

Delivery via email to: westplainsed@islllc.com

May 23, 2023

License Number: AL5509

Ms. Catina Elliot, Administrator
Sand Sage of West Plains
701 North Council Road
Oklahoma City, OK 73127

RE: Survey Event ID: K7BO11

Dear Ms. Elliot:

On **April 17, 2023**, 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 April 17, 2023.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;

(6) Be signed by the administrator.

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

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

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

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

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Sand Sage of West Plains
Address: 701 N Council Rd
City, State, Zip: OKC, OK 73127
Provider #: AL5509
Complaint #: OK00058933
Investigation Date(s): 04/10/23-04/13/23, and 04/17/23

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The facility failed to ensure proper disposal of garbage.	US
2. The facility failed to have a current contract for removal of garbage from the facility.	US

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

An unannounced on-site investigation was initiated on 04/10/2023 at 11:10 a.m.

A sample of three residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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 related to proper disposal of garbage was conducted.

The garbage bins outside and inside were observed. There were no issues with garbage or the disposing garbage.

The residents stated they had not seen any overflowing trash anywhere or garbage not being picked up from their rooms.

The staff stated trash was emptied each shift including the weekend.

At the time of the survey, there was no deficient practice related to the physical environment.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation related to a current contract for removal of garbage from the facility was conducted.

There was no garbage issues outside, at the time of the survey.

The Administrator stated the had a contract with a garbage disposal company.

The maintenance supervisor stated, "We have no issues with garbage being picked up and it's cleaned on a regular basis."

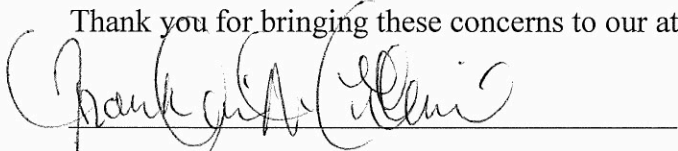
At the time of the survey, there was deficient practice related to garbage services.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. 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.

A handwritten signature in black ink, appearing to read "Franklin A. Calvin", written over a horizontal line.

Franklin A. Calvin Health Facility Surveyor III

Date report completed: 04/19/2023

INVESTIGATIVE REPORT LICENSURE

Facility: Sand Sage of West Plains
Address: 701 N Council Rd
City, State, Zip: OKC, OK 73127
Provider #: AL5509
Complaint #: OK00059061
Investigation Date(s): 04/10/23-04/13/23, and 04/17/23

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The facility failed to have and/or implement a pest control program.	US
2. The facility failed to prevent new or worsening pressure wounds.	US

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

An unannounced on-site investigation was initiated on 04/10/2023 at 11:10 a.m.

A sample of three residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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 related to the center's pest control program was conducted.

Pest control records were reviewed.

The maintenance supervisor stated, "We have no issues with pest, bugs or spiders."

During a tour of the center and specific rooms, no bed bugs were observed.

The residents had no complaints about bed bugs, at the time of the survey.

The staff stated they had not seen any pests or bed bugs, at the time of the survey.

At the time of the survey, there was no deficient practice related to the physical environment.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation related to skin assessments, turning/repositioning schedules, two hour check documentation and wound treatments were conducted.

Records were reviewed.

At the time of the survey, there were no resident's identified with pressure wounds.

At the time of the survey, no resident complained about not being checked every two hours.

At the time of the survey, the staff stated they checked on residents every two hours for toileting, repositioning and any other care needs.

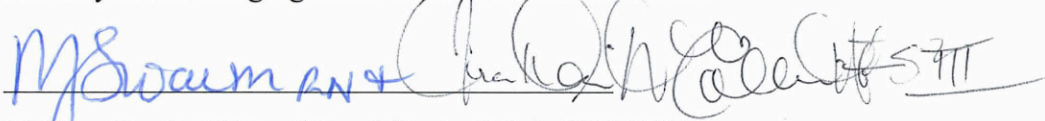
At the time of the survey, there was no deficient practice related the prevention or worsening of pressure wounds.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. 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.



