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**Delivery via email to:** [chivari\\_ioanmarius@yahoo.com](mailto:chivari_ioanmarius@yahoo.com)

November 2, 2022

License Number: AL5518

Ms. Ioan Chivari, Owner  
Crystal Place, LLC  
400 Southwest 79th Street  
Oklahoma City, OK 73139

**Survey Event ID: 8RS311**

Dear Ms. Chivari,

On **October 13, 2022**, 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 plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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

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

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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](mailto: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](mailto: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,

*Lisa Calvin*

Lisa Calvin, Enforcement Analyst  
Long Term Care  
Protective Health Services

Enclosure



## INVESTIGATIVE REPORT LICENSURE

**Facility:** Crystal Place, LLC  
**Address:** 400 Southwest 79<sup>th</sup> Street  
**City, State, Zip:** Oklahoma City, Oklahoma 73139  
**Provider #:** AL5518  
**Complaint #:** OK00059592  
**Investigation Date(s):** October 12<sup>th</sup> – 13<sup>th</sup>, 2022

| ALLEGATIONS | S = SUBSTANTIATED<br>US = UNSUBSTANTIATED |
|-------------|-------------------------------------------|
|-------------|-------------------------------------------|

|                                                                                                                        |    |
|------------------------------------------------------------------------------------------------------------------------|----|
| 1. The center failed to ensure residents were not abused, or physically or chemically restrained.                      | US |
| 2. The center failed to provide adequate staff to ensure care of dependent residents.                                  | S  |
| 3. The center failed to have a medical director to direct care for the residents.                                      | US |
| 4. The center failed to have dietary staff                                                                             | US |
| 5. The center failed to provide nutritious, palatable meals and ensure physician ordered meals were served as ordered. | S  |
| 6. The center failed to have nursing documentation, assessment or hospice records available to health care staff.      | S  |
| 7. The center failed to provide a clean, safe, homelike environment.                                                   | S  |

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 10/12/2022 at 11:23 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

**A Description of Significant Findings Related to Each Allegation is Provided Below:**

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



An investigation specific to the facility failing to ensure residents were not abused, or physically or chemically restrained was conducted.

Clinical records and medication administration records were reviewed. No grievances nor incident reports were filed.

Residents were observed being treated with dignity and respect at all times. Residents were observed to be clean, well groomed, and assisted as needed. No signs of verbal or physical abuse were observed. No residents were observed physically restrained nor overly sedated.

Residents were asked if staff treated them with dignity and respect. They all stated, "Yes." Staff stated they treated all residents like family. Staff members were asked who they reported to if they suspected abuse. They stated they reported to the owners immediately any perception of mistreatment or abuse of a resident.

At the time of the investigation, there was no deficient practice related to the facility failing to ensure residents were not abused, or physically or chemically restrained.

**Allegation #2:** Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C0911 and C0921 for details.

**Allegation #3:** Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility failing to have a medical director to direct care for the residents was conducted.

Review of assisted living regulations revealed that assisted living centers are not required to have medical directors.

At the time of the investigation, there was no deficient practice related to the facility failing to have a medical director to direct care for the residents.

**Allegation #4:** Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the facility failing to have dietary staff was conducted.

Dietary staffing schedules were reviewed.

Meal preparation and meal service was observed. Meals were observed being served in the dining room and delivered to resident apartments in a timely manner. Dietary staff and direct care staff observed assisting resident in dining room when needed.

Residents in the dining room reported receiving assistance from dietary staff if needed. Dietary staff reported a process of serving meals in a timely manner and assisting residents as requested.

At the time of the investigation, there was no deficient practice related to the facility failing to have dietary staff.

**Allegation #5:** Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tags C0940 and C1507 for details.

**Allegation #6:** Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C0521 for details.

**Allegation #7:** Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C0711 for details.

**Determination Summary and Follow-Up Action:**

Deficient practice was substantiated for allegations #2, #5, #6, and #7. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

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

Deficient practice was unsubstantiated for allegations #1, #3, and #4. No further action is required.

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

Thank you for bringing these concerns to our attention.

