



Oklahoma State Department of Health
Creating a State of Health

December 12, 2019

License Number: AL5509

Ms. Pollyette Milligan, Administrator
Emerald Square Assisted Living Community
701 North Council Road
Oklahoma City, OK 73127

RE: Survey Event ID: GUOJ11

Dear Ms. Milligan:

Enclosed is a report of the change of ownership inspection conducted at your Assisted Living Center on **October 3, 2019**. No deficiencies were cited. Oklahoma Statutes 63-1-1910 require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5509	(X2) MULTIPLE CONSTRUCTION A BUILDING: _____ B WING: _____		(X3) DATE SURVEY COMPLETED 10/03/2019
NAME OF PROVIDER OR SUPPLIER EMERALD SQUARE ASSISTED LIVING COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 701 NORTH COUNCIL ROAD OKLAHOMA CITY, OK 73127		
(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 change of ownership survey was conducted on 10/01/19 through 10/03/19. Current census was 44. No deficient practice was cited.	C 000			

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

TITLE

(X6) DATE

STATE WORKLOAD REPORT

Provider/Supplier Number AL5509	Provider/Supplier Name EMERALD SQUARE ASSISTED LIVING COMMUNITY
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Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- 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.  36191	10/01/2019	10/03/2019	1.00	0.00	16.50	0.00	5.75	1.00
2.								
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
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Total SA Clerical/Data Entry Hours....	0.00	Total RO Clerical/Data Entry Hours.....	0.00
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Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No