Melissa Swaim RN and Franklin A. Calvin CHFS III

Date report completed: 04/18/2023

INVESTIGATIVE REPORT LICENSURE

Facility: Sand Sage of West Plains
Address: 701 N Council Rd
City, State, Zip: OKC, OK 73120
Provider #: AL5509
Complaint #: OK00060398
Investigation Date(s): 04/10/23-04/13/23, and 04/17/23

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were not sexually abused and failed to follow their abuse policy.	S

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

An unannounced on-site investigation was initiated on 04/10/2023 at 11:10 a.m.

A sample of three residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1917, and C1970 for details.

An investigation related to sexual abuse was conducted.

At the time of the survey, incident reports and investigative reports were reviewed.

At the time of the survey, no resident complained about sexual abuse or expressed any fear of sexual abuse.

At the time of the survey, the staff stated they knew what abuse was and if they were aware they would notify their immediate supervisor and/or the administrator.

At the time of the survey, there was no deficient practice related to sexual abuse.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. 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.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read "Melissa Swaim RN", is written over a horizontal line.

Melissa Swaim RN

Date report completed: 04/18/2023

Oklahoma State Department of Health

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 C 04/17/2023
NAME OF PROVIDER OR SUPPLIER SAND SAGE OF WEST PLAINS		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 relicensure survey was conducted 04/10/23 through 04/13/23, and 04/17/23. Complaint investigations (#OK00058933, OK00059061, and #OK00060398) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. A-fib - atrial fibrillation (irregular heart beat) DON - director of nursing ED - executive director FIFO - food in food out IM - Intramuscular LPN - licensed practical nurse LTCA - long term care aide MAR - medication administration record mcg - micrograms mg - milligram ml - milliliter PO - by mouth ppm - parts per million PT/INR - The prothrombin time (PT) can help diagnose bleeding or clotting disorders. The INR is used to monitor the blood-thinner warfarin treatment. QA - quality assurance RN - registered nurse UA - urinalysis	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:	C 391		

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 391	Continued From page 1 Based on observation and interview, the center failed to store, date, label according to Chapter 257 Food Establishments Regulations and the center's company policy. Findings: The LPN reported 29 residents are in the center. A policy titled, "Labeling and FIFO Method", undated, read in part, "... foods that are no longer in their original containers/packaging must be labeled with the common name and dated with a preparation date or an expiration date and/or time by which they must be served or discarded". On 04/10/23 at 11:37 a.m., it was observed that potatoes and multiple jars of salad dressing items were found undated and unlabeled. On 04/10/23 at 11:37 a.m., the Cook stated they washed the potatoes yesterday and did not label or date them. The Cook also stated, "The items that are unlabeled and undated were salad dressings and soup from today."	C 391		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.	C 543		

Oklahoma State Department of Health

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C 543	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure each comprehensive assessment included a personal interview between the resident or the resident's representative and the resident's personal physician or the person completing the form for four (#1, 3, 4 and #5) of eight residents whose comprehensive assessments were reviewed. Findings: The LPN reported 29 residents were in the center. Resident #1's comprehensive assessment, dated 04/07/23, was not signed by the resident's representative and the RN or resident's personal physician. Resident #3's comprehensive assessment, dated 04/17/23, was not signed by the resident or their representative and the RN or resident's personal physician. Resident #4's comprehensive assessment, dated 04/01/23, was not signed by the resident's representative. Resident #5's comprehensive assessment, dated 08/15/22, was not signed by the resident or their representative and the RN or resident's personal physician. On 04/17/23 at 9:34 a.m., the LPN stated the assessments had not been signed to include a personal interview between the resident or the resident's representative and the RN or resident's personal physician.	C 543		

