Oklahoma State Department of Health
Creating a State of Health

December 3, 2019

License Number: RC6105
Survey Event ID: ILMG11

Ms. Chelsey Cooley, Administrator
Aspire Management, Llc
1929 Betty Jane Lane
Muskogee, OK 74403

Dear Ms. Cooley:

Enclosed is the Residential Care inspection deficiency report form, showing the summary of deficiencies noted during the survey at your facility on October 22, 2019.

The deficiencies cited resulted in ddeficiencies representing the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies.

Please note the items listed in the deficiency column of the report. Your plan of correction and anticipated date of completion must be typed in the space provided. If additional space is needed, a supplemental sheet may be attached.

The criteria for an acceptable plan of correction are:

(1) A statement of exactly how the facility has or intends to correct each deficiency.

(2) The method of correction. This includes who is responsible for the correction.

(3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

(4) A reasonable date of correction, which will normally be within 30 days of this notice.

NOTE: Please avoid naming individuals, business firms or brand names on the enclosed form since it is a public disclosure form.

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **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 this completed form for your files.

In the event that we find your Plan of Correction unacceptable, you will be notified of the reason(s) it is not acceptable and we will request another Plan of Correction. If your plan of correction is acceptable, there will be no acknowledgement. We will conduct a revisit in accordance with your stated correction dates. If you have any questions concerning this letter, please contact me at (405) 271-6868.

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
Becky Payton (*Secretary*)
Jenny Alexopulos, DO
Terry R Gerard II, DO
Charles W Grim, DDS, MHSA
R Murali Krishna, MD
Ronald D Osterhout
Charles Skillings

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An equal opportunity employer and provider

In accordance with O.S. 63 830.1, 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 833-RC). 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 833RC and the Oklahoma IDR Process Residential Care Centers.

The IDR request must be submitted within 30 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review 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.

Sincerely,

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC6105	A. BUILDING _____ B. WING _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE RETIREMENT & CARE CENTER	1220 EAST ELECTRIC BLVD MCALESTER, OK 74501

(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
R 000	INITIAL COMMENTS A re-licensure survey was conducted on 10/21/19 and 10/22/19. Current census was 10. The following deficiencies were cited.	R 000		
R 231 SS=F	310:680-3-7 (b)(4) RESIDENT RECORDS/MEDICAL-DENTAL SRVCS (b) Every resident record shall be written in ink and include as a minimum, the following information: (4) Written authorization for emergency medical/dental services signed by the resident or responsible party. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure every resident's record had an written authorization for emergency medical/dental services documented as required for 6 (#1 through #6) of 6 sampled	R 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC6105	A BUILDING _____ B WING _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE RETIREMENT & CARE CENTER	1220 EAST ELECTRIC BLVD MCALESTER, OK 74501

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R 231	Continued From page 1 residents. This failed practice had the widespread potential for more than minimal harm. Findings: On 10/22/19 at 2:00 p.m., the residents' records were reviewed with the assistance of the vice-president of operations and there was no documentation for written authorization for emergency medical/dental services in the records of residents #1 through #6. She stated none of the residents had the required authorization documentation in their records.	R 231		
R 601 SS=E	310:680-13-1 MEDICATIONS Correct medication and pharmacy techniques and principles shall be used when medications are administered or monitored. The home shall comply with the following: (1) Storage and Maintenance. This Rule is not met as evidenced by: Based to observation, interview, and record review, it was determined the home failed to ensure correct storage and maintenance of an opened insulin pen and vial for 2 (#2 and #3) of 2 sampled insulin dependent residents who had	R 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC6105	A. BUILDING. _____ B WING _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE RETIREMENT & CARE CENTER	1220 EAST ELECTRIC BLVD MCALESTER, OK 74501

