Oklahoma State Department of Health
Creating a State of Health

December 11, 2019

License Number: AL3301

Ms. Lydia Kay Stewart, Administrator
Tamarack Retirement Center
1224 East Tamarack Road
Altus, OK 73521

RE: Survey Event ID: S2Q111

Dear Ms. Stewart:

On **October 16, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on October 16, 2019.

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

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

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;

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

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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

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

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

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3301	A BUILDING _____ B WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMARACK RETIREMENT CENTER	1224 EAST TAMARACK ROAD ALTUS, OK 73521

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS On 10/14/19 through 10/16/19 a re-licensure survey was conducted. Census was 51. The following deficient practice was cited.	C 000		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review it was determined the registered nurse (RN) failed to ensure the accuracy of the RN monthly medication reviews and ensure the staff delegated to perform monthly medication counts for 2 (#7 and #10) of 2 sampled residents who self-administered medications were performed monthly and were accurate. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #7 Resident #7 diagnoses included: Sleeplessness, chronic obstructive pulmonary disease, cardiomegaly, atrial fibrillation, and macular degeneration, and heart disease. Resident #7 kept his medications in his room and self administered them on a daily basis .	C 911		

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C 911	Continued From page 1 Resident # 7's MAR (Medication Administration Record) for August, September, and October 2019, documented resident #7 self-administered his Alprazalom (Scheduled IV controlled substance) 0.25 mg (milligram) by mouth every night at bedtime for sleeplessness. Resident #7's August, 2019 monthly medication count sheet had no documentation for Alprazolam. The September, 2019 monthly medication count indicated resident #7 had 19 tablets of Alprazolam and administered Alprazolam twice a day as needed. The October, 2019 medication count sheet had not been completed for the month. On 10/15/19 at 09:40 a.m., resident #7 was asked if he administered his Alprazolam last night, he stated he did not. He was asked when the last time he took his Alprazolam, he stated it had been a while. Resident #10 Resident #10 diagnoses included: Essential hypertension, gastroesophageal reflux disease without esophagitis, dysphagia, frequency of micturition, and vitamin D deficiency. Resident #10's MAR, dated September 2019, documented resident #10 self-administered Norco 10 mg (milligrams)/325 mg every 8 hrs (hours) as needed for pain management. The resident did not self-administer Norco 10 mg/325 mg for pain management as indicated on the MAR and no Norco was in her apartment. The RN reported the MAR was sent with the resident for her physician office visit. The physician office visit dated 10/10/19, documented, medications:	C 911		

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C 911	Continued From page 2	C 911		

(no change to current medication regimen) and Norco 10 (milligrams) had been previously prescribed. The appointment on 10/10/19 documented the reason for the visit was for back pain and sinuses. Resident #10 medication count sheets documented zero tablets of Norco for July, August, and September 2019.

Resident #10's MAR's, dated for August and September 2019, documented resident #10 self-administered D3-50,000 units one capsule by mouth daily and vitamin D2-50,000 units one capsule weekly on Friday for a Vitamin D deficiency. The MAR's indicated resident #10 self-administered these medications unsupervised (U-SA).

Resident #10's August and September 2019 medication count sheet did not distinguish between vitamin D3 and vitamin D2. The medication count sheet documented resident #10 had vitamin D.

On 10/15/19 at 3:20 p.m., resident #10 was asked if she self-administer her medications as physician ordered. Resident #10 reported that she did not take her Lasix (water pill) every day as prescribed, she usually administered it three days a week. When asked if she self-administered Vitamin D2-50,000 weekly. Resident #10 stated she did not administer it weekly as prescribed, and presented another bottle of Vitamin D3- 5000 units (not 50,000 units as indicated on the MAR) that she did self-administer daily as prescribed.

Resident #10's physician's order dated 10/10/19, documented, Cefprozil (antibiotic) 500 mg one tablet by mouth twice daily.

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C 911	Continued From page 3 The October 2019, MAR for resident #10, indicated the medication was entered into the computer on 10/10/19, and indicated resident #10 self-administered the medication unsupervised from 10/10/19 through 10/14/19. On 10/14/19, resident #10 had not received this medication to self-administer. The staff obtained this antibiotic from the pharmacy on 10/15/19. On 10/14/19 at 2:43 p.m., registered nurse (RN) was asked about the policy for self-administration of medications. She stated the residents each had a lock box in their apartment and the center counted the medications monthly. At 4:15 p.m., the RN was asked who is responsible for the monthly medication counts, she replied the weekend licensed practical nurse (LPN) performed half of the medication counts and the evening shift LPN performed the remaining medication counts. The RN was asked to review resident #10's September 2019 medication count sheet. The medication count sheet was not signed nor dated. The medication count sheet did not distinguish the two different vitamin D medications as compared to her physician's orders. The RN was asked if staff notified the physician about resident #10's non-compliance with medications. She stated no. On 10/15/19 at 12:20 p.m., resident #10's vitamin D2-50,000 unit capsules were counted with LPN #1. Twelve (12) capsules were dispensed on 08/08/19 for resident #10. Ten (10) capsules remained in this bottle when counted. Resident #10 had only self- administered two capsules since 08/08/19.	C 911		

