
Delivery via email to: Slee@homesteadofclinton.com

January 26, 2023

License Number: AL2002

Ms. Julie Byerly, Administrator
Homestead Of Clinton
3200 West Hayes
Clinton, OK 73601

RE: Survey Event ID: LJ1L11

Dear Ms. Byerly:

On **January 13, 2023**, 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 **January 13, 2023**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT

Facility: Homestead of Clinton
Address: 3200 West Hayes
City, State, Zip: Clinton, OK 73601
Provider #: AL2002
Complaint #: OK00055547
Investigation Date(s): 01/10/23 through 01/13/23

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents received adequate and appropriate medical care	US
2. The center failed to provide a clean comfortable environment	US
3. The center failed to provide adequate supervision to prevent falls	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 01/10/2023 at 12:00 p.m.

A sample of nine residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to adequate and appropriate medical care was conducted.

Upon entry residents were clean, well-groomed and appropriately dressed for the season. Residents were observed throughout the survey and no concerns were identified with residents not dressed. Meal service was observed and residents received assistance appropriate for the need of the individual in the dining room and the individual living quarters. Staff were observed to assist residents with transfers and ambulation. Gait belts were observed to be utilized appropriately. There were no concerns regarding wheelchair without footrests.

The clinical records documented the functioning level of the resident. No concerns were identified with the assistance provided as required for transfers, ambulation, dressing, turning or meal assistance. One resident had a healing pressure wound that had been obtained during an acute illness that required hospitalization.

Residents voiced no concerns regarding staff assistance. Residents reported staff are kind, patient, and available to assist. Residents denied concerns with availability and/or assistance with clean clothing or dressing. Residents denied the need for assistance to turn or reposition while in bed. Residents reported the meals were served timely and choices were allowed for an alternate menu. One resident reported having a heel wound that was obtained during a hospital stay, which has improved with care at the center.

Staff were knowledgeable of resident's needs and assisted appropriately to the level of care required. Staff were knowledgeable for the services provided by third party providers for multiple residents. A communication tool was in place to ensure communication of the resident status or concerns.

At the time of the investigation, the facility provided adequate and appropriate medical care for pressure ulcers, wheelchair and equipment, transfers with gait belts, dressing, turning and repositioning, and meal assistance.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to a clean, comfortable environment was conducted.

Upon entry and throughout the investigation, random observations were made of the center's environment. There were no lingering odors. Common areas were clean and tidy. Residents were observed in the common areas and in their living quarters. There were no lingering odors. Residents were clean, well-groomed and appropriately dressed for the season. Staff were observed to assist clients for toileting, dressing, bathing, and laundry services.

Residents stated staff were helpful and available to assist as needed. Residents did not have complaints of the cleanliness or home like environment.

Staff were knowledgeable of clients whose status required assistance.

At the time of the investigation, the center was in substantial compliance to provide a clean and comfortable environment.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, C-1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation number three. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation number two. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Carrie Randall, RN, Clinical Health Facility Surveyor

Date report completed: 01/18/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/13/2023
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CLINTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WEST HAYES CLINTON, OK 73601		
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C 000	INITIAL COMMENTS A relicensure survey was conducted from 01/10/23 through 01/13/23. A complaint investigation (#OK00055547) was conducted in conjunction with the survey. The following abbreviations will be used in the writing of this report. BMI-Body Mass Index BSC-Bedside Commode h-hour HCD-Health Care Director POA-Power of Attorney q-every RCC-Resident Care Coordinator	C 000		
C1303 SS=E	310:663-13-1(c) RESIDENT SERVICE CONTRACT (c) The assisted living center shall ensure that the resident or the resident's representative, if any, is informed of all provisions of the resident service contract. This Rule is not met as evidenced by: Based on record review and interview the center failed to ensure residents or their representatives were informed on all provisions of the contract for eight (#1, 2, 3, 4, 6, 7, 8, and #9) of nine contracts reviewed.	C1303		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

