OKLAHOMA
State Department
of Health

Delivery via email to: westplainsed@islllc.com

February 12, 2024

License Number: AL5509

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

Survey Event ID: 0WXP11

Dear Ms. Elliot:

On **February 8, 2024,** 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 **d**eficiencies 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 Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action 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 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face to face, or a virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Sand Sage of West Plains**
Address: **701 North Council Road**
City, State, Zip: **Oklahoma City, Ok, 73127**
Facility ID #: **AL 5509**
Complaint #: **OK00060544**
Investigation Date(s): **02/07/24 through 02/08/24**

ALLEGATIONS

The center failed to ensure medications were administered according to the physicians' orders and failed to ensure diet was served according to the physicians' orders.
The center failed to ensure adequate staff to meet the needs of the resident in a timely manner.

An unannounced on-site investigation was initiated 02/07/2024 at 8:35 a.m.

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

The investigation was conducted following standards set by the 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. **Residents were observed for call light pendant in place.** Staff were observed interacting with residents appropriately and timely. Meal service was observed to be served as ordered. Housekeeping was observed cleaning resident rooms.

Resident records including assessments, resident care contracts, physician orders, medication administration records, living level of care records, and financial contracts were reviewed. Facility policies and procedures were reviewed. Grievances were reviewed.

Residents were interviewed related to the provision of medication administration, meals served following their diet, and the timeliness of staff response.

Staff members were interviewed regarding the facility policies on medication administration, diets as ordered, timeliness of staff response, and appropriate staff levels for resident acuity.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/08/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Sand Sage of West Plains**
Address: **701 North Council Road**
City, State, Zip: **Oklahoma City, OK, 73127**
Provider #: **AL5509**
Complaint #: **OK00062302**
Investigation Date(s): **02/07/24 through 02/08/24**

ALLEGATION(S)

The center failed to ensure residents did not elope from the facility and failed to notify the State Agency (OSDH) of the elopement.
The center failed to ensure the building was maintained in good condition and the heat was maintained in good working order.

An unannounced on-site investigation was initiated 02/07/2024 at 8:35 a.m.

A sample of 6 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls were observed for the environment being in good repair. Staff were observed assisting residents with their needs. Ambient room temperatures were obtained from resident rooms and common areas.

Resident records including assessments, resident care contracts, physician orders, living level of care records, and financial contracts were reviewed. State reportable incidents were reviewed. Maintenance reports were reviewed. Signature logs for leaving and returning to the facility were reviewed. Facility policy and procedures were reviewed. Grievance records were reviewed.

Residents were interviewed related to the provision of the process of leaving the facility, environment, housekeeping cleaning schedules, and comfortable temperatures.

Staff members were interviewed regarding the facility policy on comfortable temperatures, maintenance, representative notification with change in condition, and elopement. They were asked about the procedure for residents leaving the facility for an outing.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 02/08/2024

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 _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND SAGE OF WEST PLAINS	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 Complaint investigations (#OK00060544 and #OK00062302) were conducted on 02/07/24 through 02/08/24. Facility Census: 30 The following abbreviations will be used throughout this record. ACMA- advanced certified medication aide CMA- certified medication aide CPR- cardiopulmonary resuscitation DNR- do not resuscitate GM- grams mg- milligram	C 000		
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 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	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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SAND SAGE OF WEST PLAINS	701 NORTH COUNCIL ROAD OKLAHOMA CITY, OK 73127

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C1505	Continued From page 1 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: a. provide medications as ordered for two (#2 and #4) of three sampled residents; and b. accurately document a code status for one (#4) of three sampled residents reviewed for medication administration. The Executive Director identified a census of 30. Findings: A "Medication Refills" policy, dated 12/01/23, read in part, "...Medication refills will be obtained in a timely manner to ensure residents have all physician or other healthcare practitioner ordered medications available...CMA on-duty contacts the dispensing pharmacy to obtain a refill at least seven...days prior to a medication running out unless the medication is on a cycle refill with the	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 _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND SAGE OF WEST PLAINS	701 NORTH COUNCIL ROAD OKLAHOMA CITY, OK 73127

