OKLAHOMA
State Department
of Health

Delivery via email to: westplainsed@islllc.com; highlandsed@islllc.com

June 16, 2023

License Number: AL090201

Ms. Jillian Jones, Administrator
Sand Sage Of The Highlands
1017 West Highway 152
Mustang, OK 73064

RE: Survey Event ID: IOWI11

Dear Ms. Jones:

On **June 1, 2023**, agents from our office concluded a State Licensure survey with a complaint investigation 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

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Sand Sage of the Highlands**
Address: **1017 West Highway 152**
City, State, Zip: **Mustang, OK, 73064**
Provider #: **AL090201**
Complaint #: **OK00060587**
Investigation Date(s): **05/30/23 through 06/01/23**

ALLEGATION(S)

1. The facility failed to ensure residents were not physically, sexually or psychosocially abused and failed to investigate and notify the police, resident's representative and the OSDH in a timely manner.
2. The facility failed to ensure residents' representatives were notified of an allegation of abuse in a timely manner.

An unannounced on-site investigation was initiated 05/30/2023 at 10:05 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Staff were observed speaking to the residents in a dignified manner and assisting residents with activities of daily living.

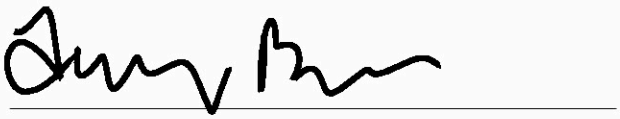
Resident records were reviewed including physician orders, resident assessments, service contracts, interdisciplinary notes, incident reports and State reportable incidents. Facility policy and procedures were reviewed.

Residents were interviewed related to abuse. They were asked if staff notified their representative when they experienced a change in condition.

Staff were interviewed regarding the facility policy for abuse and family notification.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.



Tammy Bross, RN, CHFS

Date report completed: 06/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL090201	A. BUILDING: _____ B. WING _____	C 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND SAGE OF THE HIGHLANDS	1017 WEST HIGHWAY 152 MUSTANG, OK 73064

(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 relicensure survey was conducted from 05/30/23 through 06/01/23. A complaint investigation (#OK 00060587) was conducted in conjunction with the survey. The following abbreviations will be used throughout this document. CMA- Certified Medication Aide CNA-Certified Nurse Aide RCC- Resident Care Coordinator RCD- Resident Care Director	C 000		
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	C1505		

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C1505	Continued From page 1 of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered as ordered for one (#4) of ten sampled residents reviewed for medications. The "Entrance Conference Checklist" report, dated 05/30/23, documented 60 residents resided in the facility. Findings: A "Medication Refills" policy, dated 12/02/22, read in parts, "...Medication refills will be obtained in a timely manner to ensure residents have all physician ordered medications available...The CMA...on duty contacts the dispensing pharmacy to obtain a refill at least seven...days prior to running out of a medication..." Resident #4 had diagnoses which included unspecified dementia and insomnia. "Physician Orders," dated 04/19/23, documented Resident #4 was to receive one multivitamin	C1505		

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C1505	Continued From page 2	C1505		

tablet by mouth daily and one vitamin D3 125 micrograms capsule by mouth daily.

The "Medication Sheet," dated April 2023, documented circled initials for the multivitamin and vitamin D3 on the 20th, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, and 30th. The medication notes documented the facility was awaiting pharmacy delivery.

The "Medication Sheet," dated May 2023, documented circled initials for the multivitamin and vitamin D3 on the 1st, 2nd, 3rd, and 4th. The medication notes documented the facility was awaiting pharmacy delivery.

On 05/31/23 at 1:20 p.m., the RCD and RCC were asked the policy for medication administration. The RCD stated staff were to go through the rights of medication administration and could administer medications one hour before or one hour after the scheduled time. They stated if a resident refused a medication, staff were to notify the lead staff member, family, and physician, and document the refusal.

On 05/31/23 at 1:21 p.m., the RCD and RCC were asked what the policy was if a medication was not available for administration. The RCC stated staff were to call and notify the nurse the medication was not in house.

