

Delivery via email to: westplainsed@isllc.com

August 29, 2024

License Number: AL090201

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

RE: Survey Event ID: DF1511

Dear Ms. Benson:

On **July 26, 2024**, agents from our office concluded a State Licensure survey with complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented 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 **July 26, 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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Sand Sage of the Highlands
Address: 1017 West Highway 152
City, State, Zip: Mustang, OK., 73064
Provider #: AL090201
Complaint #: OK00064008
Investigation Date(s): 07/24/24 through 07/26/24

ALLEGATION(S)
1. The center failed to ensure qualified staff provided assistance with bathing.

An unannounced on-site investigation was initiated 07/24/2024 at 11:50 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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. Residents were observed for supervision and safety. Observations were made of care being provided. Resident records including physician orders, contracts, service plans, medication administration records, grievances, incident reports, and nurse's notes were reviewed. Residents and Staff were interviewed in regard to qualified staff providing bathing assistance. The center's policies were reviewed regarding qualified staff providing care.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/07/2024

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL090201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/26/2024
NAME OF PROVIDER OR SUPPLIER SAND SAGE OF THE HIGHLANDS		STREET ADDRESS, CITY, STATE, ZIP CODE 1017 WEST HIGHWAY 152 MUSTANG, OK 73064		
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C 000	INITIAL COMMENTS A relicensure survey was conducted from 07/24/24 through 07/26/24. A complaint investigation (#OK00064008) was conducted in conjunction with the survey. The following abbreviations will be used throughout this report. ADL - activities of daily living BMI - body mass index CD - culinary director CMA - certified medication aide HS - hour of sleep LLE - left lower extremity m - month RCD - Resident Care Director RN- Registered Nurse TID - three times per day	C 000		
C 301 SS=D	310:663-3-1(a) SERVICE IN ASSISTED LIVING (a) An assisted living center shall not care for any resident needing care in excess of the level that the assisted living center is licensed to provide or capable of providing. This Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure a resident with multiple falls did not exceed the centers level of care for one (#8) of eight sampled residents.	C 301		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

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C 301	Continued From page 1 The RCD identified 50 residents resided in the facility. Findings: An "Allowable Health Conditions" policy, dated 06/01/24, read in part "It is the Community's goal to retain residents for as long as they wish to live in the Community. The Community will admit and retain stable residents with health conditions that can be safely cared for by Community staff, or in partnership with outside agencies...The assisted living center shall monitor and assure the delivery of those services...All accommodations or additional services shall be described in a written plan of accommodation..." Resident #8 had diagnoses which included, congestive heart failure, pain. A progress note, dated 01/30/24, at 10:19 p.m., documented Resident #8 was found on the floor. Resident #8 reported they tripped coming around a corner too fast. A progress note, daed 02/05/24 at 5:10 p.m., documented Resident #8 was complaining of pain to their hips. An order was obtained to perform an x-ray. A progress note, dated 02/06/24 at 1:46 p.m., documented the xray results as possible fracture to the base of the right hip. Resident #8 was non weight bearing on the right hip. A progress note, dated 02/06/24 at 5:01 p.m., documented Resident #8 requested to be sent to the emergency room. A progress note, dated 02/08/24 at 10:49 .m.,	C 301		

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C 301	Continued From page 2 documented Resident #8 had an unwitnessed fall in their room. Resident #8 had swelling to the left side of their head and an abrasion on the left knee. Resident #8 was reminded to call for assistance. The resident was transported to the hospital for evaluation. A progress note, dated 03/24/24 at 2:54 p.m., documented Resident #8 had an unwitnessed fall and hit their head. Resident was sent to the emergency room for evaluation. A progress note, dated 03/26/24 at 7:43 a.m., documented Resident #8 had returned from the hospital with a "bloody scalp". There was no documentation in the health record describing the fall. A progress note, dated 03/27/24 at 1:23 p.m., documented Resident #8 fell in the dining room with a noted head injury. A progress note, dated 04/07/24 at 9:01 p.m., documented Resident #8 had an unwitnessed fall in their room and was sent to the emergency room for a head injury. A late entry progress note, dated 04/26/24 at 2:21 p.m., documented Resident #8 had an unwitnessed fall in their room. Resident #8 refused to go to the emergency room. A progress note, dated 05/02/24 at 3:05 p.m., documented physical therapy notified staff Resident #8 had fallen in the closet. Resident #8 refused to go to the emergency room. A progress note, dated 06/04/24 at 8:56 p.m., documented Resident #8 had a fall in their room which resulted in a head injury. Resident #8 was	C 301		