*Ernestine Scovens*

Ernestine Scovens MSN, RN, CHFS

Date report completed: 10/17/2022

Oklahoma State Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CRYSTAL PLACE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 SOUTHWEST 79TH STREET</b><br><b>OKLAHOMA CITY, OK 73139</b> |                                                                                                                          |                                                                    |
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| C 000                                                         | <p>INITIAL COMMENTS</p> <p>A complaint investigation (OK00059592) was conducted on 10/12/22 and 10/13/22.</p> <p>Listed below are abbreviations used throughout this document:</p> <p>Acet - acetaminophen<br/>CDM - Certified Dietary Manager<br/>Cert. - certified<br/>CMA - Certified Medication Aide<br/>D/C'D - discontinued<br/>GERD - gastroesophageal reflux disease<br/>Inc. - Incorporated<br/>LPN - Licensed Practical Nurse<br/>MAR - medication administration record<br/>MCG - microgram<br/>MG - milligram<br/>Oct - October<br/>PRN - as needed<br/>RN - Registered Nurse<br/>tab - tablet<br/>TAR - treatment administration record<br/>U, UT - units</p> | C 000                                                                                                       |                                                                                                                          |                                                                    |
| C 521<br>SS=D                                                 | <p>310:663-5-2(a) ASSESSMENT TIMEFRAMES</p> <p>(a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission.</p> <p>This Rule is not met as evidenced by:</p>                                                                                                                                                                                                                                                                                                                                                                                                                                       | C 521                                                                                                       |                                                                                                                          |                                                                    |

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 521                                                         | <p>Continued From page 1</p> <p>Based on record review and interview the facility failed to have a registered nurse to complete an admission assessment within 30 days before or at the time of admission for one (#7) of two sampled residents reviewed for admission assessments.</p> <p>Findings:</p> <p>A 'Crystal Place Retirement Inc. Resident Contract', read in part, "...The Resident understands and agrees to the Crystal Place staff or its designee conducting Assessments to determine whether the Resident meets Crystal Place's Resident criteria ... The Admission Assessment is required within thirty (30) days before or on the Start Date ..."</p> <p>Resident #7 was admitted to facility on 10/11/22 with diagnoses that included acute kidney failure, acute respiratory failure, type 2 diabetes, congestive heart failure, chronic atrial fibrillation, fibromyalgia, depressive disorder, and anxiety disorder.</p> <p>On 10/12/22 at 12:17 p.m., Owner #2 was asked who was the nurse on staff for the facility. They replied, "I never met [unnamed nurse]. I've been calling the nurse that was here before we got the facility and [unnamed nurse] never answers."</p> <p>Owner #2 was asked if the facility had a nurse to perform assessments on new admissions. They stated no. Owner #2 was asked if a registered nurse had performed an admission assessment for resident #7 who was admitted to the facility this week. They replied, "No."</p> <p>On 10/12/22 at 5:45 p.m., Resident #7 was observed in their apartment sitting in recliner, with mild uncontrolled jerking movements noted to</p> | C 521                                                                                                       |                                                                                                                          |                                                                    |

Oklahoma State Department of Health  
STATE FORM

Oklahoma State Department of Health

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| C 711                                                         | <p>Continued From page 3</p> <p>Findings:</p> <p>On 10/12/22 at 11:54 a.m., observed two unoccupied opened resident rooms (room #23 and room #40) at the end of the hall behind the kitchen that contained paint and a drill. No staff were observed in the area.</p> <p>On 10/12/22 at 12:00 p.m., observed resident #8 in his room. The entrance wall to his room had a portion of the baseboard missing. The frame around his closet was off and leaning against the wall. There was no cover on the outlet on his right wall and the wood around his bathroom doorsill was missing on two sides. When resident #7 was asked why part of the wall had been removed, they stated, "The bathroom door was too small for my chair."</p> <p>On 10/12/22 at 12:12 p.m., observed a large open Coastal Atlantic #rubbage bin full of discarded construction trash sitting against the wall in the back hallway across from resident #6's room. The bin was unattended and accessible to residents. The floor in the entire back hallway was observed to be covered with white dust. No cones were noted in the hallway and no staff were observed in the area.</p> <p>On 10/12/22 at 12:13 p.m., observed unoccupied room #23's door fully open with a Miter saw inside on a table, a large drill on the floor leaning against the wall, and several other peices of construction equipment inside. On the floor in the hallway outside of room were peices of discarded wood and nails in a pile. There were no cones noted in hallway. The room and hallway were unattended and accessible to residents.</p> <p>On 10/12/22 at 12:14 p.m., observed unoccupied</p> | C 711                                                                                                       |                                                                                                                          |                                                                    |