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R 601	Continued From page 2 opened and undated insulin stored in the medication cart. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: On 10/21/19 at 11:28 a.m., licensed practical nurse (LPN) #1 gave a verbal report on all of the residents in the home and did not reveal that resident #2 and #3 were insulin dependent. On 10/22/19 at 1:43 p.m., an opened and undated vial of Levemir (long acting-insulin used to treat high blood sugar) insulin was observed in resident #3's medication plastic container in the medication cart. LPN #1 stated she did not know why the vial was undated, nor when it was first opened and stored at room temperature. The vial was about one-third full of clear liquid. When asked how long the the opened vial of Levemir insulin was good for used after opened and stored at room temperature, LPN #1 asked, "Is it 30 days?" At 1:52 p.m., LPN #1 identified resident #2 as an insulin dependent diabetic, when asked if any other resident in the home used insulin. LPN #1 retrieved an opened and undated Levemir FlexTouch pen from resident #2's medications in the medication cart. LPN #1 stated stated the only way to know how long the insulin pen would be good for use was if it had been dated. She stated resident #2 injected her insulin twice a day, and she had given the resident that opened pen that morning. At 1:58 p.m., the registered nurse (RN) submitted a copy of the medication packaging that was in resident #2's FlexTouch pen box that documented the insulin would be good for use 42 days, opened and at room temperature. She also	R 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC6105	A. BUILDING _____ B. WING _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE RETIREMENT & CARE CENTER	1220 EAST ELECTRIC BLVD MCALESTER, OK 74501

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R 601	Continued From page 3 submitted a copy of resident #3's patient instructions for use of the Levemir insulin vial, which did not document how long the opened pen was good for use. The RN stated the insulin was good for "probably 30 days," and she did not know the vial nor the pen had not been dated. Long term care aide/certification medicaiton aide/employee #1 stated the medicaiton employees forgot to date the insulin vial and FlexTouch pen when they were opened and stored at room temperature. At 2.29 p.m., the RN submitted a 07/25/19 laboratory report for resident #3's Hemoglobin A1c of 10.4% (percent) and that it was high (normal 4.8 to 6.0%). At 4:30 p.m., the RN submitted resident #2's most current laboratory report for Hemoglobin A1c of 7.9% (high).	R 601		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
RC6105	NEW HOPE RETIREMENT & CARE CENTER

Type of Survey (select all that apply)

2

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

Extent of Survey (select all that apply)

A

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. NV 25837	10/21/2019	10/22/2019	0.50	0.00	13.50	0.25	4.25	1.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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

DEC 05 2019

Oklahoma State Department of Health
Creating a State of Health

December 16, 2019

License Number: RC6105
Survey Event ID: ILMG11

Ms. Chelsey Cooley, Administrator
New Hope Retirement & Care Center
1220 East Electric Blvd
McAlester, OK 74501

Dear Ms. Cooley:

On October 22, 2019, a Licensure inspection was conducted at your Adult Day Care 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 will be corrected on **December 9, 2019**. We will conduct a revisit at your facility to verify that all violations have been corrected.

If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/ks

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC6105	A. BUILDING: _____ B. WING _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE RETIREMENT & CARE CENTER	1220 EAST ELECTRIC BLVD MCALESTER, OK 74501

(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
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NEW HOPE RETIREMENT & CARE CENTER	1220 EAST ELECTRIC BLVD MCALESTER, OK 74501

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	RC6105	A. BUILDING: _____ B. WING _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE RETIREMENT & CARE CENTER	1220 EAST ELECTRIC BLVD MCALESTER, OK 74501

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Cindy Cooley

PRINTED: 12/03/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC6105	A. BUILDING: _____ B. WING _____	10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE RETIREMENT & CARE CENTER	1220 EAST ELECTRIC BLVD MCALESTER, OK 74501

(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
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Christy Cooley 12/9/19

New Hope Retirement and Care Center

1220 East Electric Ave

McAlester, OK 74501

PH (918) 423-9095 Fax (918) 423-1317

Plan of Correction: R231

Date of Completion: 12/09/2019

FACILITY FAILED TO ENSURE EVERY RESIDENT RECORD HAD AN WRITTEN AUTHORIZATION FOR EMERGENCY MEDICAL/DENTAL SERVICE DOCUMENTED AS REQUIRED.