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C 301	Continued From page 3 sent to the emergency room for evaluation. A progress note, dated 06/09/24 at 9:08p.m., documented Resident #8 reported to the facility staff they had fallen and had shoulder pain. A fall risk appraisal, dated 06/24/24, documented Resident #8's score was a seven. A score of greater than four is considered at risk for falls. A progress note, dated 07/14/24 at 1:43 p.m., documented resident #8 had an unwitnessed fall in the bathroom. Was sent to the emergency room and received 10 staples in their head. A progress note, dated 07/15/24 at 1:46 p.m., documented Resident #8 requires one person stand by assistance with ADL care and has poor safety awareness due to non compliance. A reassessment and service plan will be completed and one on one services may be needed. A level of care assessment, dated 07/21/24, documented the resident required stand by assistance with grooming, bathing, required status checks eight to twelve times per day and was a fall risk. A service plan, dated 07/25/24, documented the Resident #8 required stand by assist for showers, dressing, with ambulation with walker, transfers and toileting. On 07/25/24 at 8:55 a.m., Resident #8 was asked if they had fallen. They stated, they have had 27 falls since they admitted. Resident #8 stated, "If I fall one more time they will discharge me. " They were asked who told them that. They stated the [RCD]. Resident #8 was asked if they wanted to stay in the center. They stated, "Yes, I do and it	C 301		

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C 301	Continued From page 4 scares me to think I have to leave." On 07/25/24 at 2:55 p.m., the RCD was asked if any residents had a plan of accommodation or a negotiated risk agreement. They stated, "No." On 07/26/24 at 11:47 a.m., the RCD was asked if Resident #8 exceeded the level of care the center could provide. They stated, "Yes." They stated they had a conversation with the resident about being able to meet their needs.	C 301		
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, labeled and dated according to center policy. The RCD identified 50 residents resided in the center. Findings: An undated "LABELING AND FIFO METHOD" policy, read in part "All items are labeled with delivery dated to indicate the FIFO method is being properly managed. All prepared, thawing and ready-to-eat foods that are no longer in their original container/packaging are labeled with common name and dated with preparation or	C 391		

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C 391	Continued From page 5 expiration dated and/or time by which they must be served or discarded." On 07/24/24 at 12:08 p.m., the following food items were observed during the initial kitchen observation with the culinary director: a. multiple slices of watermelon in a large stainless steel bowl with a piece of plastic wrap on the top. There was no date on the plastic wrap. The CD stated there was no date on the plastic wrap. b. a bowl of pasta with chicken that was dated 07/22/24. The CD acknowledged leftovers should only be kept for one day. c. two onions cut in half in two Ziploc bags, dated 07/13/24. The CD removed and disposed of the onions. d. two white and one yellow stacks of cheese slices wrapped in saran wrap that were not dated. The CD removed the cheese and stated they should be dated. c. a package of sliced ham in the original package with an expiration date of 09/12/24 that was not dated when opened. The CD removed the ham and disposed of it in the trash. d. two bags of zucchini and two bags of tater tots in the freezer with no date when they were received. The CD stated the packages should have dated when they were received.	C 391		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission.	C 521		

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C 521	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an admission assessment was completed within 30 days before or at the time of admission for one (#4) of eight sample residents reviewed for admission assessments. The RCD identified 50 residents resided in the center. Findings: The center's "Resident Assessments" policy, dated 12/01/23, read in part, "The resident comprehensive Assessment is completed/updated: a. prior to move in. The policy also read, "The assisted living center shall complete the comprehensive assessment with thirty (30) days before, or at the time , of admission." Resident # 4 was admitted on 04/15/24 with diagnoses which included unspecified dementia and anxiety. A "Sand and Sage level of Care Appraisal" assessment, dated 05/31/24, documented Resident #4's cognition was significantly impaired. On 07/26/24 at 9:00 a.m., Resident #4's health record was reviewed. The health record did not document an admission assessment completed within 30 days or on the date of admission.	C 521		