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C 911	Continued From page 4 Policy: A licensed nurse will check and count the resident's medication's monthly to ensure compliance.	C 911		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to ensure an antibiotic was available in the center	C1505		

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C1505	Continued From page 5 for 1 (#10) of 2 sampled residents with physician orders for self-administration. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: On 10/10/19 Resident #10 was seen by the physician and prescribed Cefprozil (antibiotic) 500 mg one tablet by mouth twice daily. On 10/15/19 at 1:30 p.m., the registered nurse (RN) was asked if resident #10 self-administered her antibiotic Cefprozil. She stated no, resident #10 did not have the medication. Then physician's order for the antibiotic was noted on 10/10/19 by licensed practical nurse (LPN) #2. At 2:50 p.m., resident #10 was asked about the antibiotic the physician had ordered for her. She stated she had received a shot, but no antibiotic. Resident #10 complained of coughing and her chest felt tight. The October 2019, medication administration record (MAR), documented, resident #10 had started the unsupervised self-administration of the Cefprozil on 10/10/19. The Cefprozil had not been delivered or picked up from the pharmacy.	C1505		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's	C1923		

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C1923	Continued From page 6 condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to maintain an individual inventory record for a schedule II medication for 1 (#10) of 1 sampled resident who self-administered Norco 10/325 mg (milligrams). This deficient practice had the potential for more than minimal harm at a pattern. Findings: Resident #10 was seen by the physician on 10/10/19, the visit note documented resident #10 administered Norco 10/325 mg for pain management as indicated on her medication administration record (MAR). On 10/14/19 at 4:15 p.m., the registered nurse (RN) stated resident #10 does not record her medications. On 10/15/19 at 09:17 a.m., certified medication aide (CMA) #1 was asked if an individual inventory count for narcotics was maintained for resident #10. She stated no they did not maintain individual inventory count for residents who self-administer narcotics. CMA #1 was asked how she would ensure they self-administered their medications. She stated the LPN would monitor	C1923		

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C1923	Continued From page 7 them monthly. July, August, and September 2019 monthly medication count sheets documented resident #10 had no Norco 10 mg/325 mg tablets available to self-administer.	C1923		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL3301	TAMARACK RETIREMENT CENTER

Type of Survey (select all that apply)

2				

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

Extent of Survey (select all that apply)

A				

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30875	10/14/2019	10/16/2019	0.25	0.00	14.00	0.00	4.50	5.00
2. 41872	10/14/2019	10/16/2019	0.25	0.00	17.75	0.00	3.50	6.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

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

DEC 12 2019

Oklahoma State Department of Health
Creating a State of Health

January 6, 2020

License Number: AL3301

Ms. Lydia Kay Stewart, Administrator
Tamarack Retirement Center
1224 East Tamarack Road
Altus, OK 73521

RE: Survey Event S2Q111

Dear Ms. Stewart:

On October 16, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 1, 2020**.

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

Sincerely,

Katie Stagner

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

SD/jt

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/20/2019** **Facility Name:** Tamarack Assisted Living Center **License Number:** AL3301-3301 **Survey Event ID:** S2Q111 **Date Survey Completed: 10/16/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 911	Based on: Interview and record review it was determined the registerd nurse failed to ensure the accuracy of the RN monthly medication reviews and ensure the staff delegated to perfrom monthly medication counts for 2 (#7 and #10) of 2 sampled residents who self-administered medications were performed monthly and were accurate.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Self- administration of medication policy and procedures have been updated to comply with the state department of health practices.

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? JAN 02 2020	Immediately after the survery was closed the facility reviewed the policy and procedure of self medication administration. All self administered medications were reviewed and clarified with the primary care physician. The weekend LPN who was responsible for monthly medication counts was counceled apon review and decided to not continue with employement. Medication counts were started and completed every two weeks there after. Resident #7- his alprazalom is now 1-2 tabs at bedtime for sleeplessness PRN. He keeps them in his lock box in his room at all times. The medication administration record is printed off every two weeks and his medications are counted using the MAR as a reference. The MAR is then to be given to the RN for review. After review is completed the Self-Administration count sheet is then scanned into chart. Resident completes his daily check off sheet of medications and the CMA checks twice daily for compliance. Resident # 10- Resident was found to be knowledgable of her medications but refused to self administer them correctly. Due to non compliance we received an order for Tamarack to administer her medications.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Each resident who is allowed to perform self-administration will have their medications counted twice monthly; then monthly after reviewing accuracy is obtained. The medications will now be counted during the week; instead of on the weekend shifts. The medication administration record will be printed as the counting reference. The MAR with the count numbers will be given directly to the RN for review after every count. A monthly

	check off sheet of each medication ordered will be handed out on the first of each month to every resident who self-administers their medications. The resident is to check off the medication daily as they are taken.
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 self-administration medication counting policy was updated to the changes to include increased frequency of counts and changed the nursing staff who complete the counts. The residents complete a daily check off of medications administered to be kept for record keeping. A quality check meeting is held by the RN Clinical Coordinator and two LPN Resident Service Coordinators to monitor new orders, medications, self medication counts, falls and assessments; in order to ensure deficient practices do not occur. If non compliance is found with self medication counts, the RN Clinical Coordinator meets with the resident and family for a care plan meeting to discuss self medication compliance and removal of medications from room when non compliance is found.
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. JAN 02 2020	The corrections will be sustained by completing frequent compliance checks and having a Quality Check meeting. The self medication policy and the Quality Assurance procedure is updated to include monitorin during this meeting. The correction will be evaluated for effectiveness every two weeks. The MAR count sheet will be reviewed with the previous count for accuracy by the RN/CC and LPN/RSC. If a discrepancy is found the RN will have a care plan meeting with the Resident and family. Removal of medications from room will be done if a solution is not found. 3 residents have changed to Tamarack administering their meds since change of policy. During the quality check meeting the MAR documentation is reviewed. The residents who have every 2 week checks are on a daily monitoring by the CMA or LPN on the floor. The order reads for the CMA/LPN to check that resident has administered their medications and checked off their daily medication administration calendar. The printed MAR count sheet will be transcribed to the Self-Medication drug inventory sheet that is then scanned into the electronic record by the LPN/RSC. The monthly check of list completed by the resident will also be scanned into the electronic record. Documentation of practices will be attached to this plan of correction.
H Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/1/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	**Date** Enter a date of signature.
		12/31/19

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.

JAN 02 2020

Tamarack Assisted Living Center
Self-Administration Medication Counting Policy

Written: 12/2019

Policy Statement: Each person who is allowed to perform self-administration will have their medications counted twice monthly; then monthly after reviewing accuracy is obtained.

1. The LPN or CMA will print a Medication Administration Record from Point Click Care.
2. On each medication listed the LPN/CMA will document the following on the line of each medication listed.
    A. Date of RX filled:
    B. # of Pills remaining
3. After counting has been completed, the LPN/CMA will place the completed count in the nursing administration office.
4. The Resident Services Coordinator will then compare to the counts of previous months to confirm accuracy in the resident's ability to self-administer.
5. A monthly check off sheet of each medication ordered will be handed out on the first of each month for every resident who self-administers their medications. The resident is to check off the medication as they are administered.
6. If the count is correct, no other action will be needed. Notation within the resident's chart will reflect the accuracy of the resident self-administration.
7. If the resident counts are not correct, the Resident Services Coordinator or the RN will visit with the resident concerning the count. A plan of correction will be agreed upon with the resident and nurse. The medication will be counted again in 2 weeks for compliance.
8. If non- compliance is found after second count the physician will be notified and a meeting will be held again with the resident. The comments from the resident as well as the failure to comply with the physician orders as noted by the counts will be addressed. Resident's family will be notified of noncompliance with physician orders and need of medication removal.

11/29/2019

Any medication ordered must be in house by the next day; preferably the same day as ordered.

If the residents pharmacy is AFB, be sure the meds ordered will be in by the next day. If the pharmacy is closed use the alternate pharmacy listed on the face sheet.

If the meds are over the counter; make a run to the store that day.

If meds that are not on MAR are noticed in a residents room; bring to the charge nurse to notify physician for order

CMA's--- there is now a new order on the MAR to check that the residents who self-administer medications are completing their check off sheet after taking the medications. Ask residents if they have taken their pills today and make sure daily check off list is completed.

Check you documentation daily before leaving shift. Make sure nothing is left undocumented

Incident reports must have an immediate intervention after a fall occurs in order to prevent the incident from happening again

Sign off all labs once completed. We charge for these at the end of each month. We are not able to charge if we haven't documented the lab was drawn.

25b is to have a shower every day

Notify Mary when bags are taken for visitors looking into admit.

Active Shooter / Ordering of Meds

Tamarack Assisted Living

Date: 11/29/19

INSERVICE SIGN IN SHEET

Topic:

Adams, Tamela Tamela Adams

Alfaro, Leticia Termed

Alejandre, Jessica

Allen, Laramie Laramie Allen

Breaux, Roxanne

Boughton, Takara Takara Boughton

Carnes, Terri

Castillo, Monica Monica Castillo

Colson, Jaime Jaime Colson

Fox, Lana CNA

Lara, Miranda CNA

Lewis, Maggie Giving Inservice

Alonzo, Desiree Desiree Alonzo

Mathison, Ariel CNA

Martinez, Alberto CNA

McGinley, Karen CNA

Murray, Taylor CNA

Osborne, Debra CNA

Patterson, Jessica Patterson

Payne, Martha

Ramirez, Marianna Marianna Ramirez

Rojas, Anna CNA

Sonnenberg, Shelby

Wilson, Brittany Brwilson

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/20/2019** **Facility Name:** Tamarack Assisted Living Center **License Number:** AL3301-3301 **Survey Event ID:** S2Q111 **Date Survey Completed: 10/16/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: observation, interview, and record review it was determined the center failed to ensure an antibiotic was available in the center for 1 (#10) of 2 sampled residents with physician orders for self- administration. This deficient practice resulted in the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Quality Check meetings have been initiated for daily review of new medication orders for compliance.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #10 now has a secondary pharmacy to use when the Air Force Base Pharmacy is not open. Broadway pharmacy is her alternate in order to receive pills in a timely manner. Resident #10 no longer administers her medications independently. Tamarack now picks up her medications instead of the family in order to remain in compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified? JAN 02 2020	Audit of all resident pharmacies was completed. Every resident with Altus Air Force Base as their pharmacy now has an atlternate in town to use when the AFB pharmacy is closed. (11/29/2019) Educated all LPNs on medications ordering and assuring medications are in house by the next day. If resident uses AFB pharmacy and we are not able to receive medication by next day; the alternate pharmacy is to be used and family is to be notified.
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?	Updated admissions procedure for admitting a resident who uses the AFB pharmacy to include an alternate local pharmacy. This is checked upon initial admission review during the Quality Check meeting with the RN/ CC and LPN/ RSC. During the Quality Check meeting the RN and LPNs review the physician communication appointment orders. All medications ordered are made sure to be in house and that administration has started.
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	The corrections will be sustained by monitoring during the Quality Check meetings which include reviewing new orders and assuring medications are received.

effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and How monitoring records will be kept to evidence the correction. JAN 02 2020	Evaluation of the correction will be monitored through out the week. On the weekend if medications are not in house by the next day on call is to be notified. Every new order will be reviewed for accuracy with the MAR and checked to be in house. The correction will be evaluated through out the week during the quality check meeting by the RN and LPNs During this review the physician communication sheet from the previous day appointments is reviewed for new orders. The electronic record is reviewed to the physician order to make sure they are in accordance. The medication is then noted to be in house with correct label. A secondary pharmacy will be on the face sheet for records. The physician communication sheet will show the date received the order and the MAR will show the date received and started the medications. For the residents who self administer their medications the medication will be checked to be in house during the QC meetings by the RN or the LPN/ RSC. Documentation of practices will be attached to this plan of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/1/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature	Administrator signature required Lydia Kay Stewart	**Date** Enter a date of signature.	1/31/19

OSDH-663-25-4(F)

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: 12/20/2019** **Facility Name:** Tamarack Assisted Living Center **License Number:** AL3301-3301 **Survey Event ID:** S2Q111 **Date Survey Completed: 10/16/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923	Based on: interview and record review it was determined the center failed to maintain an individual inventory record for a schedule II medication for 1 (#10) of 1 sampled resident who self-administered Norco 10/325 mg (milligrams). The deficient practice had the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Updated policy to adhere to independent narcotic inventory.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #10 no longer administers her medications independently. All narcotics are kept in the nursing medication cart under double lock and counted every shift. Tamarack now picks up her medications instead of the family in order to remain in compliance.
OSDH Response: Element accepted Yes ☒ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified? JAN 02 2020	Immediately after survery completion an audit of all residents who self administer their medications was conducted. All residents who self administer medications and have narcotics have a count sheet in their lock box to document when the medication is taken. One resident has a PRN narcotic and is checked twice monthly for compliance. His PRN Xanax is left in the lock box with the count sheet inside. As of this date, he continues to be in compliance. Every resident has a check off list to document administration of medications daily, which include narcotics if ordered. This sheet is turned into the RN at the end of the month for review and to be placed in the electronic record. Another resident who self administers her medication chooses her narcotic to be kept in the nursing medication cart to be counted daily and locked up. She calls for her pain medication if ever needed.
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 Self- administration medication counting policy was updated to the changes to include utilizing the Medication Adminstration record when counting medication in order to review the order and count every medication that is ordered by the physician. All schedule II medications will be kept on the nursing medication cart and counted daily

	unless the self administration resident will keep the narcotic in the lock box with a count sheet. Residents are monitored daily for compliance with medications by the CMA/LPN. The order reads to monitor that resident is administering their medications and completing the medication check off list daily. This order is monitored for completion during the quality check meeting. When the resident requests that they be allowed to administer their own medications a medication test is performed upon request, then yearly during the annual assessment. A self medication test will be conducted if a discrepancy is found during review of medication counts. If apon failure of test Tamarck will assume responsibility of medication administration.
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. JAN 02 2020	The corrections will be sustained by monitoring during the Quality Assurance Meeting. Evaluation of the correction will be monitored during the Quality Check Meeting. Any new orders or changes made to medications will be checked for accuracy daily. The CMA/LPN will monitor twice daily that medicaitons are taken and documented on the check list. The correction will be evaluated bi-weekly during the quality check meeting by the RN and LPNs. During this review the residents who self administer their medications will show what dates they have taken the narcotics with documentation and count. The narcotic count sheets will be scanned into the electronic record twice monthly by the LPN/ RSC. Documentation of practices will be attached to this plan of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/1/2020
OSDH Response: Element accepted Yes ☑ No ☐	
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Lydia Kay Stewart	**Date** Enter a date of signature. 12/31/19
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.	

Tamarack Assisted Living Center

Narcotic- Controlled Medication

Policy and Procedure

Date: 12/20189

Revision:

Policy: It is the policy of this facility to ensure the proper handling and tracking of controlled medications. Controlled medications will be subject to record keeping, change of shift count verification, storage and disposal procedures.

Procedure:

Log all controlled medications on to a Residents Narcotic Inventory Sheet.

Document the pharmacy, resident's apartment number, resident's name, name of medication, prescription number, directions, method of administration, amount received, physician name and start date.

Place the controlled drugs received in the double locked med cart immediately after they have been inventoried.

Residents who self-administer their medications who receive narcotics will need to have their own inventory sheet and medication in the provided lock box.

Narcotic Count:

At the change of shift, the oncoming and outgoing staff persons jointly count all controlled medications.

The outgoing staff person will read the residents narcotic inventory sheet while the oncoming person examines the controlled medication count.

The daily narcotic count record is to be signed by both the outgoing and the oncoming staff person at each change of shift, if the count is verified by two staff persons.

Discrepancies:

If a count discrepancy occurs at the change of shift verification, an investigation is made immediately to determine the error by the staff persons associated with the medication cart.

If the count cannot be reconciled:

Anyone associated with the administration or assistance of medication may not leave the facility. Only the administrator or assistance administrator may dismiss the staff persons involved.

If the counts are not able to be reconciled an incident form is filled out. Pharmacy, Physician and family are notified and meds are to be replaced.

Storage

All narcotics are to be stored under a double lock system.

For residents who self-administer their medications, the narcotics are to be kept in the provided lock box.

Discontinued Narcotics

Discontinued narcotics will be stored in a double locked area. The RN or Resident Services Coordinator will be notified in order to place in locked area. Two licensed persons will be needed for disposal.

JAN 0 9 2020 jm

Oklahoma State Department of Health
Creating a State of Health

February 11, 2020

License Number: AL3301

Ms. Lydia Kay Stewart, Administrator
Tamarack Retirement Center
1224 East Tamarack Road
Altus, OK 73521

RE: Survey Event S2Q112

Dear Ms. Stewart:

On **January 30, 2020,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 16, 2019,** have now been corrected effective **January 1, 2020.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL3301	A. BUILDING _____ B. WING _____	R 01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMARACK RETIREMENT CENTER	1224 EAST TAMARACK ROAD ALTUS, OK 73521

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS On 01/30/20 a follow-up survey was conducted. Census was 52. All deficient practice was cleared.	{C 000}		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL3301	TAMARACK RETIREMENT CENTER

Type of Survey (select all that apply)

2	D			

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

Extent of Survey (select all that apply)

A				

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 30875	01/30/2020	01/30/2020	0.50	0.00	1.75	0.00	2.50	2.00
2.								
3.								
4.								
5.								
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12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

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