OKLAHOMA
State Department
of Health

Delivery via email to: emeraldsquareed@islllc.com

January 23, 2023

License Number: AL5509

Ms. Catina Elliott, Executive Director
Emerald Square Assisted Living Community
701 North Council Road
Oklahoma City, OK 73127

Survey Event ID: HQ9F11

Dear Ms. Elliott:

On **January 13, 2023,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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. 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 will be completed for each violation; and
(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 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
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.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Emerald Square Assisted Living Community**
Address: **701 North Council Road**
City, State, Zip: **Oklahoma City, OK 73127**
Provider #: **AL5509**
Complaint #: **OK00059863**
Investigation Date(s): **January 12th – 13th, 2023**

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to assess, monitor and intervene to prevent the occurrence and worsening of open wounds on the resident's skin.	**US**
2. The center failed to establish and maintain an Infection Control Program to help prevent the development and transmission of disease.	**S**

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 01/12/2023 at 8:15 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility failing to assess, monitor and intervene to prevent the occurrence and worsening of open wounds on the resident's skin was conducted.

Physician's orders, wound care orders, and wound sheets were reviewed for resident with a wound residing in the facility at the time of this survey. Documentation showed progressive healing of wound.

Resident reported no concerns with receiving wound care as ordered. Family member reported wound was healing well.

At the time of this investigation, no deficient practice was observed related to the facility failing to assess, monitor and intervene to prevent the occurrence and worsening of open wounds on the resident's skin.

No clinical documents were available to review for resident named in this allegation (See the Statement of Deficiencies, Form 2567, Tag 1953 for details).

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Ernestine Scovens

Ernestine Scovens RN, CHFS

Date report completed: 01/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5509	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD SQUARE ASSISTED LIVING COMMUNITY	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 complaint investigation (#OK00059863) was conducted on 01/12/23 through 01/13/23. Listed below are abbreviations used throughout this document. CNA - Certified Nursing Assistant Dir. - Director PPE - personal protective equipment Res - resident TBP - transmission-based precautions	C 000		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and interview the facility failed to ensure PPE was appropriately discarded and hand hygiene was properly performed following care for one (#2) of one sampled resident on transmission-based precautions.

A "Resident List", dated 01/12/23, documented 29 residents resided in the facility. One resident was on transmission-based precautions.

Findings:

Resident #2 had diagnoses that included COVID-19 positive and was on TBP.

On 01/13/23 at 8:35 a.m., CNA #1 was observed bringing a breakfast tray to Res #2 in their apartment. CNA #1 sat Res #2's breakfast items on the table outside of the apartment and donned full PPE. CNA #1 removed two cups of beverage from the tray and carried them into Res #2's apartment and closed the door. After one minute, CNA #1 exited Res #2's apartment with PPE still on, retrieved Res #2's tray from the table, re-entered the apartment and closed the door.

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C1505	Continued From page 2 CNA #1 exited Res #2's apartment two minutes later, still wearing full PPE. CNA #1 then removed the PPE in the hallway and placed it in a biohazard trash container under the table. Then sanitized their hands and left the area. On 01/13/23 at 11:37 a.m., the Executive Dir. was asked how staff should discard PPE after caring for a resident on TBP. She stated staff should remove PPE and discard it in the biohazard trash container before leaving the resident's apartment. When asked if a biohazard trash container was located inside the apartment for all residents on TBP she stated yes. Executive Dir. was asked when should staff wash or sanitize their hands after caring for residents on TBP. She stated, "Staff should wash their hands before leaving the resident's apartment and sanitize their hands once they have exited the apartment before leaving the area." On 01/13/23 at 11:52 a.m., the Dir. of Sales & Marketing was observed bringing a lunch tray to Res #2 in their apartment. Dir. of Sales & Marketing donned full PPE and carried tray into Res #2's apartment and closed the door. After two minutes, they exited Res #2's apartment with PPE still on, removed the PPE in the hallway, and placed it in a biohazard container under the table. They stated there was no biohazard container in Res #2's apartment for trash. Dir of Sales & Marketing did not wash nor sanitize their hands before leaving the area. On 01/13/23 at 12:00 p.m., Res #2 was observed in their apartment, neat and appropriately dressed. No biohazard container for trash was observed in resident's apartment.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5509	A. BUILDING: _____ B. WING _____	01/13/2023

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C1953	Continued From page 3	C1953		
C1953 SS=D	310:663-19-3(c) MAINTENANCE OF RECORDS (C) Records for the previous twelve (12) months of operation, whether original, electronic, or microfilm copies, shall be maintained in such form as to be legible and readily available upon request of the attending physician, the assisted living center and any person authorized by law to make such a request. Records more than twelve (12) months old, whether original, electronic, or microfilm copies, shall be maintained in such form as to be legible and available within seventy-two (72) hours upon request of the attending physician, the continuum of care facility or assisted living center, and any person authorized by law to make such a request. This Rule is not met as evidenced by: Based on record review, observation, and interview the facility failed to maintain resident records in such a form as to be readily available upon request for one (#4) of six sampled residents whose records were requested for review. A "Resident List", dated 01/12/23, documented 29 residents resided in the facility. Findings: A "Preservation and Thinning of Records" policy, dated 07/21/2021, read in parts, " ...Records for previous twelve (12) months ...whether original, electronic, or microfilm copies, shall be maintained ...and readily available upon request of ...any person authorized by law to make such a request ..." A list of discharged residents, dated as of 01/01/23, read in parts, " ...[Res #4] ...Move In	C1953		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5509	A. BUILDING: _____ B. WING _____	01/13/2023

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EMERALD SQUARE ASSISTED LIVING COMMUNITY	701 NORTH COUNCIL ROAD OKLAHOMA CITY, OK 73127