Oklahoma State Department of Health

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C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure a service plan/care plan was developed and implemented for three (#1, 3, and #4) of eight sampled residents who required an individualized care plan. Findings: Resident #1 had a diagnoses to include vascular dementia with behavioral disturbances, type 2 diabetes mellitus, hypertension and chronic kidney disease stage III. There was no individualized care plan to go with their last assessment, dated 04/07/23. Resident #3 had a diagnoses to include diabetes mellitus with hyperglycemia, rheumatoid arthritis, atrial fibrillation, ankylosing spondylitis/spine and insomnia. The care plan was missing. Resident #4 had diagnoses to include depression, insomnia, hypertension, diabetes mellitus, edema and dementia. There was no care plan to go with the assessment, dated 04/01/23.	C 552		

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C 552	Continued From page 4 On 04/17/23 at 9:34 a.m., the LPN stated the care plans were missing or incomplete and/or not individualized to the residents.	C 552		
C 702 SS=F	Hot Water - Dietary - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. The minimum hot water temperature available for use in the dietary department shall be 120 degrees Fahrenheit (49 degrees C.). When hot water is used for sanitizing dishes and utensils, rinse water temperature shall be a minimum of 180 degrees Fahrenheit. This Rule is not met as evidenced by: Based on record review, observation and interview the center's dish machine temperature failed to reach 120 degrees for sanitizing dishes and utensils. The dishwashing logs were not completed and were observed below 50 ppm, according to Chapter 257 Regulations and the center's policy. The LPN reported 29 residents in the center. Findings: The "Culinary Sanitation and Elevate Policies and Procedures," dated 10/01/18, read in part, "...All equipment is in clean, working order. Associates	C 702		

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C 702	Continued From page 5 must use sanitizer test strips/kits according to manufacturers' instructions. Associates must complete the Sanitization Bucket Log at each meal and along with the tested sanitizer concentration along with documentation of the ppm reading. A cold water sanitizer clean solution contain no less than 50 ppm. Water temperature and chemical concentrations shall be monitored and documented prior to dishwashing..." On 04/12/23, during a tour of the kitchen with the Supervisor, the dishwasher thermometer reached a temperature of 110 degrees. A sanitization test was also conducted by the Supervisor and the test strips ranged between 25 and 50 ppm. Both the temperature of the dish machine and the ppm of the test strips were outside of the recommended parameters. On 04/12/23 at 5:05 p.m., an observation with the Cook was observed and the thermometer on the dishwasher was not in working order. They stated, "The thermometer on the dishwasher is not working today." On 04/13/23 at 10:02 a.m., the Kitchen Supervisor stated, March and April dishwasher logs were not completed. They stated, "Yes! March and April has not been done."	C 702		
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.	C 921		

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C 921	Continued From page 6 This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure monthly medication reviews were completed by the RN or pharmacy consultant at least monthly. The LPN identified 29 residents at the center. Findings: The documentation for November 2022 and February 2023 medication reviews for the residents were not completed. On 04/13/23 at 10:40 a.m., the Administrator stated, "Nobody was here in February to do the monthly medication reviews." On 04/17/23 at 10:44 a.m., the Administrator stated there was no monthly medication review conducted November 2022.	C 921		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 7 consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure the pharmacy and the center verified and monitored the resident's received physician ordered medications: a) anticoagulant medication for one (#3) of one sampled resident who missed 11 doses of anticoagulant therapy, 12 doses of antiarrhythmic and blood pressure support medication, 6 doses of immunosuppressive medication, and 11 doses	C1505		