THIS DEFICIENT PRACTICE HAS THE POTENTIAL TO AFFECT ALL RESIDENTS.

ADMISSION PACKETS HAVE BEEN UPDATED TO INCLUDE AUTHORIZATION FOR EMERGENCY MEDICAL/DENTAL SERVICE AS REQUIRED. ALL RESIDENTS CHARTS NOW INCLUDES AUTHORIZATIONS.

ADMINISTRATOR OR DESIGNEE WILL MONITOR MONTHLY X 3 MONTHS AND THEN RANDOMLY X 1 YEAR TO ENSURE COMPLIANCE.

Cindy McCoy 12/9/19

New Hope Retirement and Care Center

1220 East Electric Ave

McAlester, OK 74501

PH (918) 423-9095 Fax (918) 423-1317

Plan of Correction: R 607

Date of Completion: 12/09/2019

FACILITY FAILED TO ENSURE CORRECT STORAGE AND MAINTENANCE OF AN OPENED INSULIN PEN AND VIAL FOR RESIDENT #2 AND #3.

THIS DEFICIENT PRACTICE HAS THE POTENTIAL TO AFFECT ALL RESIDENTS.

STAFF EDUCATED ON DATING AND PROPER STORAGE AND MAINTENANCE OF AN OPENED INSULIN PEN/VIAL AND DATING

RESIDENT #2 AND # 3 INSULIN'S WERE DISGARDED AND REPLACED.

FACILITY RN/COSULTANT WILL MONITOR MONTHLY X 3 MONTHS AND THEN RANDOMLY X 1 YEAR TO ENSURE COMPLIANCE.

Christy R Cody 12/9/19

RCU

STAFF DEVELOPMENT ATTENDANCE RECORD

DATE: 12-9-19 START TIME: 2:00 END TIME: 3pm

NAME OF INSERVICE: Infection Control / Survey

METHOD OF PRESENTATION (film, demonstration, lecture, handouts):

[illegible]

[illegible]

OBJECTIVES:

INSTRUCTOR: [illegible] INSTRUCTOR:

SIGNATURES/TITLE:

Lawana Blunt CDM
Ramona Davidson Cook
Trstan Terrell RA
Norma [illegible] HSR [illegible]
Hollie Eldridge CMA
[illegible]
[illegible]
Kathy [illegible] RN
[illegible]

Oklahoma State Department of Health
Creating a State of Health

January 14, 2020

License Number: RC6105
Survey Event ID: ILMG12

Ms. Chelsey Cooley, Administrator
New Hope Retirement & Care Center
1220 East Electric Blvd
McAlester, OK 74501

Dear Ms. Cooley:

On January 8, 2020, a revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Residential Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **October 22, 2019,** have now been corrected and your facility is in compliance with licensure standards effective **December 9, 2019**.

If you have any questions concerning the information in this letter, please contact this office at (405) 271-6868.

Sincerely,

Katie Stagner

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA *(President)*
Edward A Legako, MD *(Vice-President)*
Becky Payton *(Secretary)*
Jenny Alexopulos, DO
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Charles Skillings

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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
	RC6105	A. BUILDING: _____ B. WING _____	R 01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE RETIREMENT & CARE CENTER	1220 EAST ELECTRIC BLVD MCALESTER, OK 74501

(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
{R 000}	INITIAL COMMENTS A follow-up survey was conducted on 01/08/20. Current census was 12. Both deficiencies were cleared.	{R 000}		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
RC6105	NEW HOPE RETIREMENT & CARE CENTER

Type of Survey (select all that apply)

2	D				

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

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1[illegible]25837	01/08/2020	01/08/2020	0.25	0.00	1.25	0.00	3.25	0.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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