Oklahoma State Department of Health

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| C 711                                                         | <p>Continued From page 4</p> <p>room #40's door fully open with six large buckets of previously used paint, previously used paint rollers, paint pans containing previously used paint, and assorted drop clothes spread over the floor. The room was unattended and accessible to residents.</p> <p>On 10/12/22 at 12:15 p.m., Owner #1 was asked how they ensured resident's comfort and safety during current renovations. They stated, "Painting is done in the evening when the residents are in their rooms and we close the doors. We put cones up to close off areas. Memory care residents are monitored closely. We try to do all of the work at night when they are not there."</p> <p>On 10/12/22 at 12:40 p.m., resident #5 was asked how they felt about the renovations happening at the facility. Resident #5 stated, "The painting is making everyone sick. I have been so sick I started smoking again to calm my nerves." When asked to describe 'sick', resident #5 stated, "The smell gives me constant headaches. It keeps me dizzy and sick to my stomach." Resident #5 was asked if they had reported this to anyone. They stated, "You can complain but there is no action."</p> <p>On 10/12/22 at 5:19 p.m., heard very loud noise of equipment being pulled down the front hallway on a pallet jack.</p> <p>On 10/12/22 at 5:37 p.m., heard very loud noise of equipment being pulled down the front hallway on a pallet jack.</p> <p>On 10/13/22 at 3:20 p.m., observed a large gray bin full of trash, cardboard, and empty plastic bags, against the wall in the sitting area across from room #19.</p> | C 711                                                                                                       |                                                                                                                          |                                                                    |



Oklahoma State Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CRYSTAL PLACE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 SOUTHWEST 79TH STREET</b><br><b>OKLAHOMA CITY, OK 73139</b> |                                                                                                                          |                                                                    |
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| C 711                                                         | <p>Continued From page 5</p> <p>On 10/13/22 at 8:00 a.m., observed two persons painting the facility entryway upon entering facility. Residents were observed in the open space dining area just ahead. The smell of paint could be detected in the air.</p> <p>On 10/13/22 at 11:03 a.m., resident #9 was observed rummaging through a large, open bin of discarded construction trash that was sitting in the back hallway of the building, across from occupied resident rooms. Broken pieces of ceramic tile, crumbled and torn bags containing dust from cement and plaster mix, peices of cut wood in various sizes, and miscellaneous construction trash was observed in the bin.</p> <p>On 10/13/22 at 11:04 a.m., Owner #1 appeared on the hall and made attempt to discourage resident #9 from removing items from the bin. Owner #1 was asked if it presented a safety hazard for this open bin of discarded construction items to be sitting unattended in the hallway. They stated, "There are no residents on this hall." When I pointed out to Owner #1 that I had just completed interviews with resident #6, whose room was directly across the hall from where the open bin of discarded construction materials was sitting, Owner #1 stated, "I will move this to another place," and began to push the bin up the hall.</p> <p>On 10/13/22 at 11:08 a.m., resident #3 was asked how they felt about the renovations happening at the facility. Resident #3 stated, "They sacrifice the patients to build up the building." When asked to explain what 'sacrifice the patients' meant, resident #3 stated, "You have to smell paint fumes all day. There is always dust everywhere in the hallways and sometimes the noise keeps you</p> | C 711                                                                                                       |                                                                                                                          |                                                                    |

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| C 911                                                         | <p>Continued From page 7</p> <p>On 10/12/22 at 1:59 p.m., resident #3 was asked if they received their medication timely. They stated they get their medication at different times. Resident #3 then stated, "I got the doctor to approve me to self administer my insulin so I know I'd get it when I'm supposed to."</p> <p>On 10/12/22 at 3:20 p.m., Owner #2 was asked if the facility currently employed or held a contract with a registered nurse or a licensed practical nurse. They replied, "No."</p> <p>On 10/13/22 at 11:08 a.m., resident #3 was asked if they self-administered their insulin and performed their own fingersticks. They stated, "Yes". Insulin pens were observed in resident #3's refrigerator and needle tops were observed in box on counter along with glucometer. Book where resident #3 recorded blood sugar results was on the bedside table. Resident #3 was asked how often the facility nurse checked her blood sugar results or insulin supplies. She stated, "I don't know who the nurse is now. There used to be one here but she got fired." When asked how they discarded used needles and lancets, resident #3 stated, "I put them in my trash can each day after I use them."</p> <p>A review of resident #3's clinical record contained no documentation of a service contract, plan of care, or nursing assessment.</p> <p>On 10/13/22 at 5:37 p.m., a copy of the service contract, plan of care, and nursing assessments for diabetic/insulin monitoring was requested from Office Assistant for resident #3.</p> <p>On 10/13/22 at 6:35 p.m., Office Assistant stated they were unable to locate the service contract, plan of care, or nursing assessments for</p> | C 911                                                                                                       |                                                                                                                          |                                                                    |