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C1505	Continued From page 2 pharmacy...Medication staff work to ensure medications are not allowed to run out unless directed by the prescribing physician/practitioner..." 1. Resident #2 had diagnoses which included osteoarthritis, depression, and pain. A "Physician Order", dated 10/19/23, documented tramadol 50 mg take one tablet by mouth every eight hours for low back pain. A "Physician Orders", dated 10/31/23, documented super beta prostate one capsule by mouth every morning, and super beta prostate one capsule by mouth every evening. A "Physician Order", dated 11/29/23, documented duloxetine 30 mg take one capsule by mouth once daily. The "December 2023 Medication Sheet" documented the facility was: a. "awaiting pharmacy delivery" or "medication not available" for the super beta prostate on the 5th, 6th, 7th, 8th, 9th, 10th, 11th, 12th, 13th, 14th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, 30th, and 31st; b. "awaiting pharmacy delivery" for the tramadol 50 mg on the 29th; and c. "awaiting pharmacy delivery" for the duloxetine 30 mg on the 30th. A "Physician Order", dated 01/04/24, documented tramadol 50 mg take one tablet by mouth every eight hours.	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 _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND SAGE OF WEST PLAINS	701 NORTH COUNCIL ROAD OKLAHOMA CITY, OK 73127

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C1505	Continued From page 3 The "January 2024 Medication Sheet" documented the facility was: a. "awaiting pharmacy delivery" or "medication not available" for the super beta prostate on the 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, 12th, 13th, 15th, 16th, 17th, 18th, 19th, 20th, 21st, 22nd, 24th, 25th, 26th, 27th, 28th, 29th, 30th, and 31st.; and b. "awaiting pharmacy delivery" for the tramadol 50 mg on the 31st. The "February 2024 Medication Sheet" documented the facility was: a. "awaiting pharmacy delivery" for the tramadol 50 mg on the 1st, and the 2nd; and b. "awaiting pharmacy delivery" for the super beta prostate on the 1st, 2nd, 3rd, 4th, 5th, and 6th. On 02/07/24 at 2:52 p.m., ACMA #2 stated staff verified medications were in house, and on the cart. They stated if they had questions, they would get clarification from the doctor and pharmacy to ensure medications were profiled correctly. ACMA #2 stated all ACMAs were responsible for reordering medications. They stated if they could not figure out the reason the medication was not available to administer, they would notify the nurse. On 02/07/24 at 3:00 p.m., ACMA #2 stated the pharmacy reported Resident #2's prostate medication was not available due to back order. They stated the physician was not notified because it was an over the counter medication. They were asked to provide documentation from	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 _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND SAGE OF WEST PLAINS	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 4	C1505		

the pharmacy the medication was on back order.

No documentation of the back order was provided prior to survey exit.
2. Resident #4 had a diagnosis of Alzheimer's disease, glaucoma, and cough.

Resident #4 had a signed DNR dated 07/31/17 in the facility's records.

A "Physician Order", dated 04/21/23, documented refresh cell gel 1 percent eye drops apply one drop into both eyes three times a day.

A "Physician Order", dated 06/01/23, documented Tiotropium Bromide-Olodaterol two GM inhale 2 puffs by mouth once daily.

The "Physician Order Sheet" dated 01/04/24, documented resident #4 code status as "CPR".

The "January 2024 Medication Sheet" documented:

a. the refresh cell gel was held on 01/12/24 for being "out of parameters".

b. the Tiotropium Bromide-Olodaterol was held on the 15th, 16th, 17th and 21st due to "awaiting pharmacy delivery".

On 02/07/24 at 3:20 p.m., ACMA #2 stated when a medication was held, staff was to select from preprogrammed reasons given in the system. They stated staff were supposed to order medications in enough time to allow pharmacy the approximate two weeks required to get medications delivered.

On 02/07/24 at 3:35 p.m., the Resident Care

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 _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND SAGE OF WEST PLAINS	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 5 Director stated they would expect staff to "look all through the emergency book to see if they had a DNR". On 02/08/24 at 9:13 a.m., the Executive Director stated charts were to be audited at least monthly and all the staff were responsible for the inconsistent code status documentation.	C1505		

OKLAHOMA
State Department of Health

Delivery via email to: westplainsed@islllc.com

April 2, 2024

License Number: AL5509
Survey Event ID: 0WXP12

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

Dear Ms. Elliot:

On **March 28, 2024**, an offsite/paper revisit was conducted at your facility by this agency. The findings of that visit indicate that the deficiencies cited during your survey on **February 8, 2024,** have now been corrected and your facility is in compliance with licensure standards effective **February 21, 2024**.

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

Respectfully,

Clorissa Nubine

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5509	A. BUILDING: _____ B. WING _____	R-C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND SAGE OF WEST PLAINS	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 03/28/24. 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

OKLAHOMA
State Department
of Health

Delivery via email to: westplainsed@islllc.com

March 5, 2024

License Number: AL5509

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

Survey Event ID: 0WXP11

Dear Ms. Elliot:

On **February 8, 2024,** 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 **February 21, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Clorissa Nubine

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/21/2024** **Facility Name:** Sand Sage of West Plains **License Number:** AL5509 **Survey Event ID:** 0WXP11 **Date Survey Completed: 2/8/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505 Resident Rights; Medical Care	Based on: Based on record review and interview, the center failed to: accurately document a code status for one (#4) of three sampled residents reviewed for medication administration.

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?	RCD/ED will check physical chart and EMAR system for up to date code status for accuracy on Face Sheet.
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 inserviced on the procedure of reporting new or updated medical documents turned in by family or outside services.
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?	Physical chart, EMAR, Emergency Book and face sheet audit will be conducted monthly x3, then quarterly x1 year.
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.	Chart Audits will be kept in State Binder. As of 2/21/24, all up to date with chart audit for accuracy. Deficiency will be discussed at QA monthly to determine findings. Logs of completed chart audit will be kept in State binder located in ED's office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/5/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Carina Ellett **Date** Enter a date of signature. 2/21/24
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
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 2/21/2024
Facility Name: Sand Sage of West Plains
License Number: AL5509
Survey Event ID: 0WXP11
Date Survey Completed: 2/8/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505 Resident Right Medical Care	Based on: Based on record review and interview, the center failed to:a. provide medications as ordered for two (#2 and #4) of three sampled residents;

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?	Medication was d/c'd per physician's orders on 2-12-24. CMA's will be inserviced on updating the nurse in a timely manner on any further medication outages to prevent missed meds. Communication to RCD on any medication changes. RCD will check med delivery report every business day.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Med tech to Med tech communication sheets and New Med/refill roster will be used per policy to communicate medication needs.
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?	Bi weekly med cart audits x1 month to ensure medications are in stock. CMA's will inform nurse on any missed medications in a timely manner. Implementing new med/refill roster to document medication communication.
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.	Bi weekly med cart and chart audits x 1 month. Reinforce med tech to med tech communication and med refill/roster. Will retain per policy. Enter methods to evaluate for effectiveness: Introduce and discuss in monthly QA meetings. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/5/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Carina Ellett **Date** Enter a date of signature. 2/21/24
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

OKLAHOMA
State Department of Health

Delivery via email to: westplainsed@islllc.com

April 2, 2024

License Number: AL5509
Survey Event ID: 0WXP12

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

Dear Ms. Elliot:

On **March 28, 2024**, an offsite/paper revisit was conducted at your facility by this agency. The findings of that visit indicate that the deficiencies cited during your survey on **February 8, 2024,** have now been corrected and your facility is in compliance with licensure standards effective **February 21, 2024**.

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

Respectfully,

Clorissa Nubine

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5509	A. BUILDING: _____ B. WING _____	R-C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND SAGE OF WEST PLAINS	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 03/28/24. 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