Oklahoma State Department of Health

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 C 04/17/2023
NAME OF PROVIDER OR SUPPLIER SAND SAGE OF WEST PLAINS		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
C1505	Continued From page 8 of hormone therapy; and b) Vitamin B12 IM injection for one (#1) of one sampled resident who missed their monthly injection since January, February and March of 2023 (3 doses), Findings: Appendix E of the residency agreement, read in part, "...Every resident shall have the right to receive adequate and appropriate medical care..." 1. Resident #3 had a diagnoses to include a-fib and rheumatoid arthritis. Resident #3 had a physician order for coumadin (anticoagulant/blood thinner) 5 mg, 1 tablet by mouth once daily. It was documented on the March 2023 MAR the resident had missed 12 doses. Resident #3 had a physician order for digoxin (antiarrhythmic and blood pressure support medication) 0.125 mg, 1 tablet, PO once daily. It was documented on the March 2023 MAR the resident had missed 12 doses. Resident #3 had a physician order for methotrexate (immunosuppressive medication) 2.5 mg, 4 tablets (10 mg), PO every Friday. It was documented on the February 2023 MAR they had missed 4 doses and March 2023 MAR documented they had missed 2 doses. Resident #3 had a physician order for levothyroxine (hormone therapy) 88 mcg, 1 tablet, PO every morning. It was documented on the February 2023 MAR they had missed 7 doses	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 9 and March 2023 MAR documented 4 missed doses. 2. Resident #1 had a diagnosis to include vascular dementia with behavioral disturbances. Resident #1 had a physician order to receive a vitamin B-12, 1 ml, IM injection every four weeks on Thursday for supplement. There was missing documentation on the January, February, and March 2023 MAR the resident received their monthly supplement of vitamin B-12 three times. On 04/17/23 at 9:51 a.m., the LPN stated it would have been important for resident #3 to receive their physician ordered medications to maintain therapeutic levels. On 04/17/23 at 1:30 p.m., the LPN stated resident #1 had not received their vitamin B-12 injection since January 2023.	C1505		
C1917 SS=D	310:663-19-(g) REPORTS TO THE DEPARTMENT (g) Content of Incident Report (1) The preliminary report shall at the minimum include: (A) who, what, when, and where; and (B) measures taken to protect the resident(s) during the investigation. (2) The follow-up report shall at the minimum include: (A) preliminary information; (B) the extent of the injury or damage if any; and (C) preliminary findings of the investigation. (3) The final report shall, at the minimum, include preliminary and follow-up information and:	C1917		

Oklahoma State Department of Health

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C1917	Continued From page 10 (A) a summary of the investigative actions; (B) investigative findings and conclusions based on findings; (C) corrective measures to prevent future occurrences; and (D) if items are omitted, why the items are omitted and when they will be provided. This Rule is not met as evidenced by: Based on record review and interview, the center failed to complete a detailed incident report to the Department concerning an allegation of sexual abuse for one (#1) of one resident sampled for sexual abuse. Findings: The associate handbook, "Abuse Reporting," read in part, "...Community associates must report all suspected instances of physical and emotional abuse...Law requires you to report suspected abuse...you have knowledge of an incident that reasonably appears to be abuse or you suspect abuse has taken place. All reports should be made to your manager, Executive Director and/or Adult Protective Services. All allegations of elder abuse will be quickly and thoroughly be investigated..." A policy, "Incident Reports," read in part, "...Each employee shall report to their supervisor...undesirable incidents involving a resident...any employee who witnesses or learns	C1917		

Oklahoma State Department of Health

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 C 04/17/2023
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C1917	Continued From page 11 of an incident should promptly report it to their supervisor...incidents are reported immediately to family/responsible party and physician. Document the date and time the report was made to the family/responsible party and physician in the resident's record...The Executive Director...must promptly review the incident report for accuracy and completeness assuring all appropriate state agencies, responsible parties, physician...are notified...The Resident Care Director or Executive Director must provide follow-up including, but not limited to, An evaluation of the resident to determine the need for a re-assessment and updated service plan; A determination for the need for physician follow-up; A determination if an intervention is needed to decrease the likelihood of a reoccurrence; Written documentation in the resident's record of all actions taken...Adherence to this policy is the responsibility of the Executive Director...Incidents requiring reporting...allegations and incident of resident abuse...contents of incident reports...who, what, when, and where; and measures taken to protect the resident(s) during the investigation, The follow-up report shall at the minimum include: preliminary information, the extent of the injury or damage if any; and preliminary findings of the investigation. The final report shall, at the minimum, include preliminary and follow-up information and: a summary of investigative actions; investigative findings and conclusions based on findings; corrective measures to prevent future occurrences; and if items are omitted, why the items are omitted and when they will be provided..." There was no documentation of the date and time the report was made to the family/responsible party and physician in the resident's record or written documentation in the resident's record of	C1917		