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C 521	Continued From page 7 On 07/26/24 at 9:19 a.m., the DON was asked to provide an admission assessment completed 30 days prior to admission or at the time of admission for Resident #4. The DON stated that the Executive Director resigned and a admission assessment could not be located in the resident's health record. They stated the assessment should of been completed upon admission and kept in the Residents health record.	C 521		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure assessments were coordinated by a physician or RN for one (#2) of eight sampled residence reviewed for assessments coordinated by an RN or physician. The RCD identified 50 residents resided in the center. Findings: The center's "Resident Assessments" policy, dated 12/01/23, read in part, " The assessment shall be completed by appropriate participation of health professionals trained in the assessment process. All assessments must be coordinated and signed by a registered nurse or the resident's personal physician.	C 542		

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C 542	Continued From page 8 A resident assessment, dated 09/05/23, did not document an RN or Physician signed or coordinated the assessment. Resident #2 was admitted on 09/08/23 with diagnoses which included Alzheimer's disease and unspecified psychosis. On 07/26/24 at 9:19 a.m., the DON was asked what the policy was for assessments coordinated and signed by an RN or physician. The DON stated an RN or Physician must review and sign the assessments. The DON was asked to review Resident #2's assessment dated 09/05/23. The DON stated the assessment did not contain a signature of and RN or physician and the policy was not followed.	C 542		
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	C1505		

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C1505	Continued From page 9 treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the center failed to a. ensure forty eight hour assessments were completed after falls for one (#3) of two sampled residents reviewed for falls, b. ensure the medication cart was locked when unattended, c. ensure a blood pressure cuff was sanitized between use for three (#11, #12 and #13) of five sampled residents reviewed during medication observation, and d. follow a dietician recommendation and implement meal supplements for one (#6) of one sampled resident reviewed for weight loss. The RCD identified 50 residents resided in the center. Findings:	C1505		

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C1505	Continued From page 10 A "Falls" policy, dated 12/01/23, read in part, "For forty-eight hours after any fall, the Resident Care Director or designee on each shift will monitor the resident and make a brief narrative charting entry." A "Standard Precautions" policy, dated 12-01-23, read in part "...Standard Precautions include appropriate use of...Use/handling of disposable and reusable medical equipment..." 1. Resident #3 had diagnoses which included, COPD, dementia and anxiety. A "Plan of Care Update", dated 04/20/24 to 06/18/24 was the most current Hospice plan of care for Resident #3. A progress note, dated 06/23/24 at 2:36 p.m., documented Resident #3 had a fall and had a skin tear to the right thumb and right outer forearm. There was no documentation the resident was assessed for 48 hours after the fall. A progress notes, dated 06/25/24 at 9:01 p.m., documented Resident #3 fell in the hallway. Hospice was contacted. Resident #3 stated they had hit their head. There was no documentation Resident #3 was assessed on the morning shift of 06/26/24. A progress note, dated 07/21/24 at 4:08 p.m., documented Resident #3 had an unwitnessed fall in their room. There was no documentation Resident #3 was assessed every shift for 48 hours after the fall. A hospice visit note, dated 07/21/24, read in part, "...bruising ulcer/wounds present...Ear rt, skin tear...PT has bruising to right side of face and	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL090201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/26/2024
NAME OF PROVIDER OR SUPPLIER SAND SAGE OF THE HIGHLANDS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1505	Continued From page 11 right eye along with a skin tear to right ear cartilage area...PT can lift [their] right arm, leg...Facility requested xray of face to make sure of no fractures. This nurse did not see any other wounds, abrasions, or bruising this visit post fall to right side of body..." On 07/25/24 at 1:35 p.m., the RCD was shown the progress notes and asked if the Resident had been assessed every shift for 48 hours according to policy for the dated listed above. They stated "No." On On 07/24/24 at 1:54 p.m., Resident #3 was observed sitting on their walker in the hallway. Resident #3 was observed to have deep purple discoloration to their right eye, on their neck, shoulder and arms bilateral. On 07/25/24 at 9:09 a.m., Resident #3 was observed sitting in their recliner in their room. They were asked about the bruising on their eye. They stated they had fallen in their room. A dressing was observed on Resident #3's left shin. There was no date on the dressing. On 07/25/24 at 12:54 p.m., the RCD was asked if Resident #3 had been injured when they fell on 07/21/24. They stated the incident report documented there was a bruise to the face and the residents ear was bleeding. The RCD was not aware of the fall on 07/21/24. 2. On 07/24/24 at 12:52 p.m., a medication cart was observed to be unlocked in the hallway near the medication room. Two staff were observed to come out of the medication room, one staff member opened the medication care without using their keys.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL090201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/26/2024
NAME OF PROVIDER OR SUPPLIER SAND SAGE OF THE HIGHLANDS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1505	Continued From page 12 On 07/25/24 at 1:38 p.m., the medication cart was observed to be unlocked in the hallway near the medication room. No staff were observed to be near the cart. The RCD opened the top drawer of the unsecured cart. CMA #1 was in the medication room, the RCD asked CMA #1 why the cart was unlocked. CMA #1 stated another staff member had left it unlocked. The RCD stated the cart should have been locked. On 07/25/24 at 1:55 p.m., CMA #1 was asked why the medication cart had been left unlocked. They stated they had left it unlocked when they had administered an as needed medication. 3. On 07/26/24 at 7:18 a.m., CMA #1 was observed to obtain a blood pressure on Resident #12 using a wrist cuff. They returned to the cart and placed it on the top of the cart. They were not observed to sanitize the wrist cuff. On 07/26/24 at 7:27 a.m., CMA #1 was observed to obtain a blood pressure on Resident #11 using a wrist cuff. They returned to the cart and placed it on the top of the cart. They were not observed to sanitize the wrist cuff. On 07/26/24 at 7:53 a.m., CMA #1 was observed to obtain a blood pressure on Resident #13 using a wrist cuff. They returned to the cart and placed it on the top of the cart. They were not observed to sanitize the wrist cuff. On 07/26/24 at 8:13 a.m., CMA #1 was asked when should they sanitize the wrist cuff. They stated they sanitized the cuff before and after their medication pass. CMA #1 was asked when should the cuff be sanitized. They stated in between each resident.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL090201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/26/2024
NAME OF PROVIDER OR SUPPLIER SAND SAGE OF THE HIGHLANDS		STREET ADDRESS, CITY, STATE, ZIP CODE 1017 WEST HIGHWAY 152 MUSTANG, OK 73064			
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C1505	Continued From page 13 4. Resident #6 had diagnoses which included dementia, heart failure and high blood pressure. Resident #6's weight record documented Resident #6 was 120 pounds on 04/01/24 and 109 pounds on 07/01/24. A "Dieticians Recommendations for Primary Care Provider", dated 07/16/24, read in part "Significant weight loss: Loss 9.2%/3m...Resident would benefit from nutritional supplement...HS TID to increase caloric intake due to recent weight loss and BMI 18 underweight..." The recommendation was not signed by the physician. Resident #6's physician orders, dated July 2024, did not contain documentation nutritional supplements had been ordered. Resident #6's medication administration record, dated July 2024, did not contain documentation Resident #6 had been started on the nutritional supplements related to weight loss. On 07/26/24 at 11:00 a.m., Resident #6's weights were reviewed with the RCD. They were asked if Resident #6 was receiving the nutritional supplements as recommended by the dietitian. They stated there was no physician order for supplements. They were asked where the documentation would be if Resident #6 had been started on the supplements. They reviewed the July 2024 medication administration record and stated the supplements had not been started.	C1505			
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may	C5010			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL090201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/26/2024
NAME OF PROVIDER OR SUPPLIER SAND SAGE OF THE HIGHLANDS		STREET ADDRESS, CITY, STATE, ZIP CODE 1017 WEST HIGHWAY 152 MUSTANG, OK 73064		
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C5010	Continued From page 14 receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on observation, record review and interview the center failed to coordinate care with a third party provider for one (#3) of one sampled resident reviewed for third party providers. The RCD identified 50 residents resided in the	C5010		

Oklahoma State Department of Health

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C5010	Continued From page 15 center. Findings: A "Wound and Skin Care" policy, dated 12-01-23, read in part "...Whenever a Care Staff Member observes an area of concern on a resident's skin...redness, wound...etc...the Care Staff Member is to note it on the End of Shift Report and report it to the Resident Care Director...the community nurse or designees will meet with the resident, complete the Skin Integrity Monitoring Form and document in the resident's electronic health record..." Resident #3 had diagnoses which included, COPD, dementia and anxiety. A "Plan of Care Update", dated 04/20/24 to 06/18/24 was the most current Hospice plan of care for Resident #3 in the clinical health record. Resident #3's "Outside Agency Documentation" notes, dated 06/04/24, 06/06/24, 06/10/24, 06/13/24, 06/17/24, 06/26/24, 06/26/24, 07/02/24, 07/05/24, 07/09/24, 07/13/24, and 07/16/24 documented wound care was provided. A hospice visit note, dated 07/21/24, read in part, "...bruising ulcer/wounds present...Ear rt, skin tear...PT has bruising to right side of face and right eye along with a skin tear to right ear cartilage area...PT can lift [their] right arm, leg...Facility requested xray of face to make sure of no fractures. This nurse did not see any other wounds, abrasions, or bruising this visit post fall to right side of body..." An "Outside Agency Documentation" note dated 07/23/24 at 6:54 p.m., documented Hospice	C5010		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL090201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/26/2024
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C5010	Continued From page 16 performed wound care to the resident's right ear. There was no documentation a wound was observed on Resident #3's right shin. On 07/24/24 at 1:54 p.m., Resident #3 was observed sitting on their walker in the hallway. Resident #3 was observed to have deep purple discoloration to their right eye, on their neck, shoulder and arms bilateral. On 07/25/24 at 9:09 a.m., Resident #3 was observed sitting in their recliner in their room. They were asked about the bruising on their eye. They stated they had fallen in their room. A dressing was observed on Resident #3's left shin. There was no date on the dressing. On 07/25/24 at 11:10 a.m., the RCD was asked if there was an order for wound care for Resident #3. They stated there was not one. They were asked how did they know what wound care had been provided in the past for Resident #3 according to the outside communication notes. They stated they did not know. They were asked if care had been coordinated with hospice. They stated, "No." They stated the wound to the right shin was healed on 07/19/24. On 07/25/24 at 11:42 a.m., the RCD was asked what orders were in place for the wound care on Resident #3's shin. They stated "Hospice does it." On 07/25/24 at 12:54 p.m., the RCD was asked if Resident #3 had been injured when they fell on 07/21/24. They stated the incident report documented there was a bruise to the face and the residents ear was bleeding. The RCD was not aware of the fall on 07/21/24. The RCD was asked for the current hospice plan of care.	C5010		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL090201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/26/2024
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C5010	Continued From page 17 On 07/25/24 at 1:09 a.m., the RCD peeled back the dressing and observed the wound on Resident #3's leg. They stated there was no date on the dressing and there was a dried scabbed area with a dark crust on the wound and an open area at nine o'clock. They were not aware of the wound. On 07/25/24 at 3:04 p.m., hospice nurse #1 was asked when the wound had started in the past and what were the wound care orders. They reviewed their computer notes and stated the wound had started on 06/04/24. The wound care order that had been provided in the past was cleanse with normal saline and gauze then cover with a zero foam dressing. A late entry progress note, dated 07/26/24 at 9:51 a.m., read in part, "...Late entry for 7/25/24 3:00 PM: Focus charting r/t area on LLE. State surveyor notified RCD of a bandage to residents LLE with no treatment noted, dated or initials [sic] on bandage. RCD and state surveyor went to resident room to observe area....RCD removed wet to dry dressing noted dark reddish, and yellowish drainage to bandage, no smell, on the LLE was a reopened area, warm to touch and tender upon touch...RCD notified hospice of concern..." There was no documentation from 07/21/24 through 07/26/24 in the progress notes related to the wound on Resident #3's left shin.	C5010		

Delivery via email to: westplainsed@islllc.com

September 9, 2024

License Number: AL090201

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

RE: Survey Event DF1511

Dear Ms. Benson:

On **July 26, 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 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 **October 18, 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,

Clorissa Nubine

Clorissa Nubine, 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: 9/5/2024		
	Facility Name: Sand Sage of the Highlands		
	License Number: AL090201		
	Survey Event ID: DF1511		
Date Survey Completed: 7/26/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C301		Based on: observation, record review and interview the facility failed to ensure a resident with multiple falls did not exceed the centers level of care for one (#8) of eight sampled residents.	
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?		Executive Director and Resident Care Director to schedule care conference with family and resident to discuss move to long-term care facility and provide referrals.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Executive Director and Resident Care Director to conduct full audit of resident assessments to ensure continued appropriate placement and/or need for plan of accommodation.	
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?		Executive Director, Resident Care Director or designee to conduct random audits to ensure compliance over the next 90 days.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		Enter methods to ensure corrections are sustained: Full chart audits will be completed to ensure by Executive Director, Resident Care Director or designee to ensure all requirements are met. Will be reviewed at QA Meeting. Care assessment reviews will be documented.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/18/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Laura Benson OAC 310:663-25-4(F)			Date 9/5/2024
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: 9/5/2024		
	Facility Name: Sand Sage of the Highlands		
	License Number: AL090201		
	Survey Event ID: DF1511		
Date Survey Completed: 7/26/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C391		Based on: observation, record review, and interview the enter failed to ensure food was stored, labeled and dated according to center policy.	
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?		The cook will evaluate the food prep and storage areas for items no longer in their original containers. If such food items are identified, they will be labeled and dated with preparation date and expiration date.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Culinary Services Director will inservice culinary staff on policy and procedure for labeling and dating food and proper food storage. Inservice will be documented and signed by culinary staff by 9/20.	
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?		Culinary Services Director and Executive Director will do weekly checks and random spot checks over the next 90 days to ensure policy is being followed. Checks will be documented.	
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.		Center will keep documented logs of weekly checks. Culinary Services Director and Executive Director will meet weekly to ensure checks are being completed and accurate. Discussion of deficiency each month. QA team will review documented checks for accuracy. The log binder will be created and kept in the kitchen and logs will be pulled every 30 days and placed in Executive Director office.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/18/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Laura Benson OAC 310:663-25-4(F)			Date 9/5/2024
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: 9/5/2024		
	Facility Name: Sand Sage of the Highlands		
	License Number: AL090201		
	Survey Event ID: DF1511		
Date Survey Completed: 7/26/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C521		Based on: record review and interview, the center failed to ensure an admission assessment was completed 30 days before or at the time of admission for one (#4) of eight sample residents reviewed for admission assessments.	
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?		Executive Director will conduct inservice with Resident Care Director regarding compliance of all new resident admission assessments by 9/20/24.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Resident Care Director or designee to audit all resident charts to ensure compliance of the above.	
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?		Executive Director and Resident Care Director will meet weekly 1:1 to review all new admissions and assessments and kept in binder to ensure compliance of the above.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		Enter methods to ensure corrections are sustained: Full chart audits will be completed by Executive Director, Resident Care Director or designee to ensure all requirements are met. Binder will be brought to QA meetings for discussion. The binder to be kept in Executive Director office.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/18/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Laura Benson OAC 310:663-25-4(F)			Date 9/5/2024
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: 9/5/2024		
	Facility Name: Sand Sage of the Highlands		
	License Number: AL09021		
	Survey Event ID: DF1511		
Date Survey Completed: 7/26/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C542		Based on: record review and interview, the center failed to ensure assessments were coordinated by a physician or RN for one (#2) of eight sampled residence reviewed for assessments coordinated by an RN or physician.	
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?		The RN reviewed and signed resident #2 assessment on August 12, 2024.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		The RN delegation scheduled the first week of each month to sign all RN requirements.	
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?		RN delegation binder to include assessments requiring RN signature monthly.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Enter methods to ensure corrections are sustained:	
a. How the correction will be evaluated for effectiveness;		Full chart audits will be completed to ensure RN signatures and all requirements are met. RN delegation to be continuously scheduled monthly to ensure compliance.	
b. How the correction will be incorporated into the center's quality assurance system; and		Binder will be brought to QA Meetings to discuss assessments needing signed or to file ones that need to be signed.	
c. How monitoring records will be kept to evidence the correction.		RN Delegation binder will be kept in ED office.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/18/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Laura Benson OAC 310:663-25-4(F)			Date 9/5/2024
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.			
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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: 9/5/2024

