
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 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 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, Enforcement Analyst II
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: AL5509	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/14/2024
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 from 05/13/24 through 05/14/24. Facility Census: 35 The following abbreviations will be used throughout this survey: RCD-resident care director RN- registered nurse	C 000		
C 318 SS=E	310:663-3-2(b) ADMISSION CRITERIA (b) The assisted living center's admission criteria shall be included in the assisted living center's application for license and the resident service contract. This Rule is not met as evidenced by: Based on record review and interview, the center failed to include the admission criteria in the resident contracts for six (#1, 3, 4, 5, 6, and #8) of eight sampled residents whose resident agreement were reviewed. The Executive Director identified 35 residents resided in the center. Findings: Resident #1's residency agreement, dated 04/01/22, did not document an admission criteria. Resident #8's residency agreement, dated 01/10/23, did not document an admission criteria.	C 318		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

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 05/14/2024
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C 318	Continued From page 1 Resident #6's residency agreement, dated 04/07/23, did not document an admission criteria. Resident #4's residency agreement, dated 01/31/24, did not document an admission criteria. Resident #3's residency agreement, dated 04/10/24, did not document an admission criteria. Resident #5's residency agreement, dated 04/18/24, did not document an admission criteria. On 05/14/24 at 8:24 a.m., the Executive Director stated the contracts for the residents above did not contain the criteria for admission to the center.	C 318		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for one (#6) of eight sampled residents whose assessments were reviewed.	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 2 The Executive Director identified 35 residents in the center. Findings: The "Resident Assessment and Reassessment (Oklahoma)" policy, dated 09/15, read in part, "...The Community shall complete the comprehensive assessment within 14 days after move in...then once every 12 months..." Resident #3 had an annual assessment dated 06/22/22. On 05/14/24, the RCD stated resident assessments were completed on admission, 14 days, annually or with a change in condition. On 05/14/24 at 12:57 p.m., the RCD stated Resident #6's annual assessment was not completed.	C 522		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure resident assessments were coordinated and signed by a registered nurse, or the resident's physician for two (#3 and #5) of eight sampled residents whose assessments were reviewed.	C 542		

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 05/14/2024
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C 542	Continued From page 3 The Executive Director identified 35 residents in the center. Findings: The "Resident Assessment and Reassessment (Oklahoma)" policy, dated 09/15, read in part, "...All assessments must be coordinated and signed by a registered nurse or the resident's personal physician..." 1. Resident #3 was admitted to the facility on 04/11/24. Resident #3's admission assessment, dated 04/25/24, did not document the assessment had been coordinated and signed by an RN or the Resident's physician. 2. Resident #5 was admitted to the facility on 04/18/24. Resident #5's 14 day assessment, dated 05/05/24, did not document the assessment had been coordinated and signed by an RN or the resident's physician. On 05/14/24 at 12:54 p.m., the RCD stated there was no RN or Resident's physician signature for Resident #3's admission assessment. On 05/14/24 at 1:11 p.m., the RCD stated there was no RN or Resident's physician signature for Resident #5's 14 day assessment.	C 542		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a	C 543		

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 05/14/2024
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C 543	Continued From page 4 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. This Rule is not met as evidenced by: Based on record review and interview, the center failed to conduct a personal interview between the resident and/or the resident's representative for one (#4) of eight sampled residents whose assessments were reviewed. The Executive Director identified 35 residents resided in the center. Findings: The "Resident Assessment and Reassessment (Oklahoma)" policy, dated 09/15, read in part, "...The Community 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 community shall include in the comprehensive assessment the resident's representative or personal physician..." Resident #4 was admitted to the center on 02/05/24. Resident #4's preadmission resident assessment, dated 01/30/24, did not document a personal interview between the Resident and/or the Resident's representative.	C 543		

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 05/14/2024
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C 543	Continued From page 5 On 05/14/24 at 12:30 p.m., the RCD stated Resident #4's assessment was to be signed by their representative who lived out of state. They stated the assessment had not been signed.	C 543		

Delivery via email to: westplainsed@islllc.com

June 6, 2024

License Number: AL5509

Ms. Holly L. Miller, Administrator
Sand Sage Of West Plains
701 North Council Road
Oklahoma City, OK 73127

RE: Survey Event 1J0011

Dear Ms. Miller:

On **May 14, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. **Our acceptance does not absolve the facility's responsibility for compliance** should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 30, 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,

Tempal Killman

Tempal Killman, 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: 5/28/2024		
	Facility Name: Sand Sage of West Plains		
	License Number: AL5509		
Survey Event ID: 1J0011			Date Survey Completed: 5/14/2024
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 318		Based on: Based on record review and interview, the center failed to include the admission criteria in the resident contracts for six (#1, 3, 4, 5, 6, and #8) of eight sampled residents whose resident agreement 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		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?		Addendum with admission criteria will be created and signed by current residents.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Admission criteria will be added to residency agreement.	
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?		Admission criteria added to residency agreement	
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: ED or designee will confirm criteria is listed in agreement before signing takes place. Discussion of move ins and review of residency agreement for current month of admission criteria. Kept in QA Binder	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		6/30/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required OAC 310:663-25-4(F)		Date Enter a date of signature. 5/28/24	
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: 5/28/2024

Facility Name: Sand Sage of West Plains

License Number: AL5509

Survey Event ID: 1J0011

Date Survey Completed: 5/14/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522

Based on: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for one (#6) of eight sampled residents whose 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 ☐

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

Date Enter a date of signature.

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: 5/28/2024

Facility Name: Sand Sage of West Plains

License Number: AL5509

Survey Event ID: 1J0011

Date Survey Completed: 5/14/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 542

Based on: Based on record review and interview, the center failed to ensure resident assessments were coordinated and signed by a registered nurse, or the resident's physician for two (#3 and #5) of eight sampled residents whose 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 ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator's signature required

Cristina Elliott

Date Enter a date of signature.

5/28/24

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

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
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	License Number: AL5509		
	Survey Event ID: 1J0011		
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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 or designee will conduct an interview with resident #4 representative for review and signature.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Audit completed of all charts to ensure signatures are obtained and if not, will obtain.	
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?		RCD or designee will ensure when assessment is completed, resident or representative will sign the assessment after discussion of assessment findings during care conference.	
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: Assessments will be reviewed for signature and dates of interviews with residents or their representative. Per our policy, care conferences are conducted anytime assessments updated and signatures obtained. Once signatures are obtained assessments placed in charts. Care conferences will be audited by ED monthly to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		6/30/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature. 5/28/24	
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Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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Oklahoma State Department of Health

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Oklahoma State Department of Health

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

TITLE

(X6) DATE

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 05/14/2024
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 318	Continued From page 1 Resident #6's residency agreement, dated 04/07/23, did not document an admission criteria. Resident #4's residency agreement, dated 01/31/24, did not document an admission criteria. Resident #3's residency agreement, dated 04/10/24, did not document an admission criteria. Resident #5's residency agreement, dated 04/18/24, did not document an admission criteria. On 05/14/24 at 8:24 a.m., the Executive Director stated the contracts for the residents above did not contain the criteria for admission to the center.	C 318		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for one (#6) of eight sampled residents whose assessments were reviewed.	C 522		

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 05/14/2024
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NAME OF PROVIDER OR SUPPLIER SAND SAGE OF WEST PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 701 NORTH COUNCIL ROAD OKLAHOMA CITY, OK 73127
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 522	Continued From page 2 The Executive Director identified 35 residents in the center. Findings: The "Resident Assessment and Reassessment (Oklahoma)" policy, dated 09/15, read in part, "...The Community shall complete the comprehensive assessment within 14 days after move in...then once every 12 months..." Resident #3 had an annual assessment dated 06/22/22. On 05/14/24, the RCD stated resident assessments were completed on admission, 14 days, annually or with a change in condition. On 05/14/24 at 12:57 p.m., the RCD stated Resident #6's annual assessment was not completed.	C 522		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure resident assessments were coordinated and signed by a registered nurse, or the resident's physician for two (#3 and #5) of eight sampled residents whose assessments were reviewed.	C 542		

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 05/14/2024
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 542	Continued From page 3 The Executive Director identified 35 residents in the center. Findings: The "Resident Assessment and Reassessment (Oklahoma)" policy, dated 09/15, read in part, "...All assessments must be coordinated and signed by a registered nurse or the resident's personal physician..." 1. Resident #3 was admitted to the facility on 04/11/24. Resident #3's admission assessment, dated 04/25/24, did not document the assessment had been coordinated and signed by an RN or the Resident's physician. 2. Resident #5 was admitted to the facility on 04/18/24. Resident #5's 14 day assessment, dated 05/05/24, did not document the assessment had been coordinated and signed by an RN or the resident's physician. On 05/14/24 at 12:54 p.m., the RCD stated there was no RN or Resident's physician signature for Resident #3's admission assessment. On 05/14/24 at 1:11 p.m., the RCD stated there was no RN or Resident's physician signature for Resident #5's 14 day assessment.	C 542		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a	C 543		