Oklahoma State Department of Health

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C1917	Continued From page 12 all actions taken. There was no assessment or evaluation of the resident by a healthcare professional. There was no documentation of interventions to decrease the likelihood of reoccurrence. There was no documentation of measures taken to protect the resident(s) during the investigation. On 04/11/23 at 8:54 a.m., the LPN stated all staff were interviewed. They provided no documentation at the time of the survey to include all staff were interviewed. On 04/11/23 at 11:09 a.m., the LPN stated there was no documentation of the two hour checks of the resident, "Just verbal." There was no re-assessment of the resident by the nurse or the nurse practitioner. On 04/11/23 at 2:11 p.m., the LPN was asked how they knew the labs had been completed. They stated, "They should notify me when they are here or call if after hours." There was an order for a UA, dated 04/04/23, but no healthcare professional had collected the specimen. On 04/12/23 at 10:13 a.m., LTCA #2 stated they did not report the allegation until the next day.	C1917		
C1970 SS=D	310:663-19-4(a) POLICIES (a) Each assisted living center shall have a written policy statement that expressly prohibits the abuse or neglect of residents or misappropriation of resident property it serves. The policy shall include the facility's investigative	C1970		

Oklahoma State Department of Health

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C1970	Continued From page 13 procedures and actions to be taken when incidents of abuse or neglect of residents or misappropriation of resident's property occur. This Rule is not met as evidenced by: Based on record review and interview, the center failed to implement the center's resident abuse, neglect, and exploitation policy when an allegation of abuse was reported. It was determined the center failed to take actions to assess and determine if emergency medical care was needed and failed to notify the resident's authorized responsible party and physician of the abuse allegation immediately for 1 (#1) of 1 sampled resident with an allegation of abuse. Findings: A policy, "Resident Abuse, Neglect, and Exploitation," read in part, "...required to immediately provide notification to persons/agencies as described in this policy...mandatory reporting requirements per state regulations...Staff members, as mandated reporters, have the duty to report all suspected abuse, neglect, and exploitation....Safeguarding the Resident...Any staff member who has cause to believe that an incident of any form of abuse/neglect/exploitation has occurred will take immediate action to protect the resident from additional harm...If any staff member...suspects...an incident which appears to be any form of abuse/neglect/exploitation, the staff member will immediately notify the Executive	C1970		

Oklahoma State Department of Health

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C1970	Continued From page 14 Director or manager on duty. In all cases the Executive Director will be notified as soon as possible...Upon notice of reported...suspected or at imminent risk of any form of abuse/neglect/exploitation: Immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is conducted...The alleged perpetrator will have no contact with any residents during the investigation. A thorough investigation will be conducted by the Resident Care Director or Executive Director. The resident is interviewed, and responses documented. Witnesses or other persons may need to be interviewed as part of the investigation process. The Resident Care Director arranges for medical evaluation of the resident...The family/responsible party will be notified immediately upon management becoming aware of the incident. The resident's physician is notified immediately...Provide written statement regarding what they witnessed...The Executive Director or manager on duty will do the following: Local law enforcement will be notified as required by State regulations...collaborate with and involve the staff member on the completion of all required reports...The Executive Director is responsible to ensure that the incident is reported per state regulations and laws...Additional Resident Documentation...The Resident Care Director or ED will gather the following additional information...A re-assessment will be conducted as soon as practicable after the suspected abuse...has been reported...Information from the resident's primary care provider and/or any other health care provider the resident sees secondary to the suspected abuse event is obtained..." There was no documentation to determine the immediate action taken to protect the resident	C1970		