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C1303	Continued From page 1 The RCC identified 22 residents resided in the center. Findings: The "Assisted Living Lease Agreement," for Residents #1, 2, 3, 4, 6, 7, 8, and #9 were reviewed and did not contain the resident was informed of all provisions of the contract in the agreement. On 01/13/22 at 12:43 p.m., the Administrator was shown the agreements and asked to review for the missing component (all provisions of the contract). The Administrator stated, "You looked through two and they were not there, they are all the same."	C1303		
C1329 SS=E	310:663-13-2(9) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (9) conformity with state law; This Rule is not met as evidenced by: Based on record review and interview, the center failed to include a clear statement of conformity with state law in the resident service agreement for eight (#1, 2, 3, 4, 6, 7, 8, and #9) of nine contracts reviewed. The RCC identified 22 residents resided in the center. Findings: The "Assisted Living Lease Agreement," for	C1329		

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C1329	Continued From page 2 Residents #1, 2, 3, 4, 6, 7, 8, and #9 were reviewed and did not contain a statement of conformity with state law in the agreement. On 01/13/22 at 12:43 p.m., the Administrator was shown the agreements and asked to review for the missing components (a statement of conformity with the state law). The Administrator stated, "You looked through two and they were not there, they are all the same."	C1329		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and interview the center failed to a. complete post fall risk assessments and 72 hour observation assessments for two (#1 and #3), b. update care plans with fall prevention interventions after falls for two (#1, and #3) of three sampled residents reviewed for falls, and c. monitor and implement care plan interventions for weight loss for one (#3) of three sampled residents reviewed for weight loss. The RCC identified 22 residents resided in the center. Findings: An undated "Fall Management" policy, read in parts, "...Residents will be re-evaluated annually, after each fall, and with any significant change...The facility management team will update the resident's plan of care with an intervention following each fall to reduce the risk of reoccurrence and/or future injuries...Fall	C1505		

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C1505	Continued From page 4 interventions will be communicated to all staff via the resident specific plan of care...An assessment will be completed...following each fall event...A daily follow-up nurse note will be completed in the electronic medical record for 72 hours..." An undated "Weight Monitoring" policy, read in parts, "...the person obtaining the weights will compare the residents previous monthly weight to the current weight. Re-weights will be obtained immediately when there is a difference of 3 pounds from the previous weight. If the resident has edema present, this must be assessed by a nurse...The weights will be reviewed by the RCC or designees, who will determine which residents are to be reviewed for additional interventions...Unexpected weight loss (3-5-7.5%)...report to the physician and POA..." 1. Resident #1 had diagnoses which included, anxiety, type 2 diabetes mellitus, and chronic kidney disease stage three. Resident #1's initial "Care Plan," dated 11/05/21 did not document any care plan interventions for prevention of falls. An annual "Resident Assessment Form," dated 05/03/22, read in parts, "...Alert...confused at times...good judgment...uses walker for ambulation..." A "Nurse Note," dated 07/11/22, read in parts, "...During staff round resident found sitting on buttock near back door of room...No obvious injuries...Education provided to wear call pendant at all times..." An "Assisted Living Fall Risk," dated 08/02/22 at 3:25 a.m., read in parts, "...Score 13...A score of	C1505		

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C1505	Continued From page 5 10 or more indicates high-risk for falls. If score in any section is greater than zero, resident is at risk for falls. This must be care planned and interventions put into place immediately..." A "Nurse Note," dated 08/02/22 at 4:55 p.m., read in parts, "...Staff responded to call pendant alarm and found resident sitting on buttock next to bed...Discussed with family about getting a different lower bed to help stabilize resident when [the resident] is getting up as to not slide to the floor..." Resident #1's care plan did not contain any interventions for fall prevention were implemented after the fall on 07/11/22. The clinical record did not document Resident #1 had been monitored for 72 hours after the fall. A "Nurse Note," dated 08/03/22 at 10:09 a.m., read in parts, "...During staff rounds resident found sitting next to bed on buttock and back against mattress..." Resident #1's "Care Plan" review, dated 08/03/22, read in parts, "Falls...After a fall and before moving the resident, evaluate the resident for changes in range of motion and notify the nurse before moving the resident...Fall risk assessment to be completed every six months, after a fall and with any significant change...Place non-slip adhesive to floor by bed to help prevent sliding..." The care plan dated 08/03/22, was the first care plan that addressed fall risk with interventions. The clinical record did not document the Resident had been monitored for 72 hours after the fall.	C1505		

