched the residents taking their medications. CMA #6 stated they could leave the medications at the table with the residents as long as there was a CMA or nurses to monitor that they take them. On 06/01/23 at 12:45 p.m., the charge nurse was asked what the policy was for administering medications. They stated staff were allowed to leave the medication cups on the dining table with the residents if they were not ready to take the medicine.	C1922		

OKLAHOMA
State Department
of Health

Delivery via email to: Jbarker@thecommons-umrc.com

August 9, 2023

License Number: NH2407AL

Ms. Jennifer Barker, Administrator
The Commons
301 South Oakwood Road
Enid, OK 73706

RE: Survey Event 5WZ211

Dear Ms. Barker:

On **June 1, 2023**, 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 have been corrected and you were in substantial compliance by **June 23, 2023**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date:** Click here to enter a date. **Facility Name:** The Commons **License Number:** NH2407AL **Survey Event ID:** 5WZ211 **Date Survey Completed: 6/1/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: This STANDARD is not met as evidenced by:C 391Based on observation, record review, and interview, the facility failed to ensure dietary staff changed their gloves and washed their hands toprevent cross-contamination for two (dietary cook#1 and dietary cook #2) of two staff observedduring the lunch meal preparation.

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?	Reeducate all dietary staff and servers on proper food preparation including glove changing and hand washing
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 are potentially affected by this defficiency
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?	In-service with return demonstration
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.	Enter methods to ensure corrections are sustained: An audit will be done weekly for 4 weeks PIP will be written Director of Dining Services will bring the administrator audits weekly for review
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/23/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date** Enter a date of signature.	6/23/23

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: 6/19/2023** **Facility Name:** The Commons **License Number:** NH2407AL **Survey Event ID:** 5WZ211 **Date Survey Completed: 6/1/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C911	Based on: Based on observation, record review, andinterview, the facility failed to ensure an RNconducted a self administration of medicationassessment for one (#1) of one sampled residentreviewed for self administration of medication.

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?	A Self-Administration Assessment has been done with the resident #1.
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 are potentially affected by this deficiency
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?	An audit will be done on all residents in AL to ensure a self-administration assessment has been done.
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.	Enter methods to ensure corrections are sustained: The Nurse will do an audit weekly for 4 weeks of 3 random residents PIP will be written The nurse will bring the administrator audits weekly for review
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/23/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 6/23/23

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: 6/19/2023** **Facility Name:** The Commons **License Number:** NH2407AL **Survey Event ID:** 5WZ211 **Date Survey Completed: 6/1/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954	Based on: Based on record review and interview, the facility failed to ensure direct care staff received CPR training for one (CMA #4) of five sampled staff reviewed for CPR training.

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?	CMA#4 will be CPR certified by the completion date
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 resident have the potential to be affected by this deficiency
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?	An audit will be done on all staff in AL to ensure they are all CPR certified. The facility now has a CPR instructor on staff to help keep everyone up to date.
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.	Enter methods to ensure corrections are sustained: An audit will be done on a monthly basis by CPR instructor to ensure all staff members in AL are up to date on CPR PIP will be written CPR instructor will be audit material to administrator for review
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/23/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date** Enter a date of signature.	6/23/23

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: 6/19/2023** **Facility Name:** The Commons **License Number:** NH2407AL **Survey Event ID:** 5WZ211 **Date Survey Completed: 6/1/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1922	Based on: Based on observation, record review, andinterview, the facility failed to ensure staff observed medications being swallowed for four(#4, 5, 6, and #8) of sampled residents observedduring medication administration pass.

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?	Dietary staff will have a server in the dining to help serve while the CMA's administer meds appropratiely
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 are potentially affected by this deficiency
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?	An inservice will be done with return demonstration to ensure all staff know the proper steps to administer meds.
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.	Enter methods to ensure corrections are sustained: The Nurse will do an audit weekly for 4 weeks of 3 residents PIP will be written The Nurse will bring the administrator audits weekly for review
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Click here to enter a date when corrective action will be completed. 6/23/23
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date** Enter a date of signature.	6/23/23

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

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

OKLAHOMA
State Department of Health

Delivery via email to: Jbarker@thecommons-umrc.com; MBrinker@thecommons-umrc.com

August 28, 2023

License Number: NH2407AL

Ms. Jennifer Barker, Administrator
The Commons
301 South Oakwood Road
Enid, OK 73706

RE: Survey Event 5WZ212

Dear Ms. Barker:

On **August 24, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 1, 2023,** have now been corrected effective **June 23, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2407AL	A. BUILDING: _____ B. WING _____	R 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COMMONS	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 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 08/24/23. The facility was in substantial compliance.	{C 000}		

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