



Oklahoma State Department of Health
Creating a State of Health

December 5, 2019

License Number: AL1403

Ms. Holly Jerman-Miller, Administrator
Rambling Oaks Assisted Living
1060 Rambling Oaks Drive
Norman, OK 73072

RE: Survey Event ID: FXZW11

Dear Ms. Jerman-Miller:

On **October 30, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on October 30, 2019.

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;

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- (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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,



 Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL1403	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER RAMBLING OAKS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 RAMBLING OAKS DRIVE NORMAN, OK 73072		
(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
N 000	Initial Comments A re-licensure survey was conducted on 10/28/19 through 10/30/19. Current census was 51. The following deficient practice was cited.	N 000		
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to have a licensed nurse validate certified medications skills for 11 of 12 certified medication aides. This failed practice had the potential for more than minimal harm at a pattern. Findings: Certified medication aides (CMA) skills were reviewed and documented the long term care aide (LTCA)/CMA/employee #1 had signed off on all twelve CMAs' skills validation checklist. She identified herself as the trainer/supervisor on the skills checklist. On 10/30/19 at 10:47 a.m., the LTCA)/CMA/employee #1 stated she signed off all the CMA skills validations. She stated the licensed nurse had not signed the skills validation check lists for 11 CMAs working in the center.	N1442		

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

TITLE

(X6) DATE

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N1442	Continued From page 1 POLICY A medication program policy, dated 01/2018, documented, "...The community will assure compliance with all State Law and Regulations...The Executive Director (or designee) will assure staff assisting or administering medications are trained per state requirements and have successfully passed all required training prior to assisting or administering medications..."	N1442			
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 10/28/19 through 10/30/19. Current census was 51. The following deficient practices were cited.	C 000			
C 391 SS=F	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, interview, it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regards to kitchen equipment, cleanliness, preparation and meal service: 310:257-3-16. Prohibition Except for a plain ring such as a wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry	C 391			

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C 391	Continued From page 2 on their arms or hands. 310:257-5-37. Food Storage (a) Except as specified in (b) and (c) of this Section, food shall be protected from concentration by storing the food: (3) At least 15 cm (centimeters) (6 inches) above the floor... 310:257-7-10. Nonstick coatings, use limitation Multi-use kitchenware such as frying pans, griddles, sauce pans, cookie sheets, and waffle bakers that have a perfluorocarbon resin coating shall be used with nonscoring or nonscratching utensils and cleaning aids. 310:257-7-58. Sanitizing solutions, testing devices A test kit or other device that accurately measures the concentration in mg/L (milligrams per liter) of sanitizing solutions shall be provided. 310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (a) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits... (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulations of dust, dirt, food residue, and other debris. These failed practices had the potential for more than minimal harm for all 51 residents who	C 391			

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C 391	Continued From page 3 received their nutrition from the kitchen. Findings: On 10/29/19 at 9:52 a.m., a tour of the kitchen and dining room began and the following were observed: JEWELRY At 11:28 a.m., cook/employee #16 was observed as she wore five rings and a silver colored watch while she prepared the lunch meal. She had two silver colored rings on her right hand and three silver colored rings on her left hand. She stated two of the rings had clear stones in them. Cook/employee #16 did not wear gloves as she stirred mixed vegetables in a large pan, nor did she wear gloves as she transferred tornados (rolled tortillas filled with beef and cheese processed food). FOOD STORAGE At 12:35 p.m., a storage room down the hall from the dining room was observed with the dietary manager, and was completely disorganized and overfilled with food, decorations, Styrofoam products, cleaning equipment, cases of water, and other miscellaneous items. There were stacks and piles of opened boxes of food products and gallon bottles of food products were stored on the floor. TEST KIT At 9:55 a.m., the dishwasher was checked for sanitation by dietary aide/employee and registered at 200 parts per million (ppm). She checked it again and received the same results. The bottle of test strips expired in July 2019 (3	C 391		

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C 391	Continued From page 4 months previous). ICE MACHINE At 10:11 a.m., a medium sized chest type ice machine had thick hard white deposit streaks across the top just above the lid. A strip of metal hung loosely near the streaks. The deflector shield had thick dark gray/brownish slimy substance all the way across it, with ice stacked up to and on the shield. The dietary manager stated she told maintenance/employee #15 the machine needed repair and to be cleaned, because it had been at least three months since the last cleaning. EQUIPMENT At 10:06 a.m., a tag on the ventilation hood system was dated last cleaned on February 2018. The ventilation hood had a grease buildup, with grease and dust also on the ledges. The metal and glass light covers were coated with grease and thick gray dust. At 11:01 a.m., maintenance/employee #15 was asked for the most recent cleaning date of the ventilation hood. He stated, "February 2018." At 11:25 a.m., there was a large white pedestal fan on the floor across from the dishwashing machine, with the fan shrouds and blades covered with thick gray dust. It was on high, and blew toward the sandwich preparation table. A vertical black fan with the front covered in thick gray dust was on high speed and blew toward the dishwashing machine. Five ceiling vents in the kitchen and dishwashing area were coated with rust and some of them	C 391		

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C 391	Continued From page 5 were cracked and broken. Five skillets of varying sizes hung from the ceiling, just to the right of the three compartment sink. Four of the skillets had their nonstick coating covered with scratches to the point of being completely missing. One large stainless steel skillet had thick black coating all around it. The dietary manager stated the largest skillet was used to make grilled cheese sandwiches. The tops of three toasters on the sandwich preparation table were covered with thick sticky substance, and full of crumbs, that fell out when moved. POLICY An undated dietary policy documented, "...The Community will maintain a copy of all of local and state codes or rules governing the preparation, service, and storage of food... Food is stored off the floor in a manner that permits cleaning underneath the shelves, racks, or platforms... Contents of open cases will be stored on shelves... Food is purchased in quantities which can be stored properly... Food is arranged in storage areas in food groups to make it easier to store, locate, and inventory... Maintain all major kitchen equipment in good working condition by ensuring regularly scheduled... Perform regularly scheduled maintenance and cleaning on kitchen equipment... Conduct routine cleaning of kitchen equipment on a regular basis by the food service staff... Food contact surfaces of grills, griddles, stove tops, etc. should be cleaned daily and as needed	C 391		

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C 391	Continued From page 6 throughout the day... Food contact equipment...will be cleaned and sanitized after each use .."	C 391		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment for 8 (#1 through #7 and #10) of 10 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: Residents #1 through #7 and #10's comprehensive assessments did not contain a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. On 10/30/19 at 2:22 p.m., the licensed practical nurse/regional operations specialist stated the residents or their representatives should have	C 543		

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C 543	Continued From page 7 signed the assessments indicating an interview had been conducted.	C 543			
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure hot water temperatures at faucets accessible to the residents did not exceed 115 degrees Fahrenheit (F) for 8 (#6 through #10, and #11 through #13) of 13 sampled residents' rooms. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 10/28/19 from 3:11 p.m. through 4:03 p.m., an environmental tour was completed with the assistance of maintenance/employee #15 to check hot water temperatures throughout the center. The following hot water temperatures in the rooms registered above the required 115 degrees F: Room 119 - 116.1 degrees F; Room 204 - 118.4 degrees F;	C 701			

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C 701	Continued From page 8 Room 205 - 118.6 degrees F; Room 211 - 134.6 degrees F; Room 213 - 129.5 degrees F; Room 214 - 125.6 degrees F; Room 215 - 126.1 degrees F; and Room 224 - 116.2 degrees F. At 3:39 p.m., maintenance/employee #15 stated there were six apartments/rooms on the south hall that had hot water that came from the same tank used by the kitchen and it ran "a little hot." He further stated the water had been too hot for about a year. Water temperature logs were requested after the maintenance/employee #15 stated he had documented water temperatures. No water temperature logs were submitted.	C 701		
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,	C1505		

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C1505	Continued From page 9 and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure: a) Physician's ordered blood sugar and cholesterol medications were administered correctly for 1 (#3) of 1 sampled resident who received employee administered medications; and b) Medications were available for administration for 1 (#11) of 10 sampled residents who received employee administered medications. These failed practices had the potential for more than minimal harm at a pattern. Findings: RESIDENT #3 Resident #3 had diagnoses which included diabetes and hyperlipidemia. A client coordination note, dated 02/19/19, documented an interaction between the resident's medications diltiazem (used to treat high blood pressure and chest pain) and lovastatin (used to treat high cholesterol). The physician ordered the lovastatin to be discontinued and rosuvastatin (Crestor) (cholesterol medication) 5 mg daily to be started. The Crestor medication order was not entered into the electronic medication	C1505			

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C1505	Continued From page 10 administration record (MAR) and had not been administered. A physician order for resident #3, dated 02/26/19, documented Glipizide XL (used to treat high blood sugar) 2.5 mg one tablet was to be administered daily before breakfast. The medication was not entered into the electronic MAR and had not been administered, since it was ordered. On 10/30/19 at 10:39 a.m., long term care aide/certified medication aide (LTCA/CMA) stated she contacted the physician and the Glipizide should have been started on 02/26/19. She stated it had not been administered to the resident since the order was written. At 2:22 p.m., licensed practical nurse/regional operations specialist stated the lovastatin had been discontinued on 02/19/19, but the rosuvastatin (Crestor) had not been started. She stated the medication had not been administered to the resident. RESIDENT #11 Resident #11 had an order for Vitamin D3 (uses as a supplement), Metolazone 2.5 mg (used to treat high blood pressure and fluid retention) and Pantoprazole (used to treat gastroesophageal reflux disease and stomach ulcers) 40 mg to be administered daily. A October 2019 MAR for resident #11, documented the Vitamin D3 had not been administered on 10/23/19, 10/24/19, 10/25/19 and 10/28/19, and Metolazone and Pantoprazole were not administered on 10/28/19, due to these medications not being available for	C1505		

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C1505	Continued From page 11 administration. On 10/29/19 at 3:40 p.m., the registered nurse stated she would have to check and see why the medications were not available for administration. No further explanation was given for the medications not being available for administration.	C1505		
C1921 SS=E	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to administer medication according to the physician's order for 1 (#11) of 10 sampled residents who were administered medication by the center's staff. This deficient practice had the potential for more than minimal harm at a pattern. Findings: On 10/29/19 at 11:16 a.m. resident #11 was administered hydrazaline for a diagnosis of hypertension. Resident #11's physician's orders were later reviewed and documented a stop order for the hydrazaline had been written by the physician on 10/28/19, and faxed to the center on 10/28/19 at 1:40 p.m. Resident #11's medication administration record documented the hydrazaline was administered to	C1921		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER RAMBLING OAKS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 RAMBLING OAKS DRIVE NORMAN, OK 73072		
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C1921	Continued From page 12 her on 10/28/19 at 4:00 p.m., 10/29/19 at 8:00 a.m., and 12:00 p.m., after the stop order had been received by the center. The MAR did not document the medication had been discontinued. At 3:40 p.m., the registered nurse stated the hydralazine should not have been administered on the evening of 10/28/19 or on 10/29/19. POLICY A medication program, dated 01/2018, documented, "...The Community will have Medical Provider's Orders for all medications...The Resident's Medication Administration Record (MAR) will include the Medical Provider's Orders including new orders, changes to orders, discontinued orders..."	C1921		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure records were accurate and organized, to include: a) Residents' do not resuscitate (DNR) status matched all documents in the residents' records	C1951		

Oklahoma State Department of Health

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C1951	Continued From page 13 for 4 (#3, 5, 7, and #10) of 10 sampled residents; and b) Quarterly pharmacy consultant reports were in the center and available for review for the last quarter of 2018 and the first quarter of 2019. Theses failed practices had the potential for more than minimal harm at a pattern. Findings: CODE STATUS Resident #3, 5, 7, and #10 had signed DNR consent forms in their records. The residents' electronic medication administration records (eMAR) and physicians' orders documented the residents were full codes. On 10/30/19 at 2:22 p.m., the licensed practical nurse/regional operations specialist stated the eMARs and physicians' orders were incorrect. She stated all the documents should match. She stated the residents had DNR consent forms signed and were not full codes. PHARMACY REPORTS On 10/29/19, the pharmacy consultant reports were reviewed and the last quarter 2018 and first quarter 2019 pharmacy consultant reports could not be located. The reports were requested two times during the survey and not provided. Licensed practical nurse/regional operations specialist stated she thought the reports had been provided but she did not know where the reports were located. POLICY A Resident-Advance Directives and Do Not	C1951			

Oklahoma State Department of Health

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C1951	Continued From page 14 Resuscitate (DNR) policy, dated 01/2018, documented, "...The community will make reasonable attempts to assure the health care preferences of Residents are honored...DNR status information will be added to the Community's communication system so staff is aware of the Resident's choice..."	C1951		

STATE WORKLOAD REPORT

 Provider/Supplier Number
 AL1403

 Provider/Supplier Name
 RAMBLING OAKS ASSISTED LIVING

Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. <i>mk</i> 36191	10/28/2019	10/30/2019	0.25	0.00	18.50	0.00	5.50	6.00
2. <i>mk</i> 25837	10/28/2019	10/30/2019	0.50	0.00	13.25	0.00	5.00	5.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

Total RO Clerical/Data Entry Hours....

0.00

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

 DEC 09 2019 *jm*



Oklahoma State Department of Health
Creating a State of Health

December 26, 2019

License Number: AL1403

Ms. Holly Jerman-Miller, Administrator
Rambling Oaks Assisted Living
1060 Rambling Oaks Drive
Norman, OK 73072

RE: Survey Event FXZW11

Dear Ms. Jerman-Miller:

On October 30, 2019, 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 **February 3, 2020**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

for Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

Board of Health

Gary Cox, JD
Commissioner of Health

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N 000	Initial Comments A re-licensure survey was conducted on 10/28/19 through 10/30/19. Current census was 51. The following deficient practice was cited.	N 000		
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to have a licensed nurse validate certified medications skills for 11 of 12 certified medication aides. This failed practice had the potential for more than minimal harm at a pattern. Findings: Certified medication aides (CMA) skills were reviewed and documented the long term care aide (LTCA)/CMA/employee #1 had signed off on all twelve CMAs' skills validation checklist. She identified herself as the trainer/supervisor on the skills checklist. On 10/30/19 at 10:47 a.m., the LTCA/CMA/employee #1 stated she signed off all the CMA skills validations. She stated the licensed nurse had not signed the skills validation check lists for 11 CMAs working in the center.	N1442		

*See
attached
POC*

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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N1442	Continued From page 1 POLICY A medication program policy, dated 01/2018, documented, "...The community will assure compliance with all State Law and Regulations...The Executive Director (or designee) will assure staff assisting or administering medications are trained per state requirements and have successfully passed all required training prior to assisting or administering medications..."	N1442		
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 10/28/19 through 10/30/19. Current census was 61. The following deficient practices were cited.	C 000		
C 391 SS=F	310-863-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 267 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, interview, it was determined the center failed to ensure compliance with Chapter 267 Food Service Establishment Regulations in regards to kitchen equipment, cleanliness, preparation and meal service: 310:267-3-16. Prohibition Except for a plain ring such as a wedding band, while preparing food, food employees may not	C 391		

See
Attached
POC

Oklahoma State Department of Health

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C 391	Continued From page 2 wear jewelry including medical information jewelry on their arms or hands. 310:257-5-37. Food Storage (a) Except as specified in (b) and (c) of this Section, food shall be protected from contamination by storing the food: (3) At least 15 cm (centimeters) (6 inches) above the floor... 310:257-7-10. Nonstick coatings, use limitation Multl-use kitchenware such as frying pans, griddles, sauce pans, cookie sheets, and waffle makers that have a perfluorocarbon resin coating shall be used with nonscoring or nonscratching utensils and cleaning aids. 310:257-7-58. Sanitizing solutions, testing devices A test kit or other device that accurately measures the concentration in mg/L (milligrams per liter) of sanitizing solutions shall be provided. 310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (a) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits... (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulations of dust, dirt, food residue, and other debris. These failed practices had the potential for more	C 391	see attached PDC	

Oklahoma State Department of Health

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C 391	Continued From page 3 than minimal harm for all 51 residents who received their nutrition from the kitchen. Findings: On 10/29/19 at 9:52 a.m., a tour of the kitchen and dining room began and the following were observed: JEWELRY At 11:28 a.m., cook/employee #16 was observed as she wore five rings and a silver colored watch while she prepared the lunch meal. She had two silver colored rings on her right hand and three silver colored rings on her left hand. She stated two of the rings had clear stones in them. Cook/employee #16 did not wear gloves as she stirred mixed vegetables in a large pan, nor did she wear gloves as she transferred tornados (rolled tortillas filled with beef and cheese processed food). FOOD STORAGE At 12:35 p.m., a storage room down the hall from the dining room was observed with the dietary manager, and was completely disorganized and overfilled with food, decorations, Styrofoam products, cleaning equipment, cases of water, and other miscellaneous items. There were stacks and piles of opened boxes of food products and gallon bottles of food products were stored on the floor. TEST KIT At 9:55 a.m., the dishwasher was checked for sanitation by dietary aide/employee and registered at 200 parts per million (ppm). She checked it again and received the same results.	C 391		

Oklahoma State Department of Health

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C 391	Continued From page 4 The bottle of test strips expired in July 2019 (3 months previous). ICE MACHINE At 10:11 a.m., a medium sized chest type ice machine had thick hard white deposit streaks across the top just above the lid. A strip of metal hung loosely near the streaks. The deflector shield had thick dark gray/brownish slimy substance all the way across it, with ice stacked up to and on the shield. The dietary manager stated she told maintenance/employee #15 the machine needed repair and to be cleaned, because it had been at least three months since the last cleaning. EQUIPMENT At 10:06 a.m., a tag on the ventilation hood system was dated last cleaned on February 2018. The ventilation hood had a grease buildup, with grease and dust also on the ledges. The metal and glass light covers were coated with grease and thick gray dust. At 11:01 a.m., maintenance/employee #15 was asked for the most recent cleaning date of the ventilation hood. He stated, "February 2018." At 11:25 a.m., there was a large white pedestal fan on the floor across from the dishwashing machine, with the fan shrouds and blades covered with thick gray dust. It was on high, and blew toward the sandwich preparation table. A vertical black fan with the front covered in thick gray dust was on high speed and blew toward the dishwashing machine. Five ceiling vents in the kitchen and dishwashing	C 391		

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C 391	Continued From page 5 area were coated with rust and some of them were cracked and broken. Five skillets of varying sizes hung from the ceiling, just to the right of the three compartment sink. Four of the skillets had their nonstick coating covered with scratches to the point of being completely missing. One large stainless steel skillet had thick black coating all around it. The dietary manager stated the largest skillet was used to make grilled cheese sandwiches. The tops of three toasters on the sandwich preparation table were covered with thick sticky substance, and full of crumbs, that fell out when moved. POLICY An undated dietary policy documented, "...The Community will maintain a copy of all of local and state codes or rules governing the preparation, service, and storage of food... Food is stored off the floor in a manner that permits cleaning underneath the shelves, racks, or platforms... Contents of open cases will be stored on shelves... Food is purchased in quantities which can be stored properly... Food is arranged in storage areas in food groups to make it easier to store, locate, and inventory... Maintain all major kitchen equipment in good working condition by ensuring regularly scheduled... Perform regularly scheduled maintenance and cleaning on kitchen equipment... Conduct routine cleaning of kitchen equipment on a regular basis by the food service staff... Food contact surfaces of grills, griddles, stove	C 391		

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C 391	Continued From page 6 tops, etc, should be cleaned daily and as needed throughout the day... Food contact equipment...will be cleaned and sanitized after each use..."	C 391		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure each comprehensive assessment contained a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person completing the assessment for 8 (#1 through #7 and #10) of 10 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: Residents #1 through #7 and #10's comprehensive assessments did not contain a signature to indicate a personal interview had been conducted between the resident or the resident's representative and the person who had completed the assessment. On 10/30/19 at 2:22 p.m., the licensed practical nurse/regional operations specialist stated the	C 543		

See attached POC

Oklahoma State Department of Health

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C 543	Continued From page 7 residents or their representatives should have signed the assessments indicating an interview had been conducted.	C 543		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure hot water temperatures at faucets accessible to the residents did not exceed 115 degrees Fahrenheit (F) for 8 (#6 through #10, and #11 through #13) of 13 sampled residents' rooms. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 10/28/19 from 3:11 p.m. through 4:03 p.m., an environmental tour was completed with the assistance of maintenance/employee #15 to check hot water temperatures throughout the center. The following hot water temperatures in the rooms registered above the required 115 degrees F: Room 119 - 116.1 degrees F;	C 701		

See Attached POC

Oklahoma State Department of Health

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C 701	Continued From page 8 Room 204 - 118.4 degrees F; Room 205 - 118.6 degrees F; Room 211 - 134.6 degrees F; Room 213 - 129.5 degrees F; Room 214 - 125.6 degrees F; Room 215 - 126.1 degrees F; and Room 224 - 116.2 degrees F. At 3:39 p.m., maintenance/employee #15 stated there were six apartments/rooms on the south hall that had hot water that came from the same tank used by the kitchen and it ran "a little hot." He further stated the water had been too hot for about a year. Water temperature logs were requested after the maintenance/employee #15 stated he had documented water temperatures. No water temperature logs were submitted.	C 701		
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	C1505	See attached POC	

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER RAMBLING OAKS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1080 RAMBLING OAKS DRIVE NORMAN, OK 73072		
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C1505	Continued From page 9 understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure: a) Physician's ordered blood sugar and cholesterol medications were administered correctly for 1 (#3) of 1 sampled resident who received employee administered medications; and b) Medications were available for administration for 1 (#11) of 10 sampled residents who received employee administered medications. These failed practices had the potential for more than minimal harm at a pattern. Findings: RESIDENT #3 Resident #3 had diagnoses which included diabetes and hyperlipidemia. A client coordination note, dated 02/19/19, documented an interaction between the resident's medications diltiazem (used to treat high blood pressure and chest pain) and lovastatin (used to treat high cholesterol). The physician ordered the lovastatin to be discontinued and rosuvastatin (Crestor) (cholesterol medication) 5 mg daily to be started. The Crestor medication order was not	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1403	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER RAMBLING OAKS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 RAMBLING OAKS DRIVE NORMAN, OK 73072		
(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 10 entered into the electronic medication administration record (MAR) and had not been administered. A physician order for resident #3, dated 02/26/19, documented Glipizide XL (used to treat high blood sugar) 2.5 mg one tablet was to be administered daily before breakfast. The medication was not entered into the electronic MAR and had not been administered, since it was ordered. On 10/30/19 at 10:39 a.m., long term care aide/certified medication aide (LTCA/CMA) stated she contacted the physician and the Glipizide should have been started on 02/26/19. She stated it had not been administered to the resident since the order was written. At 2:22 p.m., licensed practical nurse/regional operations specialist stated the lovastatin had been discontinued on 02/19/19, but the rosuvastatin (Crestor) had not been started. She stated the medication had not been administered to the resident. RESIDENT #11 Resident #11 had an order for Vitamin D3 (uses as a supplement), Metolazone 2.5 mg (used to treat high blood pressure and fluid retention) and Pantoprazole (used to treat gastroesophageal reflux disease and stomach ulcers) 40 mg to be administered daily. A October 2019 MAR for resident #11, documented the Vitamin D3 had not been administered on 10/23/19, 10/24/19, 10/25/19 and 10/28/19, and Metolazone and Pantoprazole were not administered on 10/28/19, due to these	C1505		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1403	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER RAMBLING OAKS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1080 RAMBLING OAKS DRIVE NORMAN, OK 73072		
(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 medications not being available for administration. On 10/29/19 at 3:40 p.m., the registered nurse stated she would have to check and see why the medications were not available for administration. No further explanation was given for the medications not being available for administration.	C1505		
C1921 SSE	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to administer medication according to the physician's order for 1 (#11) of 10 sampled residents who were administered medication by the center's staff. This deficient practice had the potential for more than minimal harm at a pattern. Findings: On 10/29/19 at 11:16 a.m. resident #11 was administered hydrazaline for a diagnosis of hypertension. Resident #11's physician's orders were later reviewed and documented a stop order for the hydrazaline had been written by the physician on 10/28/19, and faxed to the center on 10/28/19 at 1:40 p.m. Resident #11's medication administration record	C1921		

*See
Attached
POC*

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1403	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER RAMBLING OAKS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 RAMBLING OAKS DRIVE NORMAN, OK 73072		
(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
C1921	Continued From page 12 documented the hydralazine was administered to her on 10/28/19 at 4:00 p.m., 10/29/19 at 8:00 a.m., and 12:00 p.m., after the stop order had been received by the center. The MAR did not document the medication had been discontinued. At 3:40 p.m., the registered nurse stated the hydralazine should not have been administered on the evening of 10/28/19 or on 10/29/19. POLICY A medication program, dated 01/2018, documented, "...The Community will have Medical Provider's Orders for all medications...The Resident's Medication Administration Record (MAR) will include the Medical Provider's Orders including new orders, changes to orders, discontinued orders..."	C1921		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure records were accurate and organized, to include: a) Residents' do not resuscitate (DNR) status	C1951	See attached POC	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1403	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER RAMBLING OAKS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 RAMBLING OAKS DRIVE NORMAN, OK 73072		
(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
C1981	Continued From page 13 matched all documents in the residents' records for 4 (#3, 5, 7, and #10) of 10 sampled residents; and b) Quarterly pharmacy consultant reports were in the center and available for review for the last quarter of 2018 and the first quarter of 2019. These failed practices had the potential for more than minimal harm at a pattern. Findings: CODE STATUS Resident #3, 5, 7, and #10 had signed DNR consent forms in their records. The residents' electronic medication administration records (eMAR) and physicians' orders documented the residents were full codes. On 10/30/19 at 2:22 p.m., the licensed practical nurse/regional operations specialist stated the eMARs and physicians' orders were incorrect. She stated all the documents should match. She stated the residents had DNR consent forms signed and were not full codes. PHARMACY REPORTS On 10/29/19, the pharmacy consultant reports were reviewed and the last quarter 2018 and first quarter 2019 pharmacy consultant reports could not be located. The reports were requested two times during the survey and not provided. Licensed practical nurse/regional operations specialist stated she thought the reports had been provided but she did not know where the reports were located. POLICY	C1951		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1403	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2019
NAME OF PROVIDER OR SUPPLIER RAMBLING OAKS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 RAMBLING OAKS DRIVE NORMAN, OK 73072		
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C1951	Continued From page 14 A Resident-Advance Directives and Do Not Resuscitate (DNR) policy, dated 01/2018, documented, "...The community will make reasonable attempts to assure the health care preferences of Residents are honored...DNR status information will be added to the Community's communication system so staff is aware of the Resident's choice..."	C1951		



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/16/2019

Facility Name: Rambling Oaks Assisted Living

License Number: AL1403

Survey Event ID: FXZW11

Date Survey Completed: 10/30/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1442

Based on: Interview and record review, it was determined the center failed to have a licensed nurse validate certified medications skills for 11 Of 12 certified medication aides. This failed practice had the potential for more than minimal harm at a pattern.

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?

OSDH Response: Element accepted: Yes ☒ No ☐

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

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?

OSDH Response: Element accepted: Yes ☒ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

100% of current Certified Medication Aides' skills will be reviewed for competency by the nurse.

All Residents receiving Staff Medication Administration services had the potential to be affected by the same deficient practice.

Regional Director of Clinical Services In-serviced Wellness Director on completing required CMA Competency Check on hire/annually for all CMAs 11/19/19.
Executive Director will In-service Business Office Manager tracking of CMA Competency Checks on hire/annually and filling in Employee Record.
Wellness Director, or other nurse, will complete CMA Competency Checklist for CMA on hire prior to medication administration/annually ongoing.

The Executive Director, or designee, will audit for completion of correction weekly x 60 days or until 100% complete. The Business Office Manager, or designee, will audit for presence of CMA Competency Checklist for each CMA New Hire and annually with quarterly Employee Record review ongoing. Quality Assurance committee will review audits/findings mentioned above and Implement plan of correction as necessary at least quarterly.

