
Delivery via email to: Admin@ashstreetplace.com

December 4, 2024

License Number: AL4201

Ms. Kaylee Walker, Administrator
Ash Street Place
111 South Ash
Guthrie, OK 73044

RE: Survey Event ID: SX1211

Dear Ms. Walker:

On **November 27, 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 **November 27, 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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/27/2024
NAME OF PROVIDER OR SUPPLIER ASH STREET PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 111 SOUTH ASH GUTHRIE, OK 73044		
(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 on 11/26/24 and 11/27/24. Facility Census: 20 Listed below are abbreviations that will be used throughout this document. DM - dietary manager DON - Director of Nursing RN - Registered Nurse	C 000		
C 329 SS=E	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: (9) provisions for evacuation of the building structure and staff to meet the evacuation needs of residents. This Rule is not met as evidenced by: Based on record review and interview, the center failed to describe the provisions to meet the evacuation needs of the resident in the service plan for twelve (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and #12) of twelve sampled residents whose service plans were reviewed.	C 329		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 329	Continued From page 1 The administrator identified 20 residents resided at the center. Findings: The assisted living resident sample matrix, completed by the DON 11/26/24, documented the following, a. Resident #1 was ambulatory and cognitively intact, b. Resident #2 was ambulatory and cognitively intact, c. Resident #3 was ambulatory and cognitively intact, d. Resident #4 was ambulatory and cognitively intact, e. Resident #5 was ambulatory and cognitively intact, f. Resident #6 was ambulatory and had diagnoses that included dementia, g. Resident #7 was ambulatory and cognitively intact, h. Resident #8 was ambulatory and had diagnoses which included dementia, i. Resident #9 was ambulatory and cognitively intact, j. Resident #10 was ambulatory and cognitively intact, k. Resident #11 was ambulatory and cognitively intact, and l. Resident #12 was ambulatory and cognitively. There was no documentation the evacuation needs of the residents were addressed in their service plans. On 11/27/24 at 10:00 a.m., the DON was asked to review the service plans for Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and #12. After reviewing the service plans, the DON was asked if the	C 329		

Oklahoma State Department of Health

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C 329	Continued From page 2 provisions to meet each residents' evacuation needs were addressed in their service plan. They stated, "No."	C 329		
C 391 SS=E	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 center failed to ensure food items were not expired and open food items were properly labeled and stored. The administrator identified 20 residents resided at the center. Findings: On 11/26/24 at 12:56 p.m., the following observations were made during the initial tour of the kitchen with the DM: a. a stand-alone refrigerated deli-cart contained one quarter of a gallon-sized container of Italian salad dressing with an open date of 10/26/22 and one half gallon-sized container of tartar sauce with manufacturer's expiration date of 08/08/24; b. the stand-up freezer contained open packages of french fries, chicken fried steak, chicken tenders, hash browns, hamburger patties, and chicken patties with no labels and no open dates; and c. the dry storage area contained three quarters of a five-pound jar of peanut butter with an open	C 391		

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C 391	Continued From page 3 date of 08/23/23, open packages of spaghetti noodles, corn bread mix, macaroni noodles, vanilla wafers, sugar, and flour that had no open dates and were not stored in sealable bags or containers to prevent pest from getting in them. On 11/26/24 at 3:05 p.m., the DM was asked the policy for labeling and storing food items. They stated all food items should be labeled with a date when they were received, when they are opened, and when they should be thrown away. The DM also stated if food items were removed from their original container the new container should be labeled saying what was inside and all expired items should be discarded immediately. After reviewing the above findings the DM acknowledged proper procedures for food handling and storage had not been followed.	C 391		
C 393 SS=E	310:663-3-8(c) FOOD PREPARTION, STORAGE AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours. This Rule is not met as evidenced by: Based on observation and interview, the center	C 393		

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C 393	Continued From page 4 failed to ensure leftovers of potentially hazardous foods were disposed of within 24 hours and non-potentially hazardous foods were disposed of in 48 hours. The administrator identified 20 residents resided at the center. Findings: On 11/26/24 at 12:56 p.m., an initial tour of the kitchen was conducted with the DM and the following observations were made: a. stand-alone refrigerated deli-cart contained one quarter of a package of sliced roast beef lunch meat with open date of 11/16/24 and no use-by date, one half of a package of sliced ham lunch meat with open date of 11/16/24 and no use-by date, one quarter of a package of sliced turkey lunch meat with open date of 11/16/24 and no use-by date, and three quarters of a package of sliced cheese with open date of 11/15/24 and no use-by date; and b. the stand-up refrigerator contained a one quart plastic container of pre-cooked frozen pork meat with date thawed 11/22/24. On 11/26/24 at 3:00 p.m., the DM was asked the facility policy for storing and disposing of potentially hazardous and non-potentially hazardous foods. They stated, "I believe it says to discard it in 24 to 48 hours, but I serve the lunch meat until its gone. It usually doesn't last more than a week." On 11/26/24 at 3:20 p.m., the administrator was informed of the above observations made during the tour of the kitchen. They acknowledged proper food safety precautions had not been observed.	C 393		

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C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were reviewed monthly by the RN or pharmacy consultant for twelve (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and #12) of twelve residents whose clinical records were reviewed. The administrator identified 20 residents resided in the facility. Findings: There was no documentation Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, or #12's medications had been reviewed by an RN or pharmacist in 02/2024, 04/2024, 06/2024, 07/2024, 08/2024, or 10/2024. On 11/26/24 at 11:08 a.m., the administrator was asked if monthly medication reviews had been done by the RN or pharmacist for the months listed above. The administrator reported they had talked to RN #1 who stated medication reviews had not been completed for the months listed	C 921		

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C 921	Continued From page 6 above and were currently being completed every other month.	C 921		

Delivery via email to: Admin@ashstreetplace.com

December 19, 2024

License Number: AL4201

Ms. Kaylee Walker, Administrator
Ash Street Place
111 South Ash
Guthrie, OK 73044

RE: Survey Event SX1211

Dear Ms. Walker:

On **November 27, 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 **December 9, 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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure survey was conducted on 11/26/24 and 11/27/24. Facility Census: 20 Listed below are abbreviations that will be used throughout this document. DM - dietary manager DON - Director of Nursing RN - Registered Nurse	C 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law and does not waive any appeal or other rights.	
C 329 SS=E	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: (9) provisions for evacuation of the building structure and staff to meet the evacuation needs of residents. This Rule is not met as evidenced by: Based on record review and interview, the center failed to describe the provisions to meet the evacuation needs of the resident in the service plan for twelve (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and #12) of twelve sampled residents whose service plans were reviewed.	C 329	All residents listed on Sample List Provided by Surveyor assessed by Registered Nurse, no adverse effect noted from practice cited. Service Plans for all residents listed on Sample List Provided by Surveyor updated to address the evacuation needs of the resident. All Residents have the potential to be affected by this practice. Director-of-Nursing and Administrator reeducated on documenting the provisions to meet the evacuation needs of residents in their service plans. Director-of-nursing and registered nurse reviewed and revised all residents service plans to address the provisions to meet the evacuation needs of the resident.	

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

TITLE

(X6) DATE

STATE FORM

6899

SX1211

If continuation sheet 1 of 7

Oklahoma State Department of Health

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C 329	Continued From page 1 The administrator identified 20 residents resided at the center. Findings: The assisted living resident sample matrix, completed by the DON 11/26/24, documented the following, a. Resident #1 was ambulatory and cognitively intact, b. Resident #2 was ambulatory and cognitively intact, c. Resident #3 was ambulatory and cognitively intact, d. Resident #4 was ambulatory and cognitively intact, e. Resident #5 was ambulatory and cognitively intact, f. Resident #6 was ambulatory and had diagnoses that included dementia, g. Resident #7 was ambulatory and cognitively intact, h. Resident #8 was ambulatory and had diagnoses which included dementia, i. Resident #9 was ambulatory and cognitively intact, j. Resident #10 was ambulatory and cognitively intact, k. Resident #11 was ambulatory and cognitively intact, and l. Resident #12 was ambulatory and cognitively. There was no documentation the evacuation needs of the residents were addressed in their service plans. On 11/27/24 at 10:00 a.m., the DON was asked to review the service plans for Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and #12. After reviewing the service plans, the DON was asked if the	C 329	Director-of-nursing or designee will monitor on monthly basis for compliance resident service plans for the provision of evacuation needs are addressed annually and upon significant change in status. Results of this monitoring will be documented and reviewed quarterly during the Quality Assurance Meeting. Completion Date: 12/5/2024	