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C1505	Continued From page 6 A "Nurse Note," dated 08/25/22 at 3:09 p.m., read in parts, "...During rounds resident found sitting on the floor next to bed. States that [they] slid out of bed..." Resident #1's care plan did not document any fall interventions were placed after the fall. The clinical record did not document Resident #1 had been monitored for 72 hours after a fall. A "Nurse Note," dated 09/06/22 at 9:03 a.m., read in parts, "...9/4/22 [1:00a.m.]...Staff responded to call pendant alarm and found resident sitting on the floor in private bathroom within apartment blood coming from head... EMS contacted and resident sent to[hospital]...Hospital records report no acute fractures or intracranial hemorrhage..." A "Assisted Living Fall Risk," dated 09/04/22 at 03:25 a.m., read in parts, "...Score 15...A score of 10 or more indicates high-risk for falls. If score in any section is greater than zero, resident is at risk for falls. This must be care planned and interventions put into place immediately..." The clinical record did not document Resident #1 had been monitored for 72 hours after the fall. Resident #1's "Care Plan," review, dated 09/06/22, read in parts, "Falls...Therapy provided by [name] Home Health if therapy services might be needed to increase strength and work on gait/mobility..." A "Nurse Note," dated 12/09/22 at 7:24 p.m., read in parts, "...Staff responded to call pendant alarm and found resident sitting on buttock on floor in room. resident states that [they] slid onto the floor from bed...No reports of head injury. No bruising, redness noted...no reports of pain..."	C1505		

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C1505	Continued From page 7 A "Nurse Note," dated 12/09/22 at 7:30 p.m., read in parts, "...Staff reports to nurse that resident is sitting in the main living area. Increased confusion, dizziness and nausea...It is recommended by this nurse to send resident to the hospital due to changes in status..." A "Assisted Living Fall Risk," dated 12/09/22 at 11:45 [did not identify morning or night] read in parts, "...Score 13...A score of 10 or more indicates high-risk for falls. If score in any section is greater than zero, resident is at risk for falls. This must be care planned and interventions put into place immediately..." Resident #1's care plan did not document any fall interventions were placed after the fall. The clinical record did not document Resident #1 had been monitored for 72 hours after the fall on 12/09/22. On 01/12/23 at 4:04 p.m., the RCC was asked if Resident #1 had been monitored for 72 hours after the falls on 07/11/22, 08/02/22, 08/03/22, 08/25/22 and 12/09/22. They stated, "No." The RCC was asked if any care plan interventions had been put into place after the resident fell on 07/11/22. They stated, no. The RCC was asked if a fall risk assessment had been completed on 08/03/22 after the resident had a fall. The RCC stated, "Not one done." The RCC was asked in a fall risk assessment had been completed after the resident had a fall on 08/25/22. The RCC stated, "No it was not." The HCD was asked if the care plan had been updated. The HCD stated, "None in the care	C1505		

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C1505	Continued From page 8 plan." The RCC was asked if there were any interventions updated in the care plan after the fall on 12/09/22. The RCC stated, "We lowered the bed, repositioned it, assist with transfers, it is not in the care plan." 2. Resident #3 had diagnoses which included, anxiety, high blood pressure, and Alzheimer's. Resident #3's "Care Plan," dated 11/02/22, read in parts, "Falls...Encourage participation in activities that will increase strength and mobility...Sometimes [the resident] may forget to use their walker when they are walking, so please provide reminders to use assistive devices...Dietary and Nutrition...will maintain current weight...Facility to prepare and serve three meals a day 7 days a week...may need reminders to go to meals in the dining room..." A "Nurse Note, dated 12/13/22, read in parts,"...Staff responded to pendant alarm...Staff found resident sitting on the floor in bathroom doorway...Resident is requesting BSC to be used at nights due to urinary urgency..." A "Assisted Living Fall Risk," dated 12/13/22, read in parts, "...Score 6...A score of 10 or more indicates high-risk for falls. If score in any section is greater than zero, resident is at risk for falls. This must be care planned and interventions put into place immediately..." The care plan had not been updated to include fall interventions after the fall on 12/13/22. A "Nurse Note," dated 12/15/22, read in parts, "...Staff reports resident on the floor to nurse."	C1505		

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C1505	Continued From page 9 Reports that [they] lost [their] balance and "rolled down the wall and hit [their] head...EMS contacted due to facility policy of head injury and anticoagulant medication..." The care plan had not been updated to include fall interventions after the fall on 12/15/22. A "Nurse Note," dated 12/16/22 at 10:55 a.m., read in parts, " Per ER report...Acute, comminuted fracture of the distal clavicle with separation of the acromion and coracoid process suspicious for ligament injury...Resident will be re-educated for fall prevention and staff will offer bathroom assistance q 2 h..." Resident #3's care plan did not document any interventions had been put into place after the resident had a fall on 12/13/22 and 12/15/22. The clinical record contained no documentation 72 hour monitoring had been completed after the fall on 12/15/22. The clinical record documented Resident #3's weights as follows: On 10/24/22 the resident weighed 151.6 pounds, On 11/02/22 the resident weighed 150.4 pounds, On 11/09/22 the resident weighed 150.0 pounds, On 11/15/22 the resident weighed 145.6 pounds, On 11/23/22 the resident weighed 144.7 pounds (A weight loss of 6.9 pounds for a 4.55% from previous weight on 10/24/22.), and On 12/15/22 the resident weighed 142.9 pounds. A "Health Technologies Inc. Nutritional Care Form," dated 12/26/22, read in parts, "...Initial Assessment...Weight: 142.9, BMI 25...Plan of Care: Monitor food intake, should be over 75%..." The clinical record did not contain documentation	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/13/2023
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CLINTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WEST HAYES CLINTON, OK 73601		
(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 Resident #3's meal intake had been monitored per the dietician recommendation. On 01/12/23 at 3:14 p.m., the RCC was asked if a fall risk assessment was completed after Resident #3 had a fall on 12/15/22. They stated, "No." The RCC was asked what interventions were had been put into place for fall prevention after the fall on 12/13/22 and 12/15/22. They stated, there was nothing updated in the care plan. They were asked if they had followed the fall policy, they stated, no. On 01/12/23 at 4:11 p.m., the RCC was asked if they were aware of Resident #3 weight loss from 10/24/22 to 11/23/22. The RCC stated, "Yes, we have been encouraging [the resident] to eat. The RCC was asked if the physician had been aware of the weight loss. The RCC stated, the resident saw the physician on 12/16/22. The RCC was asked if the center had a dietician. They stated, yes. The RCC was asked if they had implemented care plan interventions for weight loss. They stated, "No." The RCC was asked if they could get a current weight on Resident #3. LPN #2 left and returned and stated the residents current weight was 134 pounds. Resident #3 had a weight loss of 8.9 pounds for a 6.23% from previous weight on 12/15/22. On 01/13/22 at 12:05 p.m., the RCC was asked if they had addressed Resident #3's weight loss, the RCC stated there was no documentation but they had interviewed the resident for food likes and dislikes. The RCC was asked if they had been monitoring the residents intake to ensure it was 75% per the dietician nutritional care form.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2023
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WEST HAYES CLINTON, OK 73601		
(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 They stated, "check on it but it is out of assisted living scope to assess that."	C1505			

Delivery via email to: slee@homesteadofclinton.com

February 10, 2023

License Number: AL2002

Ms. Stacey Lee, Administrator/Executive Director
Homestead Of Clinton
3200 West Hayes
Clinton, OK 73601

RE: Survey Event LJ1L11

Dear Ms. Lee:

On **January 13, 2023**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1505:** The plan of correction does not contain measurable time frames for the monitoring and audits to be completed.