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?		2/3/2020	
OSDH Response Element accepted: Yes ☐ No ☐			
Administrator's Signature <i>Administrator signature required.</i> <i>[Signature]</i>		Date Enter a date of signature. <i>2/3/20</i> <i>12/20/16</i>	
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.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 12/18/2019

Facility Name: Rambling Oaks Assisted Living

License Number: AL 1403

Survey Event ID: FXZW11

Date Survey Completed: 10/30/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: observation, interview, it was determined this center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regards to kitchen equipment, cleanliness, preparation and meal service.

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

All Dietary Staff will be Inserviced by the Executive Director, or designee, on proper Food Storage, Preparation and Service, as per the State Regulations.

All Dietary Staff will be Inserviced by the Executive Director, or designee, on the MSL Company Policy on Food Storage/Prep/Services.

The Dietary Manager will attend an update on her Food Service Training and will attend the food service training program offered or approved by the Department. The Executive Director will assist the Dietary Manager in locating this program and enrolling in the next available class.

Dietary Manager or designee will conduct random weekly audits to ensure proper sanitation standards are followed:

- 1) No jewelry is being worn at any time while prepping food.
- 2) Gloves are being worn while cooking/serving food;
- 3) Proper cooking utensils are being used while preparing food;
- 4) No personal items/belongings within the kitchen area;
- 5) Proper food storage is being utilized and all boxes/food/containers are at least 15 inches off of the floor.
- 6) The Kitchen is cleaned daily free from grease and dust and all surfaces, pans, and utensils are free from grease, dust, or unclean particles.
- 7) All storage areas for kitchen equipment is properly maintained and cleaned, as well as, containers stored within the required marked areas in the storage closets.

	The Dietary Manager, or designee, will do weekly audits to ensure the dish machine has adequate test strips that have not expired and the dish machine is being tested per company policy/state regulations. The Maintenance Director, or designee, will do weekly audits of the ice machine to ensure it is working properly, free from any hanging particles or broken areas, and being cleaned as required. The Dietary Manager, or designee, will check the ice machine 2 X per week for cleanliness and log the date and time it was cleaned on the audit log. The Executive Director, or designee, will conduct monthly kitchen audits with the Dietary Manager to ensure that the kitchen standards are maintained and remain in compliance. Audits will be presented to the Quality Assurance Committee and monitored for compliance. Any issues will be discussed during the meeting.
OSDH Response: Element accepted: Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All Residents had the potential to be affected by the same deficient practice. Executive Director, or designee, will perform monthly kitchen audits and address any concerns immediately. The Dietary Manager will attend an update on her Food Service Training and will attend the food service training program offered or approved by the Department. The Executive Director will assist the Dietary Manager in locating this program and enrolling in the next available class.
OSDH Response: Element accepted: Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All Dietary Staff will be inserviced by the Executive Director, or designee, on proper Food Storage, Preparation and Service, as per the State Regulations. All Dietary Staff will be inserviced by the Executive Director, or designee, on the MSL Company Policy on Food Storage/Prep/Services. The Dietary Manager will attend an update on her Food

		Service Training and will attend the food service training program offered or approved by the Department. The Executive Director will assist the Dietary Manager in locating this program and enrolling in the next available class. Weekly random audits will be performed by the dietary manager, or designee, to ensure proper food handling and preparation/storage and cleanliness is following required state regulations.	
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.		The Executive Director, or designee, will conduct monthly kitchen audits with the Dietary Manager, to ensure that they kitchen standards are maintained and remain in compliance. The Dietary Manager, or designee will perform random weekly audits to ensure proper food handling and preparation/storage and cleanliness is following required state regulations. The Maintenance Director will conduct weekly audits of the ice machine to ensure that it is working properly, free from any hanging particles or broken areas, and being cleaned as required. The Dietary Manager, or designee, will check the ice machine 2 X per week for cleanliness and log the date and time it was cleaned on the audit log. Audits will be presented to the Quality Assurance Committee and monitored for compliance. Any issues will be discussed during the meeting. 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?		2/3/2020	
OSDH Response: Element accepted: Yes ☐ No ☐			
Administrator's Signature Administrator Signature required. OAC 310:663-25-4(F)		Date Enter a date of signature.	
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.			