OKLAHOMA
State Department
of Health

Delivery via email to: maggielewis@jcmh.com

March 6, 2024

License Number: AL3301

Ms. Maggie Lewis, Administrator
Tamarack Retirement Center
1224 East Tamarack Road
Altus, OK 73521

RE: Survey Event ID: 160P11

Dear Ms. Lewis:

On **February 28, 2024**, agents from our office concluded a State Licensure survey with a complaint investigation 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 **February 28, 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

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility:	**Tamarack Retirement Center**
Address:	**1224 East Tamarack Road**
City, State, Zip:	**Altus, OK,73521**
Provider #:	**AL3301**
Complaint #:	**OK00062355**
Investigation Date:	**02/26/24 through 02/28/24**

ALLEGATION(S)

1. The center failed to ensure dietary protocols were followed for food preparation.

An unannounced on-site investigation was initiated 02/26/2024 at 11:00 a.m.

A sample of 12 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:
A tour of the facility was conducted upon entrance, at other various times throughout the survey, and across multiple shifts. Residents and food service were observed during two meals.

Residents were interviewed regarding any concerns related to food quality served during meals.

Resident records were reviewed including assessments, service plans, physician orders, physician progress notes, nursing notes, and medication/treatment records. Grievance records were reviewed. State reported incidents and investigations were reviewed. Dietary menus, temperature logs, and food service policies were reviewed.

Staff members were interviewed regarding the facility procedures for preparing and serving food and Residents opinions regarding the meals served.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/29/2024

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 _____	C 02/28/2024

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 A relicensure survey was conducted from 02/26/24 through 02/28/24. A complaint investigation (#OK00062355) was conducted in conjunction with the survey. Facility Census: 47 The following abbreviations will be used throughout this document: DON - Director of Nursing OSDH - Oklahoma State Department of Health T - thoracic CT - computed tomography	C 000		
C1911 SS=E	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		

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C1911	Continued From page 1	C1911		

This Rule is not met as evidenced by:
Based on record review and interview, the center failed to report required incidents to the Oklahoma State Department of Health within one department business day of the reportable incidents for five (#5, 9, 10, 11, and #12) of 12 sampled residents reviewed for incident reporting.

The Administrator identified 47 Residents resided in the facility.

Findings:

1. Resident #5 had diagnoses which included hypothyroidism and myocardial infarction.

An "Incident Report Form", dated 01/06/24, documented Resident #5 was found on the floor and neuro checks were initiated due to a possible head injury.

A facsimile confirmation and "Fax Cover Sheet", dated 01/09/24, documented the incident report was reported to OSDH on 01/09/24 at 1:08 p.m. .

2. Resident #11 had diagnoses which included hypertensive heart disease with occlusion and stenosis of bilateral carotid artery.

An "Incident Report Form",dated 01/08/24, documented Resident #11 tested positive for

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C1911	Continued From page 2 Covid. A facsimile confirmation and "Fax Cover Sheet", dated 01/10/24, documented the incident report was reported to Oklahoma State Department of health on 01/10/24 at 1:23 p.m. . 3. Resident #10 had diagnoses which included macular degeneration and and disorder of the thyroid. An "Incident Report Form", dated 01/23/24, documented Resident #10 fell while being assisted by family to the restroom and was assessed and found to have bruising to the back of the head. A facsimile confirmation sheet, documented the incident report was reported to Oklahoma State Department of health on 01/25/24 at 01:03 p.m. 4. Resident #12 had diagnoses which included low back pain and wedge compression fracture of T11-T12 vertebra. An "Incident Report Form", dated 02/13/24, documented Resident #1 was found on the floor of the public bathroom and hit their head resulting in Resident #12 being sent to the hospital for a CT scan due to head a head injury. A "Fax Cover Sheet", dated 02/15/24 documented the incident report was reported to OSDH on 02/15/24. A facsimile confirmation, documented the report was sent to OSDH on 02/16/24 at 11:47 a.m. 5. Resident #9 had diagnoses which included hypothyroidism and osteoporosis.	C1911		

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	AL3301	A. BUILDING: _____ B. WING _____	C 02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1911	Continued From page 3 An "Incident Report Form", dated 02/13/24 documented Resident #9 was found on the floor and hit the back of their head. A facsimile confirmation and the "Fax Cover Sheet", dated 02/15/24, documented the incident report was reported to OSDH on 02/15/24 at 3:57 p.m. On 02/28/24 at 10:00 a.m., the Administrator was shown the above referenced incident reports. The Administrator acknowledged by shaking their head the incident reports were not reported within one business day. On 02/28/24 at 10:20 a.m., the DON was shown the above referenced incident reports and asked if they were reported within one business day of the event. The DON stated, "No, I was doing it the way the last clinical coordinator showed me. [They] never told me they had to be faxed within 24 hours." On 02/28/24 at 10:27 a.m., the Administrator stated the new DON was given the wrong time frames for reporting incidents to OSDH. The Administrator stated the center did not have a policy regarding reporting time frames for incidents to OSDH.	C1911		

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Delivery via email to: maggielewis@jcmh.com

March 20, 2024

License Number: AL3301

Ms. Maggie Lewis, Administrator
Tamarack Retirement Center
1224 East Tamarack Road
Altus, OK 73521

RE: Survey Event 160P11

Dear Ms. Lewis:

On **February 28, 2024**, a Licensure inspection with a complaint investigation 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 **March 15, 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: 3/15/2024** **Facility Name:** Tamarack Retirement Cneter **License Number:** AL3301 **Survey Event ID:** 160P11 **Date Survey Completed: 2/28/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1911	Based on: record review and interview, the center failed to report required incidents to the Oklahoma State Department of Health within one department business day of the reportable for five (#5, 9, 10, 11,12) of 12 sampled residents reviewed for incident reporting.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The deficient practice will be corrected by creating a policy for incident reports that require notification to the state, education to those completing the state reports, educating all nursing management on how to complete state reports and continuous monitoring of the reporting timeliness for QAPI.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All state reportable events after 3/1/2024 will follow the new policy put into place for the reporting time frame guidance in 310: 633-19-1. All state reports will also be put into RL Solutions for monitoring by the Risk Manager. During review for QAPI, all state reports will be monitored for timeliness of reporting to the state health department.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Administrator/RN will be notified of all state reportable events on the day the incident occurs. The clinical coordinator will complete the state report and fax to the state department within 24 hours and report back to Administrator/ RN that the report has been completed and sent within the required time frame. A calendar has been made to track all reportable incidents and reporting timelines.
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 new clinical coordinator has been educated on the policy put into place from the current guidelines of state reporting timelines. Incidents requiring a state report will be monitored daily by nursing management.
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.	All state reports will be monitored daily for correct notification times to the state department. a.The Administrator/ RN will evaluate after each incident occurs and follow through until the final report has been sent for effectiveness of correction. b.The QAPI will monitor quarterly that all incidents have been reported according to the guidance and policy.

	c.All state reports are printed and kept in a binder with the fax notification date showing corrected action has been sustained.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/15/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Maggie Lewis** Maggie Lewis OAC 310:663-25-4(F)	**Date 3/15/2024**

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

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

Items Below Are For OSDH Use Only

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

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

OKLAHOMA
State Department of Health

Delivery via email to: maggielewis@jcmh.com

April 19, 2024

License Number: AL3301

Ms. Maggie Lewis, Administrator
Tamarack Retirement Center
1224 East Tamarack Road
Altus, OK 73521

RE: Survey Event 160P12

Dear Ms. Lewis:

On **April 17, 2024,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **February 28, 2024,** have now been corrected effective **March 15, 2024.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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

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	AL3301	A. BUILDING: _____ B. WING _____	R-C 04/17/2024

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{C 000}	INITIAL COMMENTS	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE