OKLAHOMA
State Department
of Health

Delivery via email to: jbyerly@homesteadofelkcity.com

April 9, 2024

License Number: AL0501

Ms. Julie Byerly, Administrator
Homestead Of Elk City
1000 Elkwood Blvd
Elk City, OK 73644

RE: Survey Event ID: Y1OJ11

Dear Ms. Byerly:

On **March 27, 2024**, 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 **March 27, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action 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 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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

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

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

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

Respectfully,

Lisa Calvin

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0501	A. BUILDING: _____ B. WING _____	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF ELK CITY	1000 ELKWOOD BLVD ELK CITY, OK 73644

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 03/25/24 through 03/27/24. Center census: 28 The following abbreviations will be used throughout this report. appt. - appointment CMA - certified meidcation aide COPD - chronic obstructive pulmonary disease dr - doctor MAR - medication administration record mg - milligram ox - oximetry RCC - resident care coordinator sani - sanitize TAR - treatment administration record	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 center failed to ensure food was stored in accordance with Chapter 257. The Executive Director identified 28 residents resided in the center. Findings: On 03/25/24 at 9:24 a.m., the following foods were observed and identified with the dietary	C 391		

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C 391	Continued From page 1 manager in the refrigerator: a. roast beef, dated 02/15/24, in a Ziploc bag, b. ham, dated 02/25/24, in a Ziploc bag, c. an unopened package of roast beef in the original package with an expiration date of 11/2023, d. two packages of Turkey in the original package with no expiration date or label. On 03/25/24 at 9:33 a.m., the dietary manager was asked what the expectation is when food is placed in the refrigerator. They stated it should be labeled and they had just had an inservice in August 2023 with dietary staff. The DM provided a copy of the "Lesson Plan", which read in part, "...Proper Storage of Leftovers...all perishable food items that have been opened need to be labeled with the use by date...deli meat...7 days...Items still in their original container need not be dated so long as their delivery date is on the container...lunch meats...2 months..." On 03/27/24 at 9:17 a.m., the Executive Director was asked how food should be labeled. They stated they follow the state regulations.	C 391		
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.	C 522		

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C 522	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the center failed to ensure a significant change assessment had been completed for one (#5) of eight sampled residents reviewed for significant change assessments. The Executive Director identified 28 residents resided in the center. Findings: Resident #5 had diagnoses which included COPD, Arthiritis and vertigo. A "Nurses Note", dated 03/04/24, read in part, "...Resident had a significant weight loss and decline in cognition in the last 3 months. Family educated on hospice services and had agreed...Resident will be transferring to memory care as well..." A communication form, dated 03/05/24, documented a request to admit Resident # 5 to the memory care unit due to a decrease in cognition, and the Resident had been admitted to hospice services. The communication form was signed by the physician on 03/09/24. An assessment, dated 01/11/24, documented Resident #5 needed assistance of one staff for bathing, dressing, toileting, dressing, transferring and ambulation. The clinical health record did not contain any documentation a significant change assessment	C 522		

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C 522	Continued From page 3 had been completed when Resident #5 had been moved to the memory care and admitted to hospice services. On 03/26/24 at 10:56 a.m., the RCC was asked if a significant change assessment had been completed when the resident was admitted to memory care and hospice. They acknowledged a significant change assessment should have been completed.	C 522		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 4	C1505		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview the center failed to ensure
a. staff sanitized resident equipment (blood pressure cuff and pulse oximeter) during medication observation,
b. administer medication and notify the physician according to the physician order for two (#1 and #7) of three sampled residents reviewed for physician orders, and
c. assess and implement transmission based precautions for one (#2) of one sampled resident reviewed for transmission based precautions.

The Executive Director identified 28 residents resided in the center.

Findings:

An undated, "Infection Control: Standard Precautions" policy read in part, "...use an alcohol-based instant sanitizer for routine decontamination of hands in the following situations...Between administering oral medication to each resident...before and after coming in contact with a resident's intact skin...taking a pulse or blood pressure...Ensure that reusable equipment is not used for the care