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C1953	Continued From page 4 ...06/23/2021 ...Move Out ...04/15/2022 ..." Resident #4 had diagnoses that included wounds to bilateral feet. On 01/12/23 at 11:00 a.m., the Resident Care Dir. was asked to provide the hard copy of the original closed clinical record for Res #4. On 01/12/23 at 11:40 a.m., the Executive Dir. was asked to confirm that clinical records for Res #4 could not be found in the electronic health system. She stated, "A new vendor took over the community since 04/01/22. So all the information accessible is from then. I would have to reach out to corporate to find out how to get it since it's not there." On 1/12/23 at 4:54 p.m., the Resident Care Dir. reported she was not able to locate the hard copy of the original closed clinical record for Res #4. Resident Care Dir. submitted an 'Emergency Room Summary' dated 02/10/22, a 'Physician's Progress Note' dated 03/04/22, and a 'Physician's Order Summary Report' dated 02/21/22 for Res #4 and stated, "This is all we have on [Res #4]. I will have to contact our corporate office to see if they have [Res #4's] file." On 01/13/23 at 8:31 a.m., the Executive Dir. was asked if the original or electronic clinical record for Res #4 had been located. She stated, "No, and we have searched through all of the discharged client records we have here on site. I reached out to the main office yesterday evening and I am waiting for a response." On 01/13/23 at 10:25 a.m., the Resident Care Dir. was asked if the original or electronic records had been received for Res #4. She stated, "I spoke to	C1953		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5509	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD SQUARE ASSISTED LIVING COMMUNITY	701 NORTH COUNCIL ROAD OKLAHOMA CITY, OK 73127

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C1953	Continued From page 5 corporate office and no records are available for [Res #4]." No original clinical record nor access to electronic records for Res #4 were made available during this survey.	C1953		

OKLAHOMA
State Department
of Health

Delivery via email to: emeraldsquareed@islllc.com

February 23, 2023

License Number: AL5509

Ms. Tina Elliott, Executive Director
Emerald Square Assisted Living Community
701 North Council Road
Oklahoma City, OK 73127

Survey Event ID: HQ9F11

Dear Ms. Elliott:

On **January 13, 2023,** a complaint investigation was conducted at your Assisted Living Center. 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 20, 2023**.

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,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2023.02.23 12:22:43 -06'00'

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/31/2023** **Facility Name:** Emerald Square Assisted Living **License Number:** AL5509 **Survey Event ID:** HQ9F11 **Date Survey Completed: 1/13/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Based on record review, observation, and interview the facility failed to ensure PPE was appropriately discarded and hand hygiene was properly performed following care for one (#2) of one sampled resident on transmission-based precautions.A "Resident List", dated 01/12/23, documented 29 residents resided in the facility. One resident was on transmission-based precautions.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Biohazard container to discard PPE is placed in Res #2 apartment. Pictures for donning/doffing PPE is placed on the outside and inside of the door for CNA reference. Staff providing care including food delivery for res #2 will have document training on infection control practices for transmission/contact based precautions, donning/doffing/disposing of PPE and hand hygiene. Training by ED/Designee
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Staff will be trained on transmission/contact based precautions including donning/doffing PPE, proper disposal of PPE, proper setup of PPE stations and hand hygiene. The previously mentioned training will be provided and documented on an individual basis if new transmission based/contact precautions occur. Signs will be posted indicating transmission/contact based precautions and PPE required. Signs will be posted with instructions on donning/doffing and disposing of PPE. Signs will be posted for hand hygiene. Training by ED/Designee.
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?	Training on transmission based/contact precautions will be provide during staff meeting each month for 2 months. Staff will return

	demonstrate and this will be documented when trained. Individualized training with return demonstration will occur with each transmission/contact precaution as they occur. This will be documented.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Enter methods to ensure corrections are sustained: a. documented training of staff, return demonstration from staff with documented success and retraining if necessary. Rounding of units with precautions to ensure PPE stations are set up appropriately. b. Monthly QA meetings will include review of Infection Control trainings/education/return demonstrations of PPE and hand washing to ensure all training is complete. c. Training records kept in Inservice Book and Associate Files.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/20/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.
Cakina Elliott	2/2/23

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: 1/31/2023** **Facility Name:** Emerald Square Assisted Living **License Number:** AL5509 **Survey Event ID:** HQ9F11 **Date Survey Completed: 1/13/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1953	Based on: Based on record review, observation, and interview the facility failed to maintain resident records in such a form as to be readily available upon request for one (#4) of six sampled residents whose records were requested for review. A "Resident List", dated 01/12/23, documented 29 residents resided in the facility.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Will reach out to previous Owner/Management Company to get access to Point Click Care to gain access to Medical Records.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	We will maintain all records in resident charts doing quarterly audits. We will monitor all discharge residents on day of to secure all electronic and paper records.
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?	Upon resident discharge all records will be gathered and placed in a secure location for dishcaharged resident files.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Enter methods to ensure corrections are sustained: a. We will audit charts quarterly for accuracy. b. Will discuss Move Outs and record keeping at QA meetings monthly List of discharged residents. Will keep continuing list to track and mark when chart and records are secured.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/28/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.
Carina Elliott	2/24/23

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: emeraldsquareed@islllc.com

March 24, 2023

License Number: AL5509

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

Survey Event ID: HQ9F12

Dear Ms. McDaniel:

On **March 23, 2023,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 13, 2023,** have now been corrected effective **March 20, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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
	AL5509	A. BUILDING: _____ B. WING _____	R-C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD SQUARE ASSISTED LIVING COMMUNITY	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 An offsite/paper revisit was conducted on 03/23/23. 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