OKLAHOMA
State Department
of Health

Delivery via email to: Julie Byerly <jbyerly@homesteadofelkcity.com>

April 26, 2024

License Number: AL2002

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

RE: Survey Event ID: LGMT11

Dear Ms. Byerly:

On **April 5, 2024**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **April 5, 2024**.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

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

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

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

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

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,

Lisa Calvin

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2002	A. BUILDING: _____ B. WING _____	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CLINTON	3200 WEST HAYES CLINTON, OK 73601

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 04/03/24 through 04/05/24. Facility Census: 25 Listed below are abbreviations that will be used throughout this document. Cert. - Certified CMA - Certified Medication Assistant CNA - Certified Nursing Assistant Consult. - Consultant F - farenheit mg - milligrams Mrg. - Manager O2 - oxygen PRN - as needed RCC - Resident Care Coordinator	C 000		
C 328 SS=E	310:663-3-3(a)(8) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (8) planned programs for socialization, activities and exercise; and This Rule is not met as evidenced by: Based on record review and interview, the facility	C 328		

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C 328	Continued From page 1 failed to describe the services to be provided for socialization, activities and exercise in the Service Plan for three (#3, 5, and #8) of eight sampled residents whose Service Plans were reviewed. The Administrator identified 25 residents resided at the facility. Findings: 1. Resident #3 was admitted 10/26/22 with diagnoses that included mild cognitive impairment. 2. Resident #5 was admitted 03/23/23 with diagnoses that included dementia. 3. Resident #8 was admitted 04/29/23 with diagnoses that included vascular dementia. On 04/05/24 at 1:10 p.m., the RCC was asked if the services to be provided for socialization, activities, and exercise should be addressed in each residents' Service Plan. They stated yes. The RCC was asked to review the Service Plans for Resident #3, 5, and #8. After reviewing the Service Plans, the RCC acknowledged provisions for socialization, activities, and exercise had not been addressed in the Service Plans for Resident #3, 5, and #8.	C 328		
C 329 SS=D	310:663-3-3(a)(9) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services:	C 329		

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C 329	Continued From page 2 (9) provisions for evacuation of the building structure and staff to meet the evacuation needs of residents.	C 329		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to describe the provisions to meet the evacuation needs of the resident in the Service Plan for two (#2 and #4) of eight sampled residents whose Service Plans were reviewed.

The Administrator identified 25 residents resided at the facility.

Findings:

1. Resident #2 was admitted 06/01/19 with diagnoses that included spondylolisthesis of lumbosacral region and cervical disc degeneration. The 14-Day Assessment, dated 03/17/23, documented resident required one person assist for transferring and ambulation.

2. Resident #4 was admitted 08/18/23 with diagnoses that included rhabdomyolysis and muscle weakness. The 14-Day Assessment, dated 08/18/23, documented resident required one person assist for ambulation.

On 04/05/24 at 1:10 p.m., the RCC was asked if the provisions to meet the evacuation needs of the resident should be addressed in each residents' Service Plan. They stated yes. The

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C 329	Continued From page 3 RCC was asked to review the Service Plans for Resident #2 and #4. After reviewing the Service Plans, the RCC acknowledged provisions to meet the evacuation needs had not been addressed in the Service Plans for Resident #2 and #4.	C 329		
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 and interview, the facility failed to ensure: a. open food items were properly labeled and had identified use-by dates, b. food items were stored at the proper temperatures, and c. food items were not expired. The Administrator identified 25 residents resided at the facility. Findings: On 04/03/24 at 2:45 p.m., the following observations were made during the initial tour of the kitchen. The stand-up freezer contained the following items: 1. an opened plastic bag of uncooked chicken strips with no label or use-by date, 2. a gallon-sized baggie containing herb butter with no label or use-by date, 3. an opened plastic bag containing five	C 391		

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C 391	Continued From page 4	C 391		

uncooked scones with no label or use-by date,
4. an opened plastic bag containing ten uncooked biscuits with no label or use-by date,
5. a gallon-sized baggie containing processed ham slices with no label or use-by date, and
6. a gallon-sized baggie containing slices of cheese with no label or use-by date.

The stand-up refrigerator contained the following items:
1. an opened container of sour cream with no use-by date and expiration date of 02/14/24,
2. an opened jar of chopped garlic with no use-by date and expiration date of 02/17/24, and
3. Thirty unopened 4oz cartons of Mighty Shakes with expiration date of 02/18/24.

The walk-in refrigerator contained the following items:
1. an opened case of 'long johns donuts' that read keep frozen at 0 degrees F to -10 degrees F,
2. three unopened one-half gallon jugs of low-fat buttermilk with expiration date of 03/05/24,
3. a case (3/4 full) of unopened Yoplait yogurts with expiration dates of 02/10/24, and
4. an unopened jar of chopped garlic in water with expiration dates of 02/17/24.

The dry storage room contained the following items:
1. an opened bag of uncooked pasta noodles with no date opened or use-by date,
2. an opened bag of rice krispies cereal with no label, no date opened, or use-by date,
3. an opened bag of fruit loops cereal with no label, no date opened, or use-by date,
4. a. an opened bag of raisin bran cereal with no label, no date opened, or use-by date,
5. an opened bag of pecans with no date opened or use-by date,

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C 391	Continued From page 5 6. an opened bag of yeast with no date opened or use-by date, On 04/03/24 at 3:00 p.m., the Cert. Dietary Mgr. was asked the policy for labeling and storing food items. They stated all food items should be labeled with a date when they are received, when they are opened, and when they should be thrown away. The Cert. Dietary Mgr. also stated if food items were removed from their original container the new container should be labeled saying what is inside and all expired items should be discarded immediately. After reviewing the above findings, the Cert. Dietary Mgr. acknowledged that proper procedures for food handling and storage had not been followed.	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 record review and interview, the facility failed to ensure residents' initial and comprehensive assessments included personal interviews for eight (#1, 2, 3, 4, 5, 6, 7, and #8) of eight sampled residents whose assessments were reviewed.	C 543		

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C 543	Continued From page 6 The Administrator identified 25 residents resided at the facility. Findings: Resident #1 was admitted 09/18/23. An initial assessment, dated 09/26/23, did not include a resident or representative interview. Resident #2 was admitted 06/01/19. An initial assessment, dated 03/17/23, and an annual assessment, dated 09/26/23, did not include a resident or representative interview. Resident #3 was admitted 10/26/22. An annual assessment, dated 11/02/23, did not include a resident or representative interview. Resident #4 was admitted 08/18/23. An initial assessment, dated 08/18/23, did not include a resident or representative interview. Resident #5 was admitted 03/23/23. An initial assessment, dated 03/23/23, and an annual assessment, dated 09/26/23, did not include a resident or representative interview. Resident #6 was admitted 04/20/23. An initial assessment, dated 04/20/23, did not include a resident or representative interview. Resident #7 was admitted 12/13/22. An annual assessment, dated 12/20/23, did not include a resident or representative interview. Resident #8 was admitted 04/29/23. An initial assessment, dated 04/29/23, did not include a resident or representative interview. On 02/27/24 at 2:27 p.m., Nurse Consult. #1	C 543		

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C 543	Continued From page 7 reported the facility did not have a written policy regarding required signatures on the comprehensive assessments. They stated, "We follow the State regulations." Nurse Consult. #1 was asked to review the assessment referenced above and acknowledged they did not contain the required signature for the resident or representative interviewed.	C 543		
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 8	C1505		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to follow-up on recommendations from quarterly pharmacist reviews for four (#2, 3, 6 and #7) of eight sampled residents whose quarterly pharmacy consults were reviewed.

The Administrator identified 25 residents resided at the facility.

Findings:

1. A "Quarterly Pharmacy Review" for Resident #2, dated 09/16/23, read in parts, "...Please note manufacturer prescribing information recommends the dose of citalopram (Celexa) not exceed 20 mg in patients 60 years of age or older...Would you consider reducing to 20 mg daily..."

2. A "Quarterly Pharmacy Review" for Resident #3, dated 09/22/23, read in parts, "...Resident has a routine Lotion order and often refuses it...Would you consider changing it to PRN at this time..."

3. A "Quarterly Pharmacy Review" for Resident #6, dated 09/16/23, read in parts, "...Resident is receiving multiple medications for hypertension...valsartan...clonidine...hydrochlorothiazide... hydralazine...cardizem

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C1505	Continued From page 9 LA...furosemide...Cardizem might contribute to edema. Would you consider discontinuing this medication..." 4. A "Quarterly Pharmacy Review" for Resident #7, dated 09/22/23, read in parts, "...Resident has routine and PRN orders for quetiapine...Would you evaluate and consider discontinuing PRN quetiapine at this time..." There was no documentation on the consultant pharmacist review reports or elsewhere in the medical records of Resident #2, 3, 6, or #7 that the recommendations listed above were reviewed or addressed by the prescriber or the registered nurse. On 04/04/24 at 2:45 p.m., the RCC stated consultant pharmacist review reports were sent to the doctors, but they never got them back. When asked how the above recommendations had been addressed the RCC stated they did not know. On 04/05/24 at 11:45 a.m., Nurse Consult. #1 was asked the facility procedure for handling recommendations from the consultant pharmacist review reports. They stated the reports are given to the RCC to forward to the residents' physicians for review. Nurse Consult. #1 was asked to review the recommendations for Resident #2, 3, 6, and #7 listed above and was informed there was no documentation in the clinical records these issues had been addressed. They stated, "If we don't have them from the physicians, I would say they were not followed up on."	C1505		
C1972 SS=D	310:663-19-4(c) POLICIES	C1972		

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C1972	Continued From page 10 (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure employees received abuse training within 90 days of employment for two (CNA #1 and CMA #2) of six staff reviewed for abuse training. The Administrator identified 25 residents resided at the facility. Findings: 1. CNA #1 had a hire date of 08/28/23. A 'Code of Ethics' statement documented CNA #1 completed abuse training on 02/19/24. 2. CMA #2 had a hire date of 06/16/23. A 'Code of Ethics' statement documented CMA #2 completed abuse training on 04/04/24 On 02/27/24 at 2:30 p.m., the Business Office Mgr. was asked the policy for new hires receiving abuse training. They stated new hires were required to receive abuse training within 90 days of their hire date and acknowledged CNA #1 and CMA #2 had not.	C1972		

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C6000	Continued From page 11	C6000		
C6000 SS=D	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or	C6000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CLINTON	3200 WEST HAYES CLINTON, OK 73601

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C6000	Continued From page 12 denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a criminal history background check and offender registry check was completed on hire for one (Business Office Mgr.) of six staff	C6000		

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C6000	Continued From page 13 reviewed for criminal history background and offender registry checks. The Administrator identified 25 residents resided at the facility. Findings: The Business Office Mgr. had a hire date of 12/11/23. The OK Screen and Registry Evaluation for the Business Office Mgr. was dated 02/29/24. On 04/04/24 at 3:30 p.m., the Administrator was asked the policy for new hires completing background screening and offender registry checks. They stated these checks were completed on new hires before the start of employment. After reviewing the OK Screen and Registry Evaluation for the Business Office Mgr, the Administrator acknowledged facility policy had not been followed.	C6000		

OKLAHOMA
State Department
of Health

Delivery via email to: jbyerly@homesteadofelkcity.com

May 8, 2024

License Number: AL2002

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

RE: Survey Event ID: LGMT11

Dear Ms. Byerly:

This notice replaces the letter from the Department dated **April 26, 2024**. The 2567/State Form was amended on **May 3, 2024,** under administrative review. Please submit your plan of correction in response to this AMENDED statement of deficiencies.

On **April 5, 2024**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **April 5, 2024**.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;

(5) Include dates when corrective action and monitoring will be completed for each violation;

(6) Be signed by the administrator.

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

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

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

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

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health

123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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

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

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

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

Respectfully,

Lisa Calvin

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

Enclosure

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C 000	INITIAL COMMENTS On 05/03/24, the 2567 was amended after administrative review. A relicensure survey was conducted from 04/03/24 through 04/05/24. Facility Census: 25 Listed below are abbreviations that will be used throughout this document. Cert. - Certified CMA - Certified Medication Assistant CNA - Certified Nursing Assistant Consult. - Consultant F - farenheit mg - milligrams Mrg. - Manager O2 - oxygen PRN - as needed RCC - Resident Care Coordinator	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 and interview, the facility failed to ensure: a. open food items were properly labeled and had identified use-by dates, b. food items were stored at the proper temperatures, and c. food items were not expired.	C 391		

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C 391	Continued From page 1 The Administrator identified 25 residents resided at the facility. Findings: On 04/03/24 at 2:45 p.m., the following observations were made during the initial tour of the kitchen. The stand-up freezer contained the following items: 1. an opened plastic bag of uncooked chicken strips with no label or use-by date, 2. a gallon-sized baggie containing herb butter with no label or use-by date, 3. an opened plastic bag containing five uncooked scones with no label or use-by date, 4. an opened plastic bag containing ten uncooked biscuits with no label or use-by date, 5. a gallon-sized baggie containing processed ham slices with no label or use-by date, and 6. a gallon-sized baggie containing slices of cheese with no label or use-by date. The stand-up refrigerator contained the following items: 1. an opened container of sour cream with no use-by date and expiration date of 02/14/24, 2. an opened jar of chopped garlic with no use-by date and expiration date of 02/17/24, and 3. Thirty unopened 4oz cartons of Mighty Shakes with expiration date of 02/18/24. The walk-in refrigerator contained the following items: 1. an opened case of 'long johns donuts' that read keep frozen at 0 degrees F to -10 degrees F, 2. three unopened one-half gallon jugs of low-fat buttermilk with expiration date of 03/05/24, 3. a case (3/4 full) of unopened Yoplait yogurts	C 391		

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C 391	Continued From page 2 with expiration dates of 02/10/24, and 4. an unopened jar of chopped garlic in water with expiration dates of 02/17/24. The dry storage room contained the following items: 1. an opened bag of uncooked pasta noodles with no date opened or use-by date, 2. an opened bag of rice krispies cereal with no label, no date opened, or use-by date, 3. an opened bag of fruit loops cereal with no label, no date opened, or use-by date, 4. a. an opened bag of raisin bran cereal with no label, no date opened, or use-by date, 5. an opened bag of pecans with no date opened or use-by date, 6. an opened bag of yeast with no date opened or use-by date, On 04/03/24 at 3:00 p.m., the Cert. Dietary Mgr. was asked the policy for labeling and storing food items. They stated all food items should be labeled with a date when they are received, when they are opened, and when they should be thrown away. The Cert. Dietary Mgr. also stated if food items were removed from their original container the new container should be labeled saying what is inside and all expired items should be discarded immediately. After reviewing the above findings, the Cert. Dietary Mgr. acknowledged that proper procedures for food handling and storage had not been followed.	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	C 543		

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C 543	Continued From page 3 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 record review and interview, the facility failed to ensure residents' initial and comprehensive assessments included personal interviews for eight (#1, 2, 3, 4, 5, 6, 7, and #8) of eight sampled residents whose assessments were reviewed. The Administrator identified 25 residents resided at the facility. Findings: Resident #1 was admitted 09/18/23. An initial assessment, dated 09/26/23, did not include a resident or representative interview. Resident #2 was admitted 06/01/19. An initial assessment, dated 03/17/23, and an annual assessment, dated 09/26/23, did not include a resident or representative interview. Resident #3 was admitted 10/26/22. An annual assessment, dated 11/02/23, did not include a resident or representative interview. Resident #4 was admitted 08/18/23. An initial assessment, dated 08/18/23, did not include a resident or representative interview. Resident #5 was admitted 03/23/23. An initial assessment, dated 03/23/23, and an annual	C 543		

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C 543	Continued From page 4 assessment, dated 09/26/23, did not include a resident or representative interview. Resident #6 was admitted 04/20/23. An initial assessment, dated 04/20/23, did not include a resident or representative interview. Resident #7 was admitted 12/13/22. An annual assessment, dated 12/20/23, did not include a resident or representative interview. Resident #8 was admitted 04/29/23. An initial assessment, dated 04/29/23, did not include a resident or representative interview. On 02/27/24 at 2:27 p.m., Nurse Consult. #1 reported the facility did not have a written policy regarding required signatures on the comprehensive assessments. They stated, "We follow the State regulations." Nurse Consult. #1 was asked to review the assessment referenced above and acknowledged they did not contain the required signature for the resident or representative interviewed.	C 543		
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	C1505		

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C1505	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow-up on recommendations from quarterly pharmacist reviews for four (#2, 3, 6 and #7) of eight sampled residents whose quarterly pharmacy consults were reviewed. The Administrator identified 25 residents resided at the facility. Findings: 1. A "Quarterly Pharmacy Review" for Resident #2, dated 09/16/23, read in parts, "...Please note	C1505		

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C1505	Continued From page 6 manufacturer prescribing information recommends the dose of citalopram (Celexa) not exceed 20 mg in patients 60 years of age or older...Would you consider reducing to 20 mg daily..." 2. A "Quarterly Pharmacy Review" for Resident #3, dated 09/22/23, read in parts, "...Resident has a routine Lotion order and often refuses it...Would you consider changing it to PRN at this time..." 3. A "Quarterly Pharmacy Review" for Resident #6, dated 09/16/23, read in parts, "...Resident is receiving multiple medications for hypertension...valsartan...clonidine...hydrochlorothiazide... hydralazine...cardizem LA...furosemide...Cardizem might contribute to edema. Would you consider discontinuing this medication..." 4. A "Quarterly Pharmacy Review" for Resident #7, dated 09/22/23, read in parts, "...Resident has routine and PRN orders for quetiapine...Would you evaluate and consider discontinuing PRN quetiapine at this time..." There was no documentation on the consultant pharmacist review reports or elsewhere in the medical records of Resident #2, 3, 6, or #7 that the recommendations listed above were reviewed or addressed by the prescriber or the registered nurse. On 04/04/24 at 2:45 p.m., the RCC stated consultant pharmacist review reports were sent to the doctors, but they never got them back. When asked how the above recommendations had been addressed the RCC stated they did not know.	C1505		

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C1505	Continued From page 7 On 04/05/24 at 11:45 a.m., Nurse Consult. #1 was asked the facility procedure for handling recommendations from the consultant pharmacist review reports. They stated the reports are given to the RCC to forward to the residents' physicians for review. Nurse Consult. #1 was asked to review the recommendations for Resident #2, 3, 6, and #7 listed above and was informed there was no documentation in the clinical records these issues had been addressed. They stated, "If we don't have them from the physicians, I would say they were not followed up on."	C1505		
C1972 SS=D	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure employees received abuse training within 90 days of employment for two (CNA #1 and CMA #2) of six staff reviewed for abuse training. The Administrator identified 25 residents resided at the facility. Findings:	C1972		

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C1972	Continued From page 8 1. CNA #1 had a hire date of 08/28/23. A 'Code of Ethics' statement documented CNA #1 completed abuse training on 02/19/24. 2. CMA #2 had a hire date of 06/16/23. A 'Code of Ethics' statement documented CMA #2 completed abuse training on 04/04/24 On 02/27/24 at 2:30 p.m., the Business Office Mgr. was asked the policy for new hires receiving abuse training. They stated new hires were required to receive abuse training within 90 days of their hire date and acknowledged CNA #1 and CMA #2 had not.	C1972		
C6000 SS=D	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the	C6000		

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C6000	Continued From page 9 same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services.	C6000		

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C6000	Continued From page 10	C6000		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a criminal history background check and offender registry check was completed on hire for one (Business Office Mgr.) of six staff reviewed for criminal history background and offender registry checks.

The Administrator identified 25 residents resided at the facility.

Findings:

The Business Office Mgr. had a hire date of 12/11/23.

The OK Screen and Registry Evaluation for the Business Office Mgr. was dated 02/29/24.

On 04/04/24 at 3:30 p.m., the Administrator was asked the policy for new hires completing background screening and offender registry checks. They stated these checks were completed on new hires before the start of employment. After reviewing the OK Screen and Registry Evaluation for the Business Office Mgr, the Administrator acknowledged facility policy had not been followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2002	A. BUILDING: _____ B. WING _____	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF CLINTON	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

OKLAHOMA
State Department
of Health

Delivery via email to: Julie Byerly <jbyerly@homesteadofelkcity.com>

May 22, 2024

License Number: AL2002

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

RE: Survey Event LGMT11

Dear Ms. Byerly:

On **April 5, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 3, 2024**.

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/2/2024** **Facility Name:** Homestead of Clinton **License Number:** AL2002 **Survey Event ID:** LGMT11 **Date Survey Completed: 4/5/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: observation and interview, the facility failed to ensure:a. open food items were properly labeled and had identified use-by dates, b. food items were stored at the proper temperatures, and c. food items were not expired.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: A

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?	Dietary Manager (DM) and ED will provide training to all dietary staff on the proper labeling of food, open food items, storing food items at proper temperatures and checking expiration dates by 5/10/24. All dietary staff will sign that they have received this training by 5/10/24. DM will perform routine inspections to ensure foods are properly labeled and stored by 5/10/24.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected by this practice and correction. The ED and DM will monitor compliance routinely and ongoing. The ED and/or the DM will provide additional training as need is identified and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	A schedule will be posted in the kitchen for documenting routine inspections as completed and initialed by DM by 5/10/24. ED will review the documentation routinely for compliance and address non-compliance immediately. The ED will provide additional training as need is identified by 5/10/24 and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	a. Routine audits will be performed by the ED and DM to ensure compliance. The ED and/or DM will sign off on the completion of each inspection. Implement 5/10/24 and ongoing. b. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and DM. Written and implemented 5/10/24. Routine audits of the kitchen will be performed by the ED and DM to ensure compliance. Implement 5/10/24 and ongoing. The

	completion of the audit will be kept on a log. The log will be kept with the POC in the QA binder. The ED and /or DM will document any occurrence of non-compliance ongoing and will provide disciplinary counseling and re-training of staff member beginning 5/10/24 and ongoing. The ED and/or the DM will update the Plan of Correction as needed to follow up and ensure goals are met ongoing. c. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and DM. Written and implemented . Routine audits of the audit logs and random checks will be performed by the ED and DM to ensure compliance beginning 5/10/24 and ongoing. The ED and/or the DM will document any occurrence of non-compliance ongoing and will provide disciplinary counseling and re-training as needed to staff member beginning 5/10/24 and ongoing. The completed logs will be kept with the Plan of Correction in the QA Binder. Implement 5/10/24 and ongoing. The completed logs for both kitchens will be kept with the Plan of Correction in the QA Binder. Implement 5/10/24 and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/3/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 5/13/24

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/2/2024** **Facility Name:** Homestead of Clinton **License Number:** AL2002 **Survey Event ID:** LGMT11 **Date Survey Completed: 4/5/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C543	Based on: record review and interview, the facility failed to ensure residents' initial and comprehensive assessments included personal interviews for eight (#1, 2, 3, 4, 5, 6, 7, and #8) of eight sampled residents whose assessments were 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?	The center will include the resident and /or the resident's representative in each assessment and will be verified by the resident's or representatives signature. This will be ongoing practice. The RCC will receive re-training on completion of assessments and inclusion of the resident or resident's representative by 5/10/24.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected. The center will complete an audit of all resident's assessments to ensure that the resident and/ or the resident's representative have been signed. This will be completed by 5/10/24. Enter corrective action for residents affected.
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?	Enter corrective action for residents affected. The center will conduct periodic audits and log audit findings to ensure that the deficient practice has not continued. Corrections will be made as needed. This will be completed by 5/20/24 and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	a.The center will complete an audit of all resident's assessments to ensure that the resident and/or the resident's representative have been signed. By 5/20/24 and ongoing. b. The logs of the audits will be entered into QA and trended for necessary improvements by 5/20/24. This will be ongoing practice. c. The logs of the audits will be entered into the QA binder by 5/20/24 and ongoing. Enter methods to keep monitoring records:

OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/3/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.	**Date** Enter a date of signature. 3/13/24

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/2/2024** **Facility Name:** Homestead of Clinton **License Number:** AL2002 **Survey Event ID:** LGMT11 **Date Survey Completed: 4/5/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: record review and interview, the facility failed to follow-up on recommendations from quarterly pharmacist reviews for four (#2, 3, 6 and #7) of eight sampled residents whose quarterly pharmacy consults were 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?	Upon receipt of pharmacist recommendations, the recommendation will be sent to the physician for consideration and order. All orders received will be entered into EMR. All documents with or without recommendations will be scanned into EMR. RCC will follow up with physician on any current outstanding recommendations and will log receipt of completed recommendations. This will be initiated by 5/10/24.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected by this practice. Upon receipt of pharmacist recommendations, the recommendation will be sent to the physician for consideration and order. All orders received will be entered into EMR. All documents with with or without recommendations will be scanned into EMR. RCC will follow up with physician on any current outstanding recommendations and will log receipt of completed recommendations. This will be initiated by 5/10/24. Enter corrective action for residents affected.
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?	Enter corrective action for residents affected. Upon receipt of pharmacist recommendations, the recommendation will be sent to the physician for consideration and order. All orders received will be entered into EMR. All documents with or without recommendations will be scanned into EMR. RCC will follow up with physician on any current outstanding recommendations and will log receipt of completed recommendations. This will be initiated by 5/10/24.
OSDH Response: Element accepted Yes ☐ No ☐	

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Enter methods to ensure corrections are sustained: The log of sent and received documents will be reviewed quarterly for completion by the RCC and ED starting the end of the 2nd quarter The log will be kept with the QA binder, discussed in the quarterly QA meeting and a plan of correction will be implemented as needed. This will be initiated at the end of the 2nd quarter upon receipt of the pharmacy recommendation report. The log of sent and received documents will be reviewed quarterly for completion by the RCC and ED starting the end of the 2nd quarter. Any plan of correction will be kept with the log upon initiation
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/3/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.	**Date** Enter a date of signature. 5/13/24

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

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

Items Below Are For OSDH Use Only

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/2/2024** **Facility Name:** Homestead of Clinton **License Number:** AL2002 **Survey Event ID:** LGMT11 **Date Survey Completed: 4/5/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1972	Based on: record review and interview, the facility failed to ensure employees received abuse training within 90 days of employment for two (CNA #1 and CMA #2) of six staff reviewed for abuse training

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?	Training on abuse, neglect and exploitation will be added to the onboarding process by 5/10/24. All new employees will received the training and review the policy during hiring and orientation and will verify by signing the document by 5/10/24. All current employees will receive the training and will sign that they have received the training and are aware of their responsibility by 5/15/24. The log/ document of completed training will be kept with the QA binder
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 have the potential to be affected by this practice. Training on abuse, neglect and exploitation will be added to the onboarding process by 5/10/24. All new employees will received the training and review the policy during hiring and orientation and will verify by signing the document by 5/10/24. All current employees will receive the training and will sign that they have received the training and are aware of their responsibility by 5/15/24. The log/ document of completed training will be kept with the QA binder Enter corrective action for residents affected.
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?	Enter corrective action for residents affected. Training on abuse, neglect and exploitation will be added to the onboarding process by 5/10/24. All new employees will received the training and review the policy during hiring and orientation and will verify by signing the document by 5/10/24. This training will be included on a new hire checklist to be followed with all new hires by 5/10/24. All current employees will receive the training and will sign that they have received the training and are aware of their responsibility by 5/15/24. The log/