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C1505	Continued From page 5 of another resident until it has been appropriately cleaned..." 1. On 03/27/24 at 6:58 a.m., CMA #1 was observed to pass medications to Resident #11 and obtain a pulse ox. CMA #1 returned to the cart and was not observed to sanitize the pulse oximeter. Then began to prepare Resident #3's medications. On 03/27/24 at 7:10 a.m., CMA #2 was observed to prepare medications for Resident #10, take the medications to the table and obtain a blood pressure with a wrist cuff, return to the cart and placed the cuff on the cart without sanitizing the equipment. On 03/27/24 at 7:32 a.m., CMA #2 was observed to obtain a blood pressure on Resident #9, put the cuff on the cart without sanitizing the equipment. CMA #1 then obtained a pulse ox reading on Resident #9, returned to the medication cart and was not observed to sanitize the pulse oximeter. On 03/27/24 at 8:04 a.m., CMA #2 was asked if they had sanitized their equipment during medication pass. They stated "No." They were asked what they had been instructed to use to clean their equipment. They stated they used alcohol wipes but did not have any on the cart. On 03/17/24 at 8:19 a.m., the RCC was asked what the policy was to maintain infection control on blood pressure cuffs and the pulse ox. They stated the equipment should be wiped down after each use with sani wipes. 2. Resident #1 had diagnoses which included congestive heart failure, atrial fibrillation and	C1505		

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C1505	Continued From page 6 anxiety. A "Physician Order", dated 05/31/22, documented to administer one tablet 2.5 mg of metolazone as need for a three pound weight gain in one week. Report to nurse of weight gain. Resident #1's February 2024 TAR, documented the following weekly weights: a. On 02/20/24 no weight was documented, the February MAR documented the resident had been administered an extra dose, b. On 02/21/24 weight was 188.0 the February MAR documented the resident had been administered an extra dose, and c. On 02/28/24 weight was 183.5 the February MAR documented the resident had been administered an extra dose, Resident #1's March 2024 TAR documented the following weekly weights: a. On 03/06/24 weight was 185 pounds the March 2024 MAR documented the resident had been administered an extra dose, b. On 03/13/24 weight was 185 pounds no dose was administered, and c. On 03/15/24 there was no weight documented but the March 2024 MAR documented an extra dose had been administered. On 03/26/24 at 11:02 a.m., the RCC was asked if they were Resident #5 had been receiving as needed metolazone. They were asked why had the medication been administered on 02/20/24. They were unsure. On 03/26/24 at 11:56 a.m., CMA #2 was shown the February MAR and asked if they had administered the additional dose on 02/20/24. They stated yes. They were asked if they had	C1505		

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C1505	Continued From page 7 documented the weight. They stated, "No." On 03/26/24 at 12:09 p.m., CMA #1 was asked why the additional dose had been administered on 02/28/24 when the weight was 183.5 a weight loss. They stated the documentation must have been an error. They were asked if they notify the RCC prior to giving the additional dose. They stated, "No." On 03/26/24 at 12:25 p.m., the RCC was shown the March MAR and asked if the medication had been administered correctly on 03/06/24. They stated no the resident had only had a 1.5 pound weight gain. They were asked why the MAR documented the resident had been administered a dose with no weight documented on 03/18/24. They were not aware the as needed doses had been administered. Resident #7 had diagnoses which included COPD and dependence on supplemental oxygen. A "Physician Order", dated 02/26/24, documented to monitor pulse ox before and after meals and notify physician if below 90%. Resident #7's March 2024 TAR documented the pulse ox was below 90 % on 03/04/24, 03/11/24, and 03/12/24. On 03/26/24 the RCC was asked if there was documentation the physician had been notified of the pulse ox readings. They stated, "No." There was no documentation in the clinical health record the physician had been notified. 3. Resident #2 had diagnoses which included herpes zoster, high blood pressure and gout.	C1505		

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C1505	Continued From page 8 An annual assessment, dated 03/08/24, documented Resident #2 was alert, forgetful, had good judgement and needed assistance of one staff for bathing. A "Nurses Note", dated 03/22/24, read in part," ...noted to have a small rash on [their] right hip. Denies pain, itching or concern...appt made for 3/26/24...with dr...Will keep clean and dry and covered until appt..." A "Nurses Note", dated 03/26/24, read in part, "...returns from PCP visit with diagnosis of herpes zoster to left flank...resident educated on not touching area, keeping it covered and washing hands frequently. Staff educated on the same...will continue to monitor..." On 03/27/24 at 6:40 a.m., Resident #2's door did not have any signs to indicate any transmission based precautions. On 03/27/24 at 9:55 a.m., the RCC was asked what the policy for isolation was related to herpes zoster, how did they ensure staff were aware of what precautions to take and was the rash localized or disseminated. They stated the area was covered and they had educated the resident and the staff on hand hygiene. They were asked when they had assessed the rash last. They stated on 03/22/23 they had observed the rash and again on 03/25/24. They were asked if they had assessed the rash on 03/26/24. They stated "No." On 10/12/a.m., the RN was asked if the nurse should be assessing the rash. They stated, "Yes." On 03/27/24 at 10:27 a.m., Resident #2 was	C1505		

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C1505	Continued From page 9 observed. There were three patches of rashed areas one to the left abdominal fold, left hip and left back flank. The RCC stated the rash had spread to the residents back. No policy was provided related to transmission based precautions.	C1505		

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Delivery via email to: jbyerly@homesteadofelkcity.com

April 15, 2024

License Number: AL0501

Ms. Julie Byerly, Administrator
Homestead Of Elk City
1000 Elkwood Blvd
Elk City, OK 73644

RE: Survey Event Y1OJ11

Dear Ms. Byerly:

On **March 27, 2024,** agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1505**: The plan of correction does not address corrective measures related to administering medications according to the physician orders and to follow physician orders, or when to notify the physician.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/12/2024** **Facility Name:** Homestead of Elk City **License Number:** AL0501 **Survey Event ID:** Y10J11 **Date Survey Completed: 3/27/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: observation, record review, and interview the center failed to ensure food was stored in accordance with Chapter 257.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

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 Dietary staff will receive training on How to Store Food Properly, Preventing Cross Contamination, Proper Storage of Leftovers and Survey Trends by Dining RD by 4/19 and ongoing. All staff will sign off that they have received the training. The ED and Dietary Manager will monitor compliance routinely and ongoing. The ED and/or the Dietary Manager will provide additional training as need is identified and ongoing.
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 included in this correction. The ED and Dietary Manager will monitor compliance routinely and ongoing. The ED and/or the Dietary Manager will provide additional training as need is identified and ongoing.
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?	A weekly schedule will be posted in the kitchen for documenting all food being labeled and dated and to thoroughly check expiration dates on all food. Each cook will rotate dates to document this information beginning 4/15. The ED and Dietary Manager will monitor compliance routinely and ongoing. The ED and/or the Dietary Manager will provide additional training as need is identified and ongoing.
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. Routine weekly audits will be performed by the ED and Dietary Manager to ensure compliance. Implement 4/7 and ongoing. b. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and Dietary Manager. Written and implemented 3/25. Routine weekly audits will be performed by the ED and Dietary Manager to ensure compliance. Implement 4/7 and ongoing. The ED and/or the Dietary Manager will document any occurrence of non-compliance ongoing and will provide disciplinary

	counseling to the staff member beginning 4/7 and ongoing. c. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and Dietary Manager. Written and implemented 3/25. Routine weekly audits of the documentation and random checks on stored foods and dates will be performed by the ED and Dietary Manager to ensure compliance beginning 3/25. The ED and/or the Dietary Manager will document any occurrence of non-compliance ongoing and will provide disciplinary counseling to the staff member beginning 4/7 and ongoing. The completed logs will be kept with the Plan of Correction in the QA Binder. Implement 4/7 and ongoing. The completed logs will be kept with the Plan of Correction in the QA Binder. Implement 4/7 and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Julie Byerly	**Date** Enter a date of signature.	4/12/24

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: 4/12/2024** **Facility Name:** Homestead of Elk City **License Number:** AL0501 **Survey Event ID:** Y10J11 **Date Survey Completed: 3/27/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: observation, record review and interview the center failed to ensure a significant change assessment had been completed for one (#5) of eight sampled residents reviewed for significant change assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

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?	The RCC and the ED will be provided education on the regulatory requirement for completion of the comprehensive Oklahoma Assessment for pre-admission, 14 day admission and significant change, and will signed off as having the education. The education will be provided by the Regional Clinical Consultant by 4/12 and ongoing. The ED and RCC will sign off that they have received the training. The Regional Clinical Consultant will monitor compliance routinely during monthly visits and ongoing. The Regional Clinical Consultant will provide additional training as need is identified and ongoing.
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 included in this correction. The Regional Clinical Consultant will monitor compliance routinely monthly and ongoing. The Regional Clinical Consultant will provide additional training as need is identified and ongoing beginning 4/12.
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?	The RCC will identify residents who experience a change in condition and will complete a change in condition assessment and update the service plan accordingly. This will be implemented by 4/12. The RCC will notify the ED and the Regional Clinical Consultant of the change in condition. The ED and Regional Clinical Consultant will monitor compliance routinely and ongoing. The ED and/or the Regional Clinical Consultant will provide additional training as need is identified and ongoing.
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;	a. Routine weekly audits will be performed by the Regional Clinical Consultant to ensure compliance. Implement 4/12 and ongoing. b. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and Regional

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.	Clinical Consultant. Written and implemented 4/12. Routine weekly audits will be performed by the Regional Clinical Consultant to ensure compliance. Implement 4/12 and ongoing. The ED and/or the Regional Clinical Consultant will document any occurrence of non-compliance ongoing and will provide disciplinary counseling to the RCC beginning 4/12 and ongoing. c. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and Regional Clinical Consultant. Written and implemented 4/12. Routine weekly audits of the documentation and random checks on resident charts will be performed by the Regional Clinical Consultant to ensure compliance beginning 4/12. The ED and/or the Regional Clinical Consultant will document any occurrence of non-compliance ongoing and will provide disciplinary counseling to the RCC beginning 4/12 and ongoing. The completed logs will be kept with the Plan of Correction in the QA Binder. Implement 4/12 and ongoing. The completed logs will be kept with the Plan of Correction in the QA Binder. Implement 4/12 and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4/12/2024

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/12/2024** **Facility Name:** Homestead of Elk City **License Number:** AL0501 **Survey Event ID:** Y10J11 **Date Survey Completed: 3/27/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: observation, record review, and interview the center failed to ensure a. staff sanitized resident equipment (blood pressure cuff and pulse oximeter) during medication observation,b. administer medication and notify the physician according to the physician order for two (#1 and#7) of three sampled residents reviewed for physician orders, and c. assess and implement transmission based precautions for one (#2) of one sampled resident reviewed for transmission based precautions.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

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 will receive re-training on universal precautions, infection control and sanitizing of all equipment by 4/19/24. All staff will sign off that they have received the re-training. The RCC will monitor compliance routinely and ongoing. The RCC will provide additional training as need is identified and ongoing.
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 included in this correction. The RCC will monitor compliance routinely and ongoing. The RCC will provide additional training as need is identified ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All staff will receive re-training on universal precautions, infection control and sanitizing of all equipment by 4/19/24. All staff will sign off that they have received the re-training. The RCC will monitor compliance routinely and ongoing. The RCC will provide additional training as need is identified by 4/19 and ongoing. The RCC will document any occurrence of non-compliance ongoing, and provide disciplinary counseling to the staff member. Regional RN Clinical Consultant will review any occurrence of non-compliance and do random observations of staff utilizing universal precautions, infection control and sanitizing of all equipment during routine monthly visits to the center.
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	Routine monthly audits will be performed by the RCC and Regional Clinical Consultant to ensure compliance. Implement on 4/19 and ongoing. Routine monthly audits will be performed by the RCC and Regional Clinical Consultant to ensure compliance and will include review of the non-compliance log. Implement on 4/19 and ongoing.

correction.	A Plan of Correction will be written, to address this deficiency by 4/12, to include routine monthly audits and monitoring will be performed by the RCC and Regional Clinical Consultant to ensure compliance and will include review of the non-compliance log. Implement on 4/19 and ongoing. The RCC will keep the non-compliance log updated as appropriate beginning 4/19 and ongoing
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4/12/24

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: Julie Byerly <jbyerly@homesteadofelkcity.com>

April 22, 2024

License Number: AL0501

Ms. Julie Byerly, Administrator
Homestead Of Elk City
1000 Elkwood Blvd
Elk City, OK 73644

RE: Survey Event Y1OJ11

Dear Ms. Byerly:

On **March 27, 2024**, 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 Amended 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 **April 30, 2024**.

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/12/2024** **Facility Name:** Homestead of Elk City **License Number:** AL0501 **Survey Event ID:** Y10J11 **Date Survey Completed:** 3/27/2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: observation, record review and interview the center failed to ensure a significant change assessment had been completed for one (#5) of eight sampled residents reviewed for significant change assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

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?	The RCC and the ED will be provided education on the regulatory requirement for completion of the comprehensive Oklahoma Assessment for pre-admission, 14 day admission and significant change, and will signed off as having the education. The education will be provided by the Regional Clinical Consultant by 4/12 and ongoing. The ED and RCC will sign off that they have received the training. The Regional Clinical Consultant will monitor compliance routinely during monthly visits and ongoing. The Regional Clinical Consultant will provide additional training as need is identified and ongoing.
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 included in this correction. The Regional Clinical Consultant will monitor compliance routinely monthly and ongoing. The Regional Clinical Consultant will provide additional training as need is identified and ongoing beginning 4/12.
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?	The RCC will identify residents who experience a change in condition and will complete a change in condition assessment and update the service plan accordingly. This will be implemented by 4/12. The RCC will notify the ED and the Regional Clinical Consultant of the change in condition. The ED and Regional Clinical Consultant will monitor compliance routinely and ongoing. The ED and/or the Regional Clinical Consultant will provide additional training as need is identified and ongoing.
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;	a. Routine weekly audits will be performed by the Regional Clinical Consultant to ensure compliance. Implement 4/12 and ongoing. b. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and Regional

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.	Clinical Consultant. Written and implemented 4/12. Routine weekly audits will be performed by the Regional Clinical Consultant to ensure compliance. Implement 4/12 and ongoing. The ED and/or the Regional Clinical Consultant will document any occurrence of non-compliance ongoing and will provide disciplinary counseling to the RCC beginning 4/12 and ongoing. c. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and Regional Clinical Consultant. Written and implemented 4/12. Routine weekly audits of the documentation and random checks on resident charts will be performed by the Regional Clinical Consultant to ensure compliance beginning 4/12. The ED and/or the Regional Clinical Consultant will document any occurrence of non-compliance ongoing and will provide disciplinary counseling to the RCC beginning 4/12 and ongoing. The completed logs will be kept with the Plan of Correction in the QA Binder. Implement 4/12 and ongoing. The completed logs will be kept with the Plan of Correction in the QA Binder. Implement 4/12 and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4-19-24
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. 4/19/24	**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: 4/12/2024** **Facility Name:** Homestead of Elk City **License Number:** AL0501 **Survey Event ID:** Y10J11 **Date Survey Completed: 3/27/2024**
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	**Based on:** observation, record review, and interview the center failed to ensure food was stored in accordance with Chapter 257.
ASSISTED LIVING CENTER'S PLAN OF CORRECTION	
Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.	
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 Dietary staff will receive training on How to Store Food Properly, Preventing Cross Contamination, Proper Storage of Leftovers and Survey Trends by Dining RD by 4/19 and ongoing. All staff will sign off that they have received the training. The ED and Dietary Manager will monitor compliance routinely and ongoing. The ED and/or the Dietary Manager will provide additional training as need is identified and ongoing.
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 included in this correction. The ED and Dietary Manager will monitor compliance routinely and ongoing. The ED and/or the Dietary Manager will provide additional training as need is identified and ongoing.
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?	A weekly schedule will be posted in the kitchen for documenting all food being labeled and dated and to thoroughly check expiration dates on all food. Each cook will rotate dates to document this information beginning 4/15. The ED and Dietary Manager will monitor compliance routinely and ongoing. The ED and/or the Dietary Manager will provide additional training as need is identified and ongoing.
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. Routine weekly audits will be performed by the ED and Dietary Manager to ensure compliance. Implement 4/7 and ongoing. b. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and Dietary Manager. Written and implemented 3/25. Routine weekly audits will be performed by the ED and Dietary Manager to ensure compliance. Implement 4/7 and ongoing. The ED and/or the Dietary Manager will document any occurrence of non-compliance ongoing and will provide disciplinary

	counseling to the staff member beginning 4/7 and ongoing. c. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and Dietary Manager. Written and implemented 3/25. Routine weekly audits of the documentation and random checks on stored foods and dates will be performed by the ED and Dietary Manager to ensure compliance beginning 3/25. The ED and/or the Dietary Manager will document any occurrence of non-compliance ongoing and will provide disciplinary counseling to the staff member beginning 4/7 and ongoing. The completed logs will be kept with the Plan of Correction in the QA Binder. Implement 4/7 and ongoing. The completed logs will be kept with the Plan of Correction in the QA Binder. Implement 4/7 and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4-11-24
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. 4/18/24	**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: 4/12/2024** **Facility Name:** Homestead of Elk City **License Number:** AL0501 **Survey Event ID:** Y10J11 **Date Survey Completed: 3/27/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: observation, record review, and interview the center failed to ensure a. staff sanitized resident equipment (blood pressure cuff and pulse oximeter) during medication observation,b. administer medication and notify the physician according to the physician order for two (#1 and#7) of three sampled residents reviewed for physician orders, and c. assess and implement transmission based precautions for one (#2) of one sampled resident reviewed for transmission based precautions.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

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. All staff will receive re-training on universal precautions, infection control and sanitizing of all equipment by 4/19/24. All staff will sign off that they have received the re-training. The RCC will monitor compliance routinely and ongoing. The RCC will provide additional training as need is identified and ongoing. B. All medication aides will receive re-training on medication administration and the 6 rights of medication administration. All medication aides will receive re-training on when to notify the nurse and when to notify the physician according to the physician order and to follow the physician order as it is written. C. All staff will receive re-training on universal precautions, infection control and sanitizing of all equipment by 4/19/24. All staff will sign off that they have received the re-training. The RCC will monitor compliance routinely and ongoing. The RCC will provide additional training as need is identified and ongoing. Regional RN Clinical Consultant will review any occurrence of non-compliance and do random observations of staff utilizing unerversal precautions, infection control and sanitizing of all equipment during routine monthly visits to the center.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A. All residents are included in this correction. The RCC will monitor compliance routinely and ongoing. The RCC will provide additional training as need is identified ongoing. B. All residents are included in this correction. The RCC will monitor compliance routinely and ongoing. The RCC

	will provide additional training as need is identified ongoing. C. All residents are included in this correction. The RCC will monitor compliance routinely and ongoing. The RCC will provide additional training as need is identified ongoing.
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?	A. All staff will receive re-training on universal precautions, infection control and sanitizing of all equipment by 4/19/24. All staff will sign off that they have received the re-training. The RCC will monitor compliance routinely and ongoing. The RCC will provide additional training as need is identified by 4/19 and ongoing. The RCC will document any occurrence of non-compliance ongoing, and provide disciplinary counseling to the staff member. Regional RN Clinical Consultant will review any occurrence of non-compliance and do random observations of staff utilizing universal precautions, infection control and sanitizing of all equipment during routine monthly visits to the center. B. All medication aides will receive re-training on medication administration and the 6 rights of medication administration. All medication aides will receive re-training on when to notify the nurse and when to notify the physician according to the physician order and to follow the physician order as it is written. The RCC will perform random checks with medication aides to ensure they are following the procedure of medication administration, the 6 Rights of medication administration and address any opportunity for improvement at that moment. This practice will be ongoing. C. All staff will receive re-training on universal precautions, infection control and sanitizing of all equipment by 4/19/24. All staff will sign off that they have received the re-training. The RCC will monitor compliance routinely and ongoing. The RCC will provide additional training as need is identified by 4/19/24 and ongoing. The RCC will document any occurrence of non-compliance ongoing and provide disciplinary counseling to the staff member. Regional RN Clinical Consultant will review any occurrence of non-compliance and do random observations of staff utilizing unerversal precautions, infection control and sanitizing of all equipment during routine monthly visits to the center.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:	A. Routine monthly audits and observations will be performed by the RCC and Regional Clinical Consultant to ensure compliance. Implement on 4/19 and ongoing.

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.	B. Routine monthly audits and observations will be performed by the RCC and Regional Clinical Consultant to ensure compliance and will include review of the non-compliance log. Implement on 4/19 and ongoing. Any further identified concerns regarding this deficiency will be addressed through QA with a plan of correction. C. A Plan of Correction will be written, to address this deficiency by 4/12, to include routine monthly audits and monitoring will be performed by the RCC and Regional Clinical Consultant to ensure compliance and will include review of the non-compliance log. Implement on 4/19 and ongoing. The RCC will keep the non-compliance log updated as appropriate beginning 4/19 and ongoing
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Julie Byerly OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4/18/2024

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

Addendum Date	Enter a date of addendum. 4/18/2024	**Submitted by**	Enter name of person submitting addendum. Julie Byerly

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: Julie Byerly <jbyerly@homesteadofelkcity.com>

May 9, 2024

License Number: AL0501

Ms. Julie Byerly, Administrator
Homestead Of Elk City
1000 Elkwood Blvd
Elk City, OK 73644

RE: Survey Event Y1OJ12

Dear Ms. Byerly:

On **May 8, 2024,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 27, 2024,** have now been corrected effective **April 30, 2024.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL0501	A. BUILDING: _____ B. WING _____	R 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF ELK CITY	1000 ELKWOOD BLVD ELK CITY, OK 73644

(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 05/08/24. 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