Facility Name: Sand Sage of the Highlands

License Number: AL090201

Survey Event ID: DF1511

Date Survey Completed: 7/26/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: observation, record review and interview the enter failed to a. ensure forty eight hour assessments were completed after falls for one (#3) of two sampled residents reviewed for falls, b. ensure the medication cart was locked when unattended, c. ensure a blood pressure cuff was sanitized between use for three (#11, #12 and #13) of five sampled residents reviewed during medication observation, and d. follow a dietician recommendation and implement meal supplements for one (#6) of one sampled resident reviewed for weight loss.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Inservice to be conducted by Executive Director to Resident Care Director to ensure that all residents who have falls to complete alert charting for 48 hours by 9/20/24.

Inservice to be conducted by Resident Care Director to all CMA/MAT's to ensure that medication cart is to remain locked at all times when unattended as well as inservice on infection control to specifically include sanitizing blood pressure cuff in between resident use by 9/20/24.

Executive Director to inservice Resident Care Director and Culinary Services Director to ensure all dietary recommendations are being followed and documented by 9/20/24.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

Resident Care Director or designee to audit all resident charts to ensure compliance of the above.

Resident Care Director to inservice care staff on infection control by 9/20/24.

Culinary Services Director to audit dietary orders for any special dietary recommendations by 9/20/24.

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?

Random checks for incidents requiring 48 hour alert charting.

Executive Director, Resident Care Director or designee to conduct weekly med cart checks over 30 days.

		Culinary Services Director to conduct random dietary orders over the next 30 days.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		Enter methods to ensure corrections are sustained: Full chart audits will be completed to ensure by Executive Director, Resident Care Director or designee to ensure all requirements are met. Binder will be brought to QA meetings for discussion. The binder to be kept in Executive Director office.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/18/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Laura Benson OAC 310:663-25-4(F)		Date 9/5/2024	
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: 9/5/2024		
	Facility Name: Sand Sage of the Highlands		
	License Number: AL090201		
	Survey Event ID: DF1511		
Date Survey Completed: 7/26/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C5010		Based on: observation, record review and interview the center failed to coordinate care with a third party provider for one (#3) of one sampled resident reviewed for third party providers.	
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?		Resident Care Director will conduct a Care and Services-Coordination of Care inservice to all care staff to ensure compliance to include care coordination form and end of shift 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?		Monthly coordination of care meetings to be performed with every third-party provider that services residents in the facility. Training and coordination with Third-party on documentation and processes they need to follow to by 9/20/24.	
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?		Monthly coordination of care meeting will be performed to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		Enter methods to ensure corrections are sustained: Random chart audits will be completed by Executive Director, Resident Care Director or designee to ensure all requirements are met for the next 90 days. Will be reviewed at QA meeting. Monthly coordination of care meetings will be documented.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/18/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Laura Benson OAC 310:663-25-4(F)			Date 9/5/2024
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.			
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Delivery via email to: westplainsed@islllc.com

October 22, 2024

License Number: AL090201
Survey Event ID: DF1512

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

Dear Ms. Benson:

On **October 22, 2024**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **July 26, 2024**, have now been corrected and your facility is in compliance with licensure standards effective **October 18, 2024**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
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: AL090201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/22/2024
NAME OF PROVIDER OR SUPPLIER SAND SAGE OF THE HIGHLANDS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 On 10/22/24, an offsite/revisit was conducted. The deficiencies from 07/26/24 were cleared.	{C 000}			

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Delivery via email to: westplainsed@islllc.com

October 22, 2024

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Oklahoma State Department of Health

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(X6) DATE