Oklahoma State Department of Health

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C 329	Continued From page 2 provisions to meet each residents' evacuation needs were addressed in their service plan. They stated, "No."	C 329		
C 391 SS=E	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 center failed to ensure food items were not expired and open food items were properly labeled and stored. The administrator identified 20 residents resided at the center. Findings: On 11/26/24 at 12:56 p.m., the following observations were made during the initial tour of the kitchen with the DM: a. a stand-alone refrigerated deli-cart contained one quarter of a gallon-sized container of Italian salad dressing with an open date of 10/26/22 and one half gallon-sized container of tartar sauce with manufacturer's expiration date of 08/08/24; b. the stand-up freezer contained open packages of french fries, chicken fried steak, chicken tenders, hash browns, hamburger patties, and chicken patties with no labels and no open dates; and c. the dry storage area contained three quarters of a five-pound jar of peanut butter with an open	C 391	All food items in freezer, refrigerated deli-cart and dry storage immediately sealed, and properly labeled and dated; all other expired items discarded. All dietary staff re-educated on storing foods in accordance with professional standards for food service safety. All residents have the potential to be affected by this practice. All dietary staff re-educated on storing food in accordance with professional standards for food service safety related to the dating, labeling, serving and storage of prepared foods and leftover foods. Cook will monitor dry storage, refrigerator, and freezer before meal service for proper food storage related to dating, labeling, serving, and storage of prepared foods and leftover foods daily. Dietary Manager will monitor food storage areas for proper food storage labeling, dating and sealing of foods in accordance with professional standards for food service safety. Administrator or Designee will monitor proper labeling, sealing, and dating of food in food storage areas for compliance daily. Results of this monitoring will be documented and reviewed quarterly during Quality Assurance Meeting. Completion Date: December 5, 2024	

Oklahoma State Department of Health

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C 391	Continued From page 3 date of 08/23/23, open packages of spaghetti noodles, corn bread mix, macaroni noodles, vanilla wafers, sugar, and flour that had no open dates and were not stored in sealable bags or containers to prevent pest from getting in them. On 11/26/24 at 3:05 p.m., the DM was asked the policy for labeling and storing food items. They stated all food items should be labeled with a date when they were received, when they are opened, and when they should be thrown away. The DM also stated if food items were removed from their original container the new container should be labeled saying what was inside and all expired items should be discarded immediately. After reviewing the above findings the DM acknowledged proper procedures for food handling and storage had not been followed.	C 391		
C 393 SS=E	310:663-3-8(c) FOOD PREPARTION, STORAGE AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours. This Rule is not met as evidenced by: Based on observation and interview, the center	C 393	All leftover food items, potentially hazardous and non-potentially hazardous, in freezer and refrigerated deli-cart were immediately discarded. All dietary staff re- educated on storing leftover foods in accordance with professional standards for food service safety. All residents have the potential to be affected by this practice. All dietary staff re-educated on storing, preparing, distributing, and serving food in accordance with professional standards for food service safety related to leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours.	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/27/2024
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NAME OF PROVIDER OR SUPPLIER ASH STREET PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 111 SOUTH ASH GUTHRIE, OK 73044
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(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 393	Continued From page 4 failed to ensure leftovers of potentially hazardous foods were disposed of within 24 hours and non-potentially hazardous foods were disposed of in 48 hours. The administrator identified 20 residents resided at the center. Findings: On 11/26/24 at 12:56 p.m., an initial tour of the kitchen was conducted with the DM and the following observations were made: a. stand-alone refrigerated deli-cart contained one quarter of a package of sliced roast beef lunch meat with open date of 11/16/24 and no use-by date, one half of a package of sliced ham lunch meat with open date of 11/16/24 and no use-by date, one quarter of a package of sliced turkey lunch meat with open date of 11/16/24 and no use-by date, and three quarters of a package of sliced cheese with open date of 11/15/24 and no use-by date; and b. the stand-up refrigerator contained a one quart plastic container of pre-cooked frozen pork meat with date thawed 11/22/24. On 11/26/24 at 3:00 p.m., the DM was asked the facility policy for storing and disposing of potentially hazardous and non-potentially hazardous foods. They stated, "I believe it says to discard it in 24 to 48 hours, but I serve the lunch meat until its gone. It usually doesn't last more than a week." On 11/26/24 at 3:20 p.m., the administrator was informed of the above observations made during the tour of the kitchen. They acknowledged proper food safety precautions had not been observed.	C 393	Cook will monitor disposal of both potentially hazardous and non-potentially hazardous leftovers daily. Dietary Manager will monitor food storage areas for proper leftover food storage labeling, dating and sealing of leftover foods in accordance with professional standards for food service safety daily. Administrator or Designee will monitor proper labeling, sealing, and dating of leftover food in food storage areas for compliance. Results of this monitoring will be documented and reviewed quarterly during Quality Assurance Meeting. Completion Date: December 5, 2024	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/27/2024
NAME OF PROVIDER OR SUPPLIER ASH STREET PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 111 SOUTH ASH GUTHRIE, OK 73044		
(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 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were reviewed monthly by the RN or pharmacy consultant for twelve (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and #12) of twelve residents whose clinical records were reviewed. The administrator identified 20 residents resided in the facility. Findings: There was no documentation Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, or #12's medications had been reviewed by an RN or pharmacist in 02/2024, 04/2024, 06/2024, 07/2024, 08/2024, or 10/2024. On 11/26/24 at 11:08 a.m., the administrator was asked if monthly medication reviews had been done by the RN or pharmacist for the months listed above. The administrator reported they had talked to RN #1 who stated medication reviews had not been completed for the months listed	C 921	All residents listed on Sample List Provided by Surveyor assessed by Registered Nurse, no adverse effect noted from practice cited. Medication reviews for all residents completed by Registered Nurse. All Residents have the potential to be affected by this practice. Director-of-Nursing and Administrator re-educated on monthly medication reviews by a registered nurse or pharmacist and quarterly by a consultant pharmacist for all residents. Process for monthly review of medications by registered nurse or pharmacist including check-off system reviewed and revised. Registered Nurse completed medication reviews for all residents. Registered nurse or consultant pharmacist to review all resident medications, document, and maintain record of completed reviews on a monthly basis. Director-of-nursing or designee will monitor resident medication reviews monthly for compliance. Results of this monitoring will be documented and reviewed quarterly during the Quality Assurance Meeting. Completion Date: 12/9/2024	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/27/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ASH STREET PLACE

**111 SOUTH ASH
GUTHRIE, OK 73044**

(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 921	Continued From page 6 above and were currently being completed every other month.	C 921		



OKLAHOMA
State Department
of Health

Oklahoma State Department of Health

Long Term Care

123 Robert S Kerr Ave, Suite 1702

Oklahoma City, OK 73012-6406

p. (405) 426-8200

f. (405) 900-7594

Assisted Living Informal Dispute Resolution Request Form
In Accordance with the Continuum of Care and Assisted Living Act

Assisted Living Centers must complete this form to dispute cited deficiencies. If you have any questions, contact the IDR Coordinator by telephone at (405) 426-8200 or via e-mail at IDRCoordinator@hcahlt.ok.gov.

Submission

Complete this form, attach all documentary evidence relevant to each disputed deficiency and submit within **ten (10) calendar days** of receiving the official Statement of Deficiencies. Submit this form to Oklahoma State Department of Health, Long Term Care, Attention: IDR Coordinator, 123 Robert S Kerr Ave, Suite 1702, Oklahoma City, OK 73102-6406. **An IDR will not be granted when a request form is incomplete or inaccurate. Documentary evidence submitted past the required timeframe will not be considered.**

IDR Type: (Check One)

Face-to-Face Meeting ☐

Record Review ☒

Telephone/Virtual Conference ☐

Facility Name: Ash Street Place, LLC

Facility ID: AL4201

Facility Administrator: Kaylee Walker

E-mail: admin@ashstreetplace.com

Mailing Address: P O Box 1095

Telephone Number: () 405-282-2000

City: Guthrie Zip Code: 73044

Facsimile Number: () 405-282-5731

Date Statement of Deficiencies Received: 12 / 04 / 2024

Survey Exit Date: 11 / 27 / 2024

Dispute Description

Tag Number **Explanation of Dispute** (Why is facility disputing the deficiency? List reason for each.)