On 05/31/23 at 1:24 p.m., the RCD and RCC were asked to review the resident's medication sheets for April and May 2023 and identify the reason the multivitamin and vitamin D3 were not administered. The RCC stated, "Awaiting pharmacy delivery." The RCC stated staff should have called the pharmacy. The RCD stated the physician should also have been notified to get

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C1505	Continued From page 3 the medications on hold. They were asked how many days the resident went without the medications. The RCC stated the resident went two weeks without the multivitamin and 13 days without the vitamin D3.	C1505		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		

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C1911	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a reportable incident was submitted to the State Department within one department business day for one (#3) of three sampled residents reviewed for abuse. The "Entrance Conference Checklist" report, dated 05/30/23, documented 60 residents resided in the facility. Findings: A "Resident Abuse and Neglect" policy, dated December 2014, read in parts, "...Resident abuse and neglect are prohibited...Safeguarding the Resident...Once the resident is protected, promptly proceed with the reporting guidelines that follow...The Executive Director or manager on duty will do the following...Promptly notify State agencies as required by law..." Resident #3 had diagnoses which included dementia and anxiety. A "State Incident Report Form," dated 04/24/23, documented Resident #3 was observed in the dining room clapping, and when asked what was wrong they stated a CNA tried to rape them. It documented staff was suspend pending the investigation. The report documented the physician evaluated the resident and reported no signs of physical abuse had been found. It documented the allegation was unsubstantiated and the staff member was allowed to return to work. The report was marked "Combined Initial and Final" and was faxed to the State agency on 12/28/23 at 6:11 p.m. On 05/31/23 at 2:12 p.m., the RCD was asked	C1911		

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C1911	Continued From page 5 the policy for an allegation of abuse. They stated anytime abuse was suspected, staff were to report it to the abuse coordinator or the RCD. The RCD stated the facility would report the event to the State agency within two hours. They stated if staff were involved in the allegation, they would be suspended until the investigation was completed. On 05/31/23 at 2:15 p.m., the RCD was asked to review the State reportable for Resident #3 dated 04/24/23 and identify what type of incident report it was. They stated it was an allegation of abuse/mistreatment and was a combined initial and finial report. The RCD was asked to identify when the State agency was notified of the allegation of abuse. They stated April 28th at 6:11 p.m. The RCD was asked if the policy was followed. They stated, "No." On 05/31/23 at 2:40 p.m., Administrator #1 was asked the facility abuse policy. They stated the nurse would notify the RCD, the RCD would notify the Administrator and any staff involved would be suspended pending the investigation. They stated the family, physician, and local law enforcement would be notified. They stated once corporate human resources cleared the employee, they would be allowed to return to work. Administrator #1 stated they waited for law enforcement to give the clearance. They stated they reported abuse allegations in the assisted living within two hours, and in memory care, they would speak with the physician and try to report immediately depending on the situation. They stated Resident #3's timeline was off because they were waiting for local law enforcement and regional.	C1911		

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C1916	Continued From page 6	C1916		
C1916 SS=D	310:663-19-1(f) REPORTS TO THE DEPARTMENT (f) Each continuum of care facility and assisted living center shall report allegations and occurrences of resident abuse, neglect, or misappropriation of resident's property by a nurse aide to the Nurse Aide Registry by submitting a completed "Notification of Nurse Aide Abuse, Neglect, Mistreatment or Misappropriation of Property" form (ODH Form 718), which requires the following: (1) facility/center name, address and telephone; (2) facility type; (3) date; (4) reporting party name or administrator name; (5) employee name and address; (6) employee certification number; (7) employee social security number; (8) employee telephone number; (9) termination action and date (if applicable); (10) other contact person name and address; and (11) the details of the allegation or occurrence of abuse, neglect, or misappropriation of resident property. This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to notify the nurse aide registry of an allegation of abuse involving CNA #2 for one (#1) of three sampled residents reviewed for abuse. The "Entrance Conference Checklist" report, dated 05/30/23, documented 60 residents resided in the facility.	C1916		

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C1916	Continued From page 7 Findings: A "Resident Abuse and Neglect" policy, dated December 2014, read in part, "...Promptly notify state agencies as required by law..." A "State reportable," dated 02/10/23, "...Resident #1 stated that resident #1 told another caregiver that CNA #2 allegedly hit [them] in the face with pendent...the resident care director immediately removed caregiver from providing care." There was no documentation (Form 718) CNA #2 was reported to the nurse aide registry in conjunction with the abuse allegation. A statement from CNA #2, dated 02/10/23, read in parts, "At 8:05 p.m., I answered the call light for apartment 201, the resident stated [they] needed [their] television remote from under [their] pillow. I handed [them] the remote and ask resident to reset [their] pendent around [their] neck. The pendent snapped away from [their] neck. I reset it and reattached it to [their] ribbon that it attaches to. I asked the resident if [they] needed anymore help, [they] stated no and I left the room." On 05/31/23 at 2:20 p.m., the RCD was asked when there was an allegation of abuse involving a staff member, what did the facility do. They stated they would send them home or separate them until the investigation was completed. The RCD was given the State reportable for Resident #1 dated 02/10/23 to review. The RCD was asked if the nurse aide registry was notified of the alleged incident with form 718. They stated, "No I do not see a 718 form."	C1916		

OKLAHOMA
State Department
of Health

Delivery via email to: westplainsed@islllc.com

July 14, 2023

License Number: AL090201

Ms. Catina Elliot, Executive Director
Sand Sage of The Highlands
1017 West Highway 152
Mustang, OK 73064

Survey Event ID: IOWI11

Dear Ms Elliot:

On **June 1, 2023,** a Relicensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. **Our acceptance does not absolve the facility's responsibility** for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **July 28, 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: 6/28/2023** **Facility Name:** Sand Sage of the Highlands **License Number:** AL090201 **Survey Event ID:** IOWI11 **Date Survey Completed: 6/1/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: The facility failed to ensure medications were administered as ordered for one (#4) of ten sampled resdients reviewed for medications.

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) Resident physician were notified of medication errors. The RCD in-serviced clinical staffon administering residents medication per physician orders. B) All medication aides were in-serviced on the use of the facility implemented medication reconcialation form.
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 other residents had the potential to be affected by the identified practice. An audit of all residents was completed by pharmacy consultant June 16, 2023
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) 1. All physician orders will be reviewed in the morning clinical meeting. Additionally the RCD will review all physician orders for clarity and appropriate dosage instructions and request clarification orders as indicated. 2. All medication aides were in-serviced on following physician order and documentation of medication given. All medication aides will receive this training as part of orientatation and annually. B) 1. A medication form was implemented and will be used to track when medications are ordered and received. This form will include date ordered, date received, quantity received, and date family notified. The form will kept on each medication cart. The RCD will review each book weekly manner to, to ensure

	medications are ordered and received in a timely manner. 2.) All medication aides were in-serviced on the use of the facility implemented medication reconcialation form. A policy on medication packaging, requiring daily pre-packaged medication and prohibiting bottles, unless prohibitedby manufacture or unavaible through pharmacy of choice was sent to families on June 21, 2023 with required implementation by July 15th, 2023 or next billing cycle.
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.	1) The RCD, RCC, and/or GCC will conduct weely medication audits twice each week at randow for 12 weeks to ensure medications are administered per physician orders. After 12 weeks of audits will be conducted random. Audits will be kept in the ED office. Findings will be reviewed by QA committee to ensure continued compliance and to determine the plan works effectively. 2) The RCD, RCC, and/or GCC will pull a missed medication report daily to review errors and address any issues. This will continue for the 3rd quarter of 2023 and will be reviewed by QA committee at the 2023 3rd quarter QA meeting. A record will be kept in ED office. 3) The RN consultant will review all orders monthly and make recommendations to the QA committee. 4.) The pharmacy consultant will review physician orders at least quarterly and make recommendations to RCD and/or residents physcians. The pharmacy consultant will observe the medication aides medication administration to ensure appropriate procedures and physician order is followed. Findings will be docmented in the pharmacy consultant report. Any identified areas of improvement will be addressed in the facilities QAPI process. Each residents medication reconciliation forms will bekept on file as part tof the residents chart.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/28/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Catina Elliott OAC 310:663-25-4(F)	**Date 6/29/2023**

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: 6/28/2023** **Facility Name:** Sand Sage of the Highlands **License Number:** AL090201 **Survey Event ID:** IOWI11 **Date Survey Completed: 6/1/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1911	Based on: record review and interview, the facility failed to ensure a reportable incident was submitted to the State Department within one department business day for one (#3) of three sampled residents reviewed for abuse.