Oklahoma State Department of Health

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C1970	Continued From page 15 without an assessment, documented two hour checks of the resident, no medication review, no other resident(s) interviewed, or documented interviews with all staff. There was no documentation of the resident interviewed. There was no additional information documented, no assessment, no information from the resident's primary care provider or any other health care provider. The family or resident representative, physician, and law enforcement were not notified immediately. On 04/12/23 at 9:58 a.m., LTCA #1 was asked if they witnessed abuse at the center. They stated, "Not here." When LTCA #2 was asked about an allegation of sexual abuse which was not reported immediately, they stated they didn't say anything until the next day. On 04/12/23 at 11:40 a.m., the LPN was asked if there was any person they were suspicious of. They stated, "No one in particular." They stated their visiting hours were changed to 8:00 a.m. to 8:00 p.m. When the LPN was asked about narrative notes to review they stated there weren't any. On 04/12/23 at 11:54 a.m., LTCA #3 stated they checked on residents every two hours. When they were asked if there was anything out of the ordinary Sunday night (04/02/23) they stated, "No, nothing." On 04/12/23 at 1:35 p.m., the LPN stated the updated visiting hours and improved	C1970		

Oklahoma State Department of Health

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C1970	Continued From page 16 neighborhood lighting was for the protection of all residents. On 04/12/23 at 3:44 p.m., LTCA #4 was asked about the last bed check the morning of 04/03/23 at 5:00 a.m. They stated they didn't see anything out of the ordinary or different. On 04/12/23 at 3:59 p.m., the RN was asked about the assessment completed 04/07/23. They stated the reason for the assessment was computer generated and was due. When asked about the allegation of sexual abuse and their assessment, they stated, "Yeah, no, nobody had informed me about that at all." There was no documentation the resident had been assessed by a health care professional, at the time of the allegation. On 04/13/23 at 1:54 p.m., the administrator stated there were no cameras located in the area the resident lived in. They stated there was no playback feature after a weeks time. They stated they now had access to the cameras and they could now sign on/log in if they wanted to view or replay. On 04/17/23 at 2:40 p.m., during lab record review, the LPN was asked about the physician ordered urinalysis dated 04/04/23, they stated it was not collected until 04/11/23. The additional tests were ordered 04/05/23, but weren't collected until 04/17/23. Labwork had not been collected in a timely manner.	C1970		

Oklahoma State Department of Health

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C5010	Continued From page 17	C5010			
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on record review and interview, the center failed to coordinate care with third party providers	C5010			

Oklahoma State Department of Health

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C5010	Continued From page 18 to ensure services were provided and an accurate list of physicians ordered medications or blood labwork between the assisted living center and the home health agency for two (#1 and #3) of two resident's who had third party provider services. There were 10 residents with home health and 4 residents with hospice services. Findings: A policy, "Home Health and Other Outside Agencies," read in part, "...coordinate care... Verify the physician's order if a homehealth or other agency arrives in the Community...The nurse/health professional should document any significant status change and care plan updates to provide continuity of care and to ensure a prohibited condition is not developing...apprised of all new orders, medication changes, and response to interventions...The care plan of the home health/outside agency should be completely consistent with the Community's Service Plan...The assisted living center shall monitor and assure the delivery of [home care] services..." On 04/10/23, there were no 485's (home health certification period plan of care) or hospice orders on hand at the center in the resident chart or separate binder or QA. 1. Resident #3 A pharmacy report, dated 03/09/23, documented recommendations to include, "Please ensure weekly monthly INR in patient chart for review." There was no documentation provided to include	C5010		

Oklahoma State Department of Health

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 C 04/17/2023
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C5010	Continued From page 19 weekly or monthly PT/INR's to ensure third party services were provided. 2. Resident #1 The physician orders and the medication list from home health agency did not match. On 04/17/23 at 2:39 p.m., the LPN stated the third party provider physician orders needed to be updated.	C5010		

Delivery via email to: westplainsed@isllc.com

June 7, 2023

License Number: AL5509

Ms. Tina Elliot, Administrator
Sand Sage of West Plains
701 North Council Road
Oklahoma City, OK 73127

Survey Event ID: K7BO11

Dear Ms. Elliot:

On **April 17, 2023**, a Relicensure survey and a complaint investigation were 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 **July 17, 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

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

enc



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/2/2023

Facility Name: Sand Sage of West Plains

License Number: AL5509

Survey Event ID: K7B011

Date Survey Completed: 4/17/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391 Food
Storage and preparation

Based on: Failed to store, date, label according to Chapter 257 Food Establishments regulations and the center's company policy.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

Administrator signature required

OAC 310:663-25-4(F)

Cashia Elliott

Date Enter a date of signature.

6/2/23

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

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/2/2023

Facility Name: Sand Sage of West Plains

License Number: AL5509

Survey Event ID: K7B011

Date Survey Completed: 4/17/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 543 Conduct
of Assessment

Based on: Failed to ensure each comprehensive assessment included a personal interview between the resident or the resident's representative and the resident's personal physician or the person completing the form for four (#1, 3, 4, #5 of assessments were reviewed.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The community will conduct a personal interview and obtain the following signatures for the comprehensive assessment: #1, 3, 5: resident or resident's representative and the RN or personal physician; #4 resident's representative

Audits of comprehensive assessment will be completed. Those assessments identified with missing signatures: the community will conduct a personal interview with the resident or resident representative and RN or resident's personal physician. The signature will be obtained at the personal interview.

The community will review the regulations requirements for completing a comprehensive assessment and conducting a personal interview with the resident or resident representative and with the RN or resident's personal physician. New comprehensive assessments will be reviewed by ED during morning meeting.

Audits will be conducted on comprehensive assessments:

Monthly audits for 3 months on all comprehensive assessments completed for signatures and personal interviews.

Comprehensive Audit completed by 3rd party will include review of comprehensive assessments for completion and signatures. This will be schedule every 6 months.

Completed Audit tools will be kept in an audit/QA binder

7/17/2023

Administrator's Signature Administrator signature required <i>Catrina Elliott</i>		Date Enter a date of signature. <i>6/2/23</i>	
OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



OKLAHOMA
State Department
of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/2/2023

Facility Name: Sand Sage of West Plains

License Number: AL5509

Survey Event ID: K7B011

Date Survey Completed: 4/17/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 552 Use of
Assessment

Based on: the center failed to ensure a service plan/care plan was developed and implemented for three (#1, 3, and #4)

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Residents #1, 3, 4: service plans will be reviewed and updated to reflect the individual needs of the resident.

Audits of resident service plans will be completed. Those service plans not individualized or incomplete will be updated to reflect the individual needs of the resident.

As resident assessments come due and service plans/agreements are updated, a meeting will be held with resident/families and community staff to review and modify the service plans/agreements. Signatures will be obtained on the service agreement.

Service plan audits:

Monthly audits for 3 months on all service plans for individualization and completion

Comprehensive Audit completed by 3rd party will include review of service plans for individualization and completeness. This will be schedule every 6 months.

Completed Audit tools will be kept in an audit/QA binder

7/17/2023

Administrator's Signature Administrator signature required.

OAC 310:663-25-4(F)

Carolina Elliott

Date Enter a date of signature.

6/2/23

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Addendum Date Enter a date of addendum.

Submitted by

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OKLAHOMA
State Department
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/2/2023

Facility Name: Sand Sage of West Plains

License Number: AL5509

Survey Event ID: K7B011

Date Survey Completed: 4/17/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 702-Hot
water - Dietary

Based on: the center's dish machine temperature failed to reach 120 degrees for sanitizing dishes and utensils, rinse water temperature shall be a minimum of 180 degrees

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

Administrator signature required

OAC 310:663-25-4(F)

Cathina Elliott

Date Enter a date of signature.

6/2/23

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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/2/2023

Facility Name: Sand Sage of West Plains

License Number: AL5509

Survey Event ID: K7B011

Date Survey Completed: 4/17/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 921
Medication Staffing

Based on: the center failed to ensure monthly medication review wer completed by the RN or Pharamcy consultant at least monthly

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Administrator signature required.
OAC 310:663-25-4(F)

Catrina Elliott

Date Enter a date of signature.

6/2/23

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