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| C 911                                                         | Continued From page 8<br><br>diabetc/insulin monitoring as requested for<br>resident #3.<br><br>By the time of survey exit, the facility failed to<br>provide service contract, plan of care, or nursing<br>assessments for diabetc/insulin monitoring as<br>requested for resident #3.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | C 911                                                                                                       |                                                                                                                          |                                                                    |
| C 921<br>SS=F                                                 | 310:663-9-2(a) MEDICATION STAFFING<br><br>(a) Each assisted living center shall provide or<br>arrange qualified staff to administer medications<br>based on the needs of residents. Medications<br>shall be reviewed monthly by a registered nurse<br>or pharmacist and quarterly by a consultant<br>pharmacist.<br><br>This LEVEL B is not met as evidenced by:<br>Based on record review and interview the facility<br>failed to:<br>(a) ensure the medication review was completed<br>on admission for one (#7) of two sampled<br>resident newly admitted to the facility, and<br>(b) provide or arrange a registered nurse,<br>pharmacist, or consultant pharmacist to perform<br>routine medication reviews for 16 of 16 residents<br>residing in the facility.<br><br>Findings:<br><br>A "Crystal Place Assisted Living Policy: Ensure<br>Safe Medication Administration", effective<br>10/19/2007, read in part, "...Nurse will check | C 921                                                                                                       |                                                                                                                          |                                                                    |

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| C 921                                                         | <p>Continued From page 9</p> <p>MARS weekly for review..."</p> <p>Resident #7 was admitted on 10/11/22 with diagnoses that included atherosclerotic heart disease, diastolic congestive heart failure, chronic atrial fibrillation, acute kidney failure, acute respiratory failure, fibromyalgia, type 2 diabetes, hyperlipidemia, hypothyroidism, GERD, depressive disorder, and anxiety disorder.</p> <p>Resident #7's "Medication Review Report" received on admission from discharging facility, dated Oct 11, 2022, read in part, "...Amlodipine Besylate Tablet 10 MG Give 1 tablet by mouth one time a day...Apixaban Tablet 5 MG Give 0.5 tablet by mouth every 12 hours...Atorvastatin Calcium Tablet 40 MG Give 1 tablet by mouth at bedtime...Cholecalciferol Tablet 25 MG (1000 UT) Give 2 tablet by mouth one time a day...Losartan Potassium Tablet 100 MG Give 1 tablet by mouth one time a day...Melatonin Tablet 3 MG Give 2 tablet by mouth at bedtime...Metoprolol Tartrate Tablet 100 MG Give 1 tablet by mouth every 12 hours...Oxycodone HCL Tablet 10 MG Give 1 tablet by mouth at bedtime...Oxycodone HCL Tablet 10 MG Give 1 tablet by mouth every 8 hours as needed for pain...Ferrous Sulfate Tablet 325 MG Give 1 tablet by mouth two times a day...Ipratropium Bromide Solution 0.02% 1 dose inhale orally every 6 hours as needed for wheezing...Magnesium Citrate Capsule 125MG Give 1 capsule by mouth one time a day...Miralax Powder 17GM/Scoop Give 1 scoop by mouth one time a day...Potassium Tablet Give 40 mEq by mouth one ttime a day...Protonix Tablet Delayed Release 40MG Give 1 tab by mouth one time a day...Senna 8.6MG Tablet Give 1 tablet by mouth two times a day..."</p> <p>Resident #7's "MAR", dated October 2022, read</p> | C 921                                                                                                       |                                                                                                                          |                                                                    |

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| C 921                                                         | <p>Continued From page 10</p> <p>in part, "...Amlodipine Besylate 5MG Tablet 1 tab by mouth daily...Eliquis [Apixaban] 5MG Tablet 1 tab by mouth twice daily...Rosuvastatin Calcium 10MG Tablet 1 tab by mouth every evening...Vitamin D