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 05/14/2024
NAME OF PROVIDER OR SUPPLIER SAND SAGE OF WEST PLAINS		STREET ADDRESS, CITY, STATE, ZIP CODE 701 NORTH COUNCIL ROAD OKLAHOMA CITY, OK 73127		
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C 543	Continued From page 4 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. This Rule is not met as evidenced by: Based on record review and interview, the center failed to conduct a personal interview between the resident and/or the resident's representative for one (#4) of eight sampled residents whose assessments were reviewed. The Executive Director identified 35 residents resided in the center. Findings: The "Resident Assessment and Reassessment (Oklahoma)" policy, dated 09/15, read in part, "...The Community 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 community shall include in the comprehensive assessment the resident's representative or personal physician..." Resident #4 was admitted to the center on 02/05/24. Resident #4's preadmission resident assessment, dated 01/30/24, did not document a personal interview between the Resident and/or the Resident's representative.	C 543		

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 05/14/2024
NAME OF PROVIDER OR SUPPLIER SAND SAGE OF WEST PLAINS			STREET ADDRESS, CITY, STATE, ZIP CODE 701 NORTH COUNCIL ROAD OKLAHOMA CITY, OK 73127		
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C 543	Continued From page 5 On 05/14/24 at 12:30 p.m., the RCD stated Resident #4's assessment was to be signed by their representative who lived out of state. They stated the assessment had not been signed.	C 543			

Delivery via email to: westplainsed@islllc.com

June 6, 2024

License Number: AL5509

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

RE: Survey Event 1J0011

Dear Ms. Elliott:

On **May 14, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. **Our acceptance does not absolve the facility's responsibility for compliance** should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 30, 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,

Tempal Killman

Tempal Killman, 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: 5/28/2024		
	Facility Name: Sand Sage of West Plains		
	License Number: AL5509		
	Survey Event ID: 1J0011		
Date Survey Completed: 5/14/2024			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 318		Based on: Based on record review and interview, the center failed to include the admission criteria in the resident contracts for six (#1, 3, 4, 5, 6, and #8) of eight sampled residents whose resident agreement 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		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?		Addendum with admission criteria will be created and signed by current residents.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Admission criteria will be added to residency agreement.	
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?		Admission criteria added to residency agreement	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Enter methods to ensure corrections are sustained:	
a. How the correction will be evaluated for effectiveness;		ED or designee will confirm criteria is listed in agreement before signing takes place.	
b. How the correction will be incorporated into the center's quality assurance system; and		Discussion of move ins and review of residency agreement for current month of admission criteria.	
c. How monitoring records will be kept to evidence the correction.		Kept in QA Binder	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		6/30/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required OAC 310:663-25-4(F)		Date Enter a date of signature. 5/28/24	
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: 5/28/2024

Facility Name: Sand Sage of West Plains

License Number: AL5509

Survey Event ID: 1J0011

Date Survey Completed: 5/14/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522

Based on: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for one (#6) of eight sampled residents whose 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 ☐

Administrator's Signature

Administrator signature required.

OAC 310:663-25-4(F)

Date Enter a date of signature.

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: 5/28/2024

Facility Name: Sand Sage of West Plains

License Number: AL5509

Survey Event ID: 1J0011

Date Survey Completed: 5/14/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 542

Based on: Based on record review and interview, the center failed to ensure resident assessments were coordinated and signed by a registered nurse, or the resident's physician for two (#3 and #5) of eight sampled residents whose 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:

- 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.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator's signature required

Cristina Elliott

Date Enter a date of signature.

5/28/24

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

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 5/28/2024		
	Facility Name: Sand Sage of West Plains		
	License Number: AL5509		
	Survey Event ID: 1J0011		
			Date Survey Completed: 5/14/2024
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 543		Based on: Based on record review and interview, the center failed to conduct a personal interview between the resident and/or the resident's representative for one (#4) of eight sampled residents whose 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		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 or designee will conduct an interview with resident #4 representative for review and signature.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Audit completed of all charts to ensure signatures are obtained and if not, will obtain.	
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?		RCD or designee will ensure when assessment is completed, resident or representative will sign the assessment after discussion of assessment findings during care conference.	
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: Assessments will be reviewed for signature and dates of interviews with residents or their representative. Per our policy, care conferences are conducted anytime assessments updated and signatures obtained. Once signatures are obtained assessments placed in charts. Care conferences will be audited by ED monthly to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		6/30/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature. 5/28/24	
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.
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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 05/14/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted from 05/13/24 through 05/14/24. Facility Census: 35 The following abbreviations will be used throughout this survey: RCD-resident care director RN- registered nurse	C 000		
C 318 SS=E	310:663-3-2(b) ADMISSION CRITERIA (b) The assisted living center's admission criteria shall be included in the assisted living center's application for license and the resident service contract. This Rule is not met as evidenced by: Based on record review and interview, the center failed to include the admission criteria in the resident contracts for six (#1, 3, 4, 5, 6, and #8) of eight sampled residents whose resident agreement were reviewed. The Executive Director identified 35 residents resided in the center. Findings: Resident #1's residency agreement, dated 04/01/22, did not document an admission criteria. Resident #8's residency agreement, dated 01/10/23, did not document an admission criteria.	C 318		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

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 05/14/2024
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C 318	Continued From page 1 Resident #6's residency agreement, dated 04/07/23, did not document an admission criteria. Resident #4's residency agreement, dated 01/31/24, did not document an admission criteria. Resident #3's residency agreement, dated 04/10/24, did not document an admission criteria. Resident #5's residency agreement, dated 04/18/24, did not document an admission criteria. On 05/14/24 at 8:24 a.m., the Executive Director stated the contracts for the residents above did not contain the criteria for admission to the center.	C 318		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for one (#6) of eight sampled residents whose assessments were reviewed.	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 2 The Executive Director identified 35 residents in the center. Findings: The "Resident Assessment and Reassessment (Oklahoma)" policy, dated 09/15, read in part, "...The Community shall complete the comprehensive assessment within 14 days after move in...then once every 12 months..." Resident #3 had an annual assessment dated 06/22/22. On 05/14/24, the RCD stated resident assessments were completed on admission, 14 days, annually or with a change in condition. On 05/14/24 at 12:57 p.m., the RCD stated Resident #6's annual assessment was not completed.	C 522			
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure resident assessments were coordinated and signed by a registered nurse, or the resident's physician for two (#3 and #5) of eight sampled residents whose assessments were reviewed.	C 542			

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C 542	Continued From page 3 The Executive Director identified 35 residents in the center. Findings: The "Resident Assessment and Reassessment (Oklahoma)" policy, dated 09/15, read in part, "...All assessments must be coordinated and signed by a registered nurse or the resident's personal physician..." 1. Resident #3 was admitted to the facility on 04/11/24. Resident #3's admission assessment, dated 04/25/24, did not document the assessment had been coordinated and signed by an RN or the Resident's physician. 2. Resident #5 was admitted to the facility on 04/18/24. Resident #5's 14 day assessment, dated 05/05/24, did not document the assessment had been coordinated and signed by an RN or the resident's physician. On 05/14/24 at 12:54 p.m., the RCD stated there was no RN or Resident's physician signature for Resident #3's admission assessment. On 05/14/24 at 1:11 p.m., the RCD stated there was no RN or Resident's physician signature for Resident #5's 14 day assessment.	C 542		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a	C 543		

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 05/14/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 543	Continued From page 4 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. This Rule is not met as evidenced by: Based on record review and interview, the center failed to conduct a personal interview between the resident and/or the resident's representative for one (#4) of eight sampled residents whose assessments were reviewed. The Executive Director identified 35 residents resided in the center. Findings: The "Resident Assessment and Reassessment (Oklahoma)" policy, dated 09/15, read in part, "...The Community 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 community shall include in the comprehensive assessment the resident's representative or personal physician..." Resident #4 was admitted to the center on 02/05/24. Resident #4's preadmission resident assessment, dated 01/30/24, did not document a personal interview between the Resident and/or the Resident's representative.	C 543		

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 05/14/2024
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 543	Continued From page 5 On 05/14/24 at 12:30 p.m., the RCD stated Resident #4's assessment was to be signed by their representative who lived out of state. They stated the assessment had not been signed.	C 543			

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: AL5509	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/30/2024
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 An offsite/paper revisit was conducted 07/30/24. 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