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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services



Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/30/2023

Facility Name: Homestead of Clinton

License Number: AL2002

Survey Event ID: LJ1L11

Date Survey Completed: 1/13/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1303

Based on: Based on record review and interview the center failed to ensure residents or their representatives were informed on all provisions of the contract for eight (#1,2,3,4,6,7,8 and #9) of nine contracts reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required
John Byrd

Date Enter date of signature.

2/1/23

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.](#)



Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/30/2023

Facility Name: Homestead of Clinton

License Number: AL2002

Survey Event ID: LJ1L11

Date Survey Completed: 1/13/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1329

Based on: Based on record review and interview the center failed to include a clear statement of conformity with state law in the resident service agreement for eight (#1,2,3,4,6,7,8 and #9) of nine contracts reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature *John B. Blythe*

OAC 310:663-25-4(F)

Date Enter a date of signature.

2/1/23

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

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2023
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WEST HAYES CLINTON, OK 73601		
(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 They stated, "check on it but it is out of assisted living scope to assess that."	C1505			

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.](#)



Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/30/2023

Facility Name: Homestead of Clinton

License Number: AL2002

Survey Event ID: LJ1L11

Date Survey Completed: 1/13/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: a. complete post fall risk assessments and 72hour observation assessments for two (#1 and #3), b. update care plans with fall prevention interventions after falls for two (#1, and #3) of three sampled residents reviewed for falls, and c. monitor and implement care plan interventions for weight loss for one (#3) of three sampled residents reviewed for weight loss. The RCC identified 22 residents resided in the center.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

a. A fall risk assessment will be completed after every fall.
B. The resident will be observed for and documented on, post fall adverse effects for 72 hours. The care plan will be updated with interventions post falls. Staff will be educated to report any s/s for 72 hours post fall and on care plan interventions.
c. Resident wts will be monitored weekly for gain/loss. The person taking the wts and/or resident care coordinator will compare previous wts to the current wts. If there is a difference of 3 lbs. from the previous wt. the nurse will assess the resident and report to the physician and POA. Care plans will be updated to address gain/loss. Staff will be educated to report changes in wts to the nurse routinely.

OSDH Response: Element accepted Yes ☐ No ☐

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

Every fall will be addressed in the same manner as stated above.
Every resident's weights will be addressed in the same manner as stated 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?

The resident care coordinator will ensure that the monitoring of fall reporting, documentation and care plan updates occur for every fall. Staff will be educated on importance of reporting to the nurse in a timely manner. The resident care coordinator will monitor weights weekly on every resident. Staff will be educated to report changes in wts to the nurse routinely.
The regional RN and float LPN will monitor compliance with random audits. Resident care coordinator will report concerns to the regional RN.

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 regional RN and float LPN will monitor compliance with random audits. a. The resident care coordinator, regional RN and float LPN will monitor resident findings for wt. gain/loss with the expectation that trending information will identify issues to be addressed, in a timely manner. The resident care coordinator will report concerns to the regional RN. b. Residents who have been identified as having issues with wt. gain/loss will be trended for improvement post implementation of interventions to address issue. Falls are trended to identify residents with falls and repeat falls. Interventions will be evaluated for effectiveness for both wt gain/loss and falls. c. Record of trending, effectiveness of interventions will be maintained in the QA binder.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/24/2023	
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.			

Delivery via email to: jbyerly@homesteadofelkcity.com

February 15, 2023

License Number: AL2002

Ms. Julie Byerly, Administrator
Homestead Of Clinton
3200 West Hayes
Clinton, OK 73601

Survey Event ID: LJ1L11

Dear Ms. Byerly:

On **January 13, 2023**, a Relicensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **March 1, 2023**.