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?	It is the policy of this community to ensure the highest level of care and safety for all resdients. Resident and family member was notifed at the time of the incident of the reporting regulations and company policy and procudres of tiemlines.Advised of the OSDH reporting regulations of any allegations for abuse or neglect will be within 1 day.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any staff member who has cause to believe that an incident of any form of abuse/neglect/exploitation has occurred will take immediate action to protect the resident from additional harm. 2. If any staff member who has observed, suspects, has knowledge of, or is told by a resident or other staff member, of an incident which appears to be any form of abuse/neglect/exploitation, the staff member will immediately notify the Executive Director or manager on duty. In all cases the Executive Director will be notified as soon as possible. 3. Upon the notice of reported, observed, suspected or at imminent risk of any form of abuse/neglect/exploitation: a) Immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is conducted.

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?	1. All staff members will receive training on abuse, neglect, and exploitation and the mandatory reporting requirements per state regulations during orientation and at least annually thereafter. a) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. 2. Staff members, as mandated reporters, have a duty to report all suspected abuse, neglect, and exploitation. 3. Staff will not be terminated nor reprimanded for reporting suspected or actual cases of resident abuse. 4. Adherence to this policy is the responsibility of the Resident Care Director Executive Director.
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.	Monthly audits of incident reports will continue to take place along with our quarterly QA meetings to measure effectiveness and determine performance improvement goals. Staff communication and quality assurance tools such as Internal Occurrence Reports, Incident Reports, End of Shift Report and CMA/MAT to CMA/MAT Communication Log shall be kept 90 days and then destroyed. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/28/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Catina Elliott** OAC 310:663-25-4(F)	**Date 6/29/2023**

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: 6/28/2023** **Facility Name:** Sand Sage of the Highlands **License Number:** AL090201 **Survey Event ID:** IOWI11 **Date Survey Completed: 6/1/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1916	Based on: interview and record review, it was determined the facility failed to notify the nurse aide registry of an allegation of abuse involving CNA #2 for one (#1) of three sampled residents reviewed for abuse.

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.)The resident identified was immediately assessed by nurse for any signs and symptoms of redness, bruising, and/or discoloration. B.)OSDH Nurse Aide Registry was notified by fax (Form 718), of the abuse allegation on CNA #2 .Staff member,resident along with responble party was educated on the reporting regulations and processes.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Continued education on reporting guidelines and regulations will be conducted with all new hires and new admissions . Monthly inservice meetings with the nursing department will be routine for the next 60 days.
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?	1. All staff members will receive training on abuse, neglect, and exploitation and the mandatory reporting requirements per state regulations during orientation and at least annually thereafter. a) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files.

	2. Staff members, as mandated reporters, have a duty to report all suspected abuse, neglect, and exploitation. 3. Staff will not be terminated nor reprimanded for reporting suspected or actual cases of resident abuse.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Audits of incident reports will continue to take place along with our quarterly QA meetings to measure effectiveness and determine performance improvement goals. Copies of all 718 forms will be kept in RCD and ED office.Staff communication and quality assurance tools such as Internal Occurrence Reports, Incident Reports, End of Shift Report and CMA/MAT to CMA/MAT Communication Log shall be kept 90 days and then destroyed. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/28/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Catina Elliott** OAC 310:663-25-4(F)	**Date 6/29/2023**

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: westplainsed@islllc.com

September 21, 2023

License Number: AL090201

Catina Elliot, Administrator
Sand Sage Of The Highlands
1017 West Highway 152
Mustang, OK 73064

RE: Survey Event IOWI12

Dear Ms. Elliot:

On **September 12, 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 **July 28, 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
	AL090201	A. BUILDING: _____ B. WING _____	R-C 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND SAGE OF THE HIGHLANDS	1017 WEST HIGHWAY 152 MUSTANG, OK 73064

(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 09/12/23. 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