A separate sheet may be attached, but must clearly identify the following: facility name, ID, survey exit date, tag number, and the explanation of the dispute. All documentary evidence submitted must also identify these items.

1. C329 Description of Services - Please see attached explanation

2. _____

3. _____

4. _____

Submitted by: Kaylee Walker

Date: 12 / 13 / 2024



January 7, 2025

VIA EMAIL

Ms. Kaylee Walker, Administrator
Ash Street Place
111 South Ash
Guthrie, OK 73044

Subject: State Survey Agency Informal Dispute Resolution Determination
Re: AL4201, Ash Street Place January 6, 2025 Informal Dispute Resolution

Dear Ms. Walker:

The Department of Health has received the determination of the Informal Dispute Resolution (IDR) Decision Making Panel concerning the November 27, 2024 complaint investigation conducted at Ash Street Place. The findings of the IDR Decision Making Panel have been reviewed. It is the determination of the State Survey Agency to uphold the Decision Making Panel's determination. The amended State Statement of Deficiencies (Form CMS-2567) is enclosed. If applicable, further instructions regarding the impact of these changes on any previous enforcement action will be forthcoming from the Long Term Care Enforcement office.

The facility is encouraged to submit an amended plan of correction on the enclosed Statement of Deficiencies. The amended Statement of Deficiencies must be signed, dated, and indicate the signee's title in the appropriate spaces on page one (1). Return the amended Statement of Deficiencies with your plan of correction to:

LTCEnforcement@health.ok.gov

The amended copy of the Statement of Deficiencies (Form CMS-2567) will be the releasable copy *only* when a signed amended plan of correction is provided by the facility. The original Form CMS-2567 is disclosable if a signed amended plan of correction is not submitted by the facility. [Chapter 7, State Operations Manual §7212]

Sincerely,

A handwritten signature in dark ink, appearing to read "Philip Miller", is written over a light blue horizontal line.

Philip Miller
Director, Long Term Care Services
Protective Health Services

cn

c: William Whited, Ombudsman
Lindsay Jeffries, Nurse Aide Registry
IDR Decision Making Panel
Edward Roth
Survey Team
Facility File



**OKLAHOMA
State Department
of Health**

January 6, 2025

VIA EMAIL

Ms. Kaylee Walker, Administrator
Ash Street Place
111 South Ash
Guthrie, OK 73044

**Re: Ash Street Place - Informal Dispute Resolution Determination Report
License Number: AL4201**

Dear Ms. Walker:

Thank you for participating in the Informal Dispute Resolution (IDR) panel process of the Oklahoma State Department of Health concerning the survey conducted at your facility on November 27, 2024. The IDR Panel was present at the meeting. The disputed deficiencies are discussed in the attached determination report.

A copy of this determination has been forwarded to the State Survey Agency for review.

Sincerely,

Amanda Terrel
Chairperson
IDR Decision Making Panel
Protective Health Services

cn

Enclosure

c: Philip Miller
IDR Panel
Survey Team
Facility File

IDR
Informal Dispute Resolution
Impartial Decision Making Panel
Determination Report
Today's Date: 01-06-2025

Facility Name:
Ash Street Place

Facility ID:
AL4201

Survey Date:
11-27-2024

IDR Date:
01-06-2025

Tags Disputed:
1. C329 s/s=E

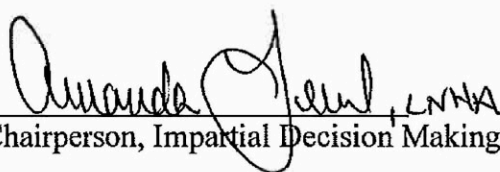
Status Change *

Panel Members:
Amanda Terrel, Chairperson
Connie Beeler
JR Gutierrez
Seana Sutterfield
Sheila McLeod, OSDH

Determination Report:

After a records review was completed, it is the determination of the IDR panel that the facility did include all requirements for evacuation in the resident service contract per regulation and are in agreement that the tag should be removed.

Signature


Chairperson, Impartial Decision Making Panel

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/27/2024
NAME OF PROVIDER OR SUPPLIER ASH STREET PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 111 SOUTH ASH GUTHRIE, OK 73044		
(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 on 11/26/24 and 11/27/24. The 2567 has been amended based on a determination resulting from an Informal Dispute Resolution (IDR) removing C329 s/s=E. Facility Census: 20 Listed below are abbreviations that will be used throughout this document. DM - dietary manager DON - Director of Nursing RN - Registered Nurse	C 000		
C 391 SS=E	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 center failed to ensure food items were not expired and open food items were properly labeled and stored. The administrator identified 20 residents resided at the center. Findings: On 11/26/24 at 12:56 p.m., the following observations were made during the initial tour of the kitchen with the DM:	C 391		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

12/13/24

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/27/2024
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C 391	Continued From page 1 a. a stand-alone refrigerated deli-cart contained one quarter of a gallon-sized container of Italian salad dressing with an open date of 10/26/22 and one half gallon-sized container of tartar sauce with manufacturer's expiration date of 08/08/24; b. the stand-up freezer contained open packages of french fries, chicken fried steak, chicken tenders, hash browns, hamburger patties, and chicken patties with no labels and no open dates; and c. the dry storage area contained three quarters of a five-pound jar of peanut butter with an open date of 08/23/23, open packages of spaghetti noodles, corn bread mix, macaroni noodles, vanilla wafers, sugar, and flour that had no open dates and were not stored in sealable bags or containers to prevent pest from getting in them. On 11/26/24 at 3:05 p.m., the DM was asked the policy for labeling and storing food items. They stated all food items should be labeled with a date when they were received, when they are opened, and when they should be thrown away. The DM also stated if food items were removed from their original container the new container should be labeled saying what was inside and all expired items should be discarded immediately. After reviewing the above findings the DM acknowledged proper procedures for food handling and storage had not been followed.	C 391		
C 393 SS=E	310:663-3-8(c) FOOD PREPARTION, STORAGE AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially	C 393		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/27/2024
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C 393	Continued From page 2 hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours. This Rule is not met as evidenced by: Based on observation and interview, the center failed to ensure leftovers of potentially hazardous foods were disposed of within 24 hours and non-potentially hazardous foods were disposed of in 48 hours. The administrator identified 20 residents resided at the center. Findings: On 11/26/24 at 12:56 p.m., an initial tour of the kitchen was conducted with the DM and the following observations were made: a. stand-alone refrigerated deli-cart contained one quarter of a package of sliced roast beef lunch meat with open date of 11/16/24 and no use-by date, one half of a package of sliced ham lunch meat with open date of 11/16/24 and no use-by date, one quarter of a package of sliced turkey lunch meat with open date of 11/16/24 and no use-by date, and three quarters of a package of sliced cheese with open date of 11/15/24 and no use-by date; and b. the stand-up refrigerator contained a one quart plastic container of pre-cooked frozen pork meat with date thawed 11/22/24. On 11/26/24 at 3:00 p.m., the DM was asked the	C 393		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/27/2024
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C 393	Continued From page 3 facility policy for storing and disposing of potentially hazardous and non-potentially hazardous foods. They stated, "I believe it says to discard it in 24 to 48 hours, but I serve the lunch meat until its gone. It usually doesn't last more than a week." On 11/26/24 at 3:20 p.m., the administrator was informed of the above observations made during the tour of the kitchen. They acknowledged proper food safety precautions had not been observed.	C 393		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were reviewed monthly by the RN or pharmacy consultant for twelve (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and #12) of twelve residents whose clinical records were reviewed. The administrator identified 20 residents resided in the facility.	C 921		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/27/2024
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C 921	Continued From page 4 Findings: There was no documentation Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, or #12's medications had been reviewed by an RN or pharmacist in 02/2024, 04/2024, 06/2024, 07/2024, 08/2024, or 10/2024. On 11/26/24 at 11:08 a.m., the administrator was asked if monthly medication reviews had been done by the RN or pharmacist for the months listed above. The administrator reported they had talked to RN #1 who stated medication reviews had not been completed for the months listed above and were currently being completed every other month.	C 921		

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure survey was conducted on 11/26/24 and 11/27/24. The 2567 has been amended based on a determination resulting from an Informal Dispute Resolution (IDR) removing C329 s/s=E. Facility Census: 20 Listed below are abbreviations that will be used throughout this document. DM - dietary manager DON - Director of Nursing RN - Registered Nurse	C 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law and does not waive any appeal or other rights.	
C 391 SS=E	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 center failed to ensure food items were not expired and open food items were properly labeled and stored. The administrator identified 20 residents resided at the center. Findings: On 11/26/24 at 12:56 p.m., the following observations were made during the initial tour of the kitchen with the DM:	C 391	C391 FOOD STORAGE, PREPARATION AND SERVICE All food items in freezer, refrigerated deli-cart and dry storage immediately sealed, and properly labeled and dated; all other expired items discarded. All dietary staff re-educated on storing foods in accordance with professional standards for food service safety. All Residents have the potential to be affected by this practice. All dietary staff re-educated on storing food in accordance with professional standards for food service safety related to the dating, labeling, serving and storage of prepared foods and leftover foods.	

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

TITLE

(X6) DATE

12/13/24

STATE FORM

6899

SX1211

If continuation sheet 1 of 5

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/27/2024
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C 391	Continued From page 1 a. a stand-alone refrigerated deli-cart contained one quarter of a gallon-sized container of Italian salad dressing with an open date of 10/26/22 and one half gallon-sized container of tartar sauce with manufacturer's expiration date of 08/08/24; b. the stand-up freezer contained open packages of french fries, chicken fried steak, chicken tenders, hash browns, hamburger patties, and chicken patties with no labels and no open dates; and c. the dry storage area contained three quarters of a five-pound jar of peanut butter with an open date of 08/23/23, open packages of spaghetti noodles, corn bread mix, macaroni noodles, vanilla wafers, sugar, and flour that had no open dates and were not stored in sealable bags or containers to prevent pest from getting in them. On 11/26/24 at 3:05 p.m., the DM was asked the policy for labeling and storing food items. They stated all food items should be labeled with a date when they were received, when they are opened, and when they should be thrown away. The DM also stated if food items were removed from their original container the new container should be labeled saying what was inside and all expired items should be discarded immediately. After reviewing the above findings the DM acknowledged proper procedures for food handling and storage had not been followed.	C 391	Cook will monitor dry storage, refrigerator, and freezer before meal service for proper food storage related to dating, labeling, serving, and storage of prepared foods and leftover foods daily. Dietary Manager will monitor food storage areas for proper food storage labeling, dating and sealing of foods in accordance with professional standards for food service safety. Administrator of Designee will monitor proper labeling, sealing, and dating of food in food storage areas for compliance daily. Results of this monitoring will be documented and reviewed quarterly during Quality Assurance Meeting. Completion Date: December 5, 2024 C393 FOOD PREPARATION, STORAGE AND SERVICE	
C 393 SS=E	310:663-3-8(c) FOOD PREPARTION, STORAGE AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially	C 393	All leftover food items, potentially hazardous and non-potentially hazardous, in freezer and refrigerated deli-cart were immediately discarded. All dietary staff re-educated on storing leftover foods in accordance with professional standards for food service safety.	

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER ASH STREET PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 111 SOUTH ASH GUTHRIE, OK 73044		
(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 393	Continued From page 2 hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours. This Rule is not met as evidenced by: Based on observation and interview, the center failed to ensure leftovers of potentially hazardous foods were disposed of within 24 hours and non-potentially hazardous foods were disposed of in 48 hours. The administrator identified 20 residents resided at the center. Findings: On 11/26/24 at 12:56 p.m., an initial tour of the kitchen was conducted with the DM and the following observations were made: a. stand-alone refrigerated deli-cart contained one quarter of a package of sliced roast beef lunch meat with open date of 11/16/24 and no use-by date, one half of a package of sliced ham lunch meat with open date of 11/16/24 and no use-by date, one quarter of a package of sliced turkey lunch meat with open date of 11/16/24 and no use-by date, and three quarters of a package of sliced cheese with open date of 11/15/24 and no use-by date; and b. the stand-up refrigerator contained a one quart plastic container of pre-cooked frozen pork meat with date thawed 11/22/24. On 11/26/24 at 3:00 p.m., the DM was asked the	C 393	All Residents have the potential to be affected by this practice. All dietary staff re-educated on storing, preparing, distributing, and serving food in accordance with professional standards for food service safety related to leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours. Cook will monitor disposal of both potentially hazardous and non-potentially hazardous leftovers daily. Dietary Manager will monitor food storage areas for proper leftover food storage labeling, dating and sealing of leftover foods in accordance with professional standards for food service safety daily. Administrator or Designee will monitor proper labeling, sealing, and dating of leftover food storage areas for compliance. Results of this monitoring will be documented and reviewed quarterly during Quality Assurance Meeting. Completion Date: December 5, 2024	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/27/2024
NAME OF PROVIDER OR SUPPLIER ASH STREET PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 111 SOUTH ASH GUTHRIE, OK 73044		
(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 393	Continued From page 3 facility policy for storing and disposing of potentially hazardous and non-potentially hazardous foods. They stated, "I believe it says to discard it in 24 to 48 hours, but I serve the lunch meat until its gone. It usually doesn't last more than a week." On 11/26/24 at 3:20 p.m., the administrator was informed of the above observations made during the tour of the kitchen. They acknowledged proper food safety precautions had not been observed.	C 393		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were reviewed monthly by the RN or pharmacy consultant for twelve (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and #12) of twelve residents whose clinical records were reviewed. The administrator identified 20 residents resided in the facility.	C 921	C921 MEDICATION STAFFING All residents listed on Sample List Provided by Surveyor assessed by Registered Nurse, no adverse effect noted from practice cited. Medication reviews for all residents completed by Registered Nurse. All Residents have the potential to be affected by this practice. Director-of-Nursing and Administrator re-educated on monthly medication reviews by a registered nurse or pharmacist and quarterly by a consultant pharmacist for all residents. Process for monthly review of medications by registered nurse or pharmacist including check-off system reviewed and revised. Registered Nurse completed medication reviews for all residents. Registered nurse or consultant pharmacist to review all resident medications, document, and maintain record of completed reviews on a monthly basis.	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/27/2024
NAME OF PROVIDER OR SUPPLIER ASH STREET PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 111 SOUTH ASH GUTHRIE, OK 73044		
(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 921	Continued From page 4 Findings: There was no documentation Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, or #12's medications had been reviewed by an RN or pharmacist in 02/2024, 04/2024, 06/2024, 07/2024, 08/2024, or 10/2024. On 11/26/24 at 11:08 a.m., the administrator was asked if monthly medication reviews had been done by the RN or pharmacist for the months listed above. The administrator reported they had talked to RN #1 who stated medication reviews had not been completed for the months listed above and were currently being completed every other month.	C 921	Director-of-nursing or designee will monitor reviews monthly for compliance. Results of this monitoring will be documented and reviewed quarterly during the Quality Assurance Meeting. Completion Date: 12/9/2024		

Delivery via email to: Admin@ashstreetplace.com

January 7, 2025

License Number: AL4201
Survey Event ID: SX1212

Ms. Kaylee Walker, Administrator
Ash Street Place
111 South Ash
Guthrie, OK 73044

Dear Ms. Walker:

On **January 7, 2025**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **November 27, 2024**, have now been corrected and your facility is in compliance with licensure standards effective **December 19, 2024**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL4201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/07/2025
NAME OF PROVIDER OR SUPPLIER ASH STREET PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 111 SOUTH ASH GUTHRIE, OK 73044		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 01/07/25. The facility was in substantial compliance.	{C 000}		

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