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

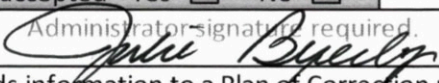
Respectfully,

Tempal Killman
Digitally signed by Tempal Killman
Date: 2023.02.15 09:01:55 -06'00'

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

enc

 OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/30/2023	
	Facility Name: Homestead of Clinton	
	License Number: AL2002	
	Survey Event ID: LJ1L11	
Date Survey Completed: 1/13/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1303	Based on: Based on record review and interview the center failed to ensure residents and their representatives were informed on all provisions of the contract for eight (#1,2,3,4,6,7,8 and #9) of nine contracts reviewed.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.		
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		All residents will sign the state approved Lease Agreement which includes the signature acknowledgment of review and receipt page. Implementing 2/6 and request return of signed contract by 2/24. The ED will audit completion of this action on 2/21 and will contact any residents and family/POA members who have not signed, to complete immediately.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		All residents are included in his correction. All residents will sign the state approved Lease Agreement which includes the signature acknowledgment of review and receipt page. Implementing 2/6 and request return of signed contract by 2/24. The ED will audit completion of this action on 2/21 and will contact any residents and family/POA members who have not signed, to complete immediately.
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 previous versions will be removed. The ED will ensure that all future signings will be completed on the state approved Lease Agreement beginning 2/1. Routine audits will be performed by the ED of the center to ensure the state approved Lease Agreement is being used at all times beginning 2/24 and ongoing. Enter methods to evaluate for effectiveness:
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		a. Routine audits will be performed by the ED of the center to ensure the state approved Lease Agreement is being used at all times beginning 2/24 and ongoing. b. The plan of corrections will be written to address this citation and include the monitoring plan by the ED. The plan will be written by 2/6 and implemented immediately.

c. How monitoring records will be kept to evidence the correction.		Enter methods to incorporate into QA system: c. The ED will keep a log of reviews completed upon completion of each review. Implement on 2/6 and ongoing	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/1/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. 		Date Enter a date of signature. 2-10-23	
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

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/30/2023

Facility Name: Homestead of Clinton

License Number: AL2002

Survey Event ID: UJ1L11

Date Survey Completed: 1/13/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1329

Based on: Based on record review and interview the center failed to include a clear statement of conformity with state law in the resident service agreement for eight (#1,2,3,4,6,7,8 and #9) of nine contracts reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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 residents will sign the state approved Lease Agreement which contains the statement for conformity with state law. Center will begin contacting residents and family/POA members on 2/6 to sign contract and return by 2/24. The ED will audit completion of this action on 2/21 and will contact any residents and family/POA members who have not signed, to complete immediately.

OSDH Response: Element accepted Yes ☐ No ☐

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

All residents are included in this correction. All residents will sign the state approved Lease Agreement which contains the statement for conformity with state law. Center will begin contacting residents and family/POA members on 2/6 to sign contract and return by 2/24. The ED will audit completion of this action on 2/21 and will contact any residents and family/POA members who have not signed, to complete immediately.

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

The center will use the state approved Lease Agreement going forward. All previous versions will be removed. Center will begin contacting residents and family/POA members on 2/6 to sign contract and return by 2/24. The ED will audit completion of this action on 2/21 and will contact any residents and family/POA members who have not signed, to complete immediately. The ED will ensure that all future signings will be completed on the state approved Lease Agreement beginning 2/1.

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;

The ED will ensure that all future signings will be completed on the state approved Lease Agreement beginning 2/1 and ongoing.

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.		Routine audits will be performed by the ED of the center to ensure the state approved Lease Agreement is being used at all times beginning 2/24 and ongoing. The plan of corrections will be written to address this citation and include the monitoring plan by the ED. The plan will be written by 2/6 and implemented immediately. The ED will keep a log of reviews completed upon completion of each review. Implement on 2/6 and ongoing	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/1/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) 		Date Enter a date of signature. 2-10-23	
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.			



Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/30/2023

Facility Name: Homestead of Clinton

License Number: AL2002

Survey Event ID: UJ1L11

Date Survey Completed: 1/13/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: a. complete post fall risk assessments and 72hour observation assessments for two (#1 and #3), b. update care plans with fall prevention interventions after falls for two (#1, and #3) of three sampled residents reviewed for falls, and c. monitor and implement care plan interventions for weight loss for one (#3) of three sampled residents reviewed for weight loss. The RCC identified 22 residents resided in the center.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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

a. A fall risk assessment will be completed after every fall. Implemented 2/1 and ongoing.
B. The resident will be observed for and documented on, post fall adverse effects for 72 hours. The care plan will be updated with interventions post falls. Implemented on 2/1 and ongoing. Staff will be educated to report any s/s for 72 hours post fall and on care plan interventions. Completed on 1/26.
c. Resident wts will be monitored weekly for gain/loss. Implemented on 2/1. The person taking the wts and/or resident care coordinator will compare previous wts to the current wts. Implemented on 2/1 and ongoing. If there is a difference of 3 lbs. from the previous wt. the nurse will assess the resident and report to the physician and POA. Implemented on 2/1 and ongoing. Care plans will be updated to address gain/loss. Implemented on 2/1 and ongoing. Staff will be educated to report changes in wts to the nurse routinely. Completed on 1/26.
Audit of compliance will be conducted by 3/1 for the month of February and will continue on a monthly basis.

OSDH Response: Element accepted Yes ☐ No ☐

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

Every fall will be addressed in the same manner as stated above.
Every resident's weights will be addressed in the same manner as stated above.
Audit of compliance will be conducted by 3/1 for the month of February and will continue on a monthly basis.

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

The resident care coordinator will ensure that the monitoring of fall reporting, documentation and care plan updates occur for every fall. Implemented on 2/1 and ongoing. Staff will be educated on importance of

	reporting to the nurse in a timely manner. Completed on 1/26. The resident care coordinator will monitor weights weekly on every resident. Implemented on 2/1. Staff will be educated to report changes in wts to the nurse routinely. Completed 1/26. The regional RN and float LPN will monitor compliance with random audits. Implemented on 2/1 and ongoing. Resident care coordinator will report concerns to the regional RN. Implemented 2/1 and ongoing. Audit of compliance will be conducted by 3/1 for the month of February and will continue on a monthly basis.
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 regional RN and float LPN will monitor compliance with random audits. Implemented on 2/1 and ongoing. Audit of compliance will be conducted by 3/1 for the month of February and will continue on a monthly basis. a. The resident care coordinator, regional RN and float LPN will monitor resident findings for wt. gain/loss with the expectation that trending information will identify issues to be addressed, in a timely manner. The resident care coordinator will report concerns to the regional RN. Implemented 2/1 and ongoing. Audit of compliance will be conducted by 3/1 for the month of February and will continue on a monthly basis. b. Residents who have been identified as having issues with wt. gain/loss will be trended for improvement post implementation of interventions to address issue. Implemented 2/1 and ongoing. Falls are trended to identify residents with falls and repeat falls. Implemented 2/1 and ongoing. Interventions will be evaluated for effectiveness for both wt gain/loss and falls. Implemented on 2/1 and ongoing. Audit of compliance will be conducted by 3/1 for the month of February and will continue on a monthly basis. c. Record of trending, effectiveness of interventions will be maintained in the QA binder. Implemented 2/1. Audit of compliance will be conducted by 3/1 for the month of February and will continue on a monthly basis.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/1/2023
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. 	Date Enter a date of signature. 2-10-23

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.			

Delivery via email to: slee@homesteadofclinton.com

March 29, 2023

License Number: AL2002

Ms. Stacey Lee, Administrator
Homestead Of Clinton
3200 West Hayes
Clinton, OK 73601

RE: Survey Event LJ1L12

Dear Ms. Lee:

On **March 27, 2023**, an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 13, 2023**, have now been corrected effective **March 1, 2023**.

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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL2002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 03/27/2023
NAME OF PROVIDER OR SUPPLIER HOMESTEAD OF CLINTON		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 WEST HAYES CLINTON, OK 73601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 03/23/23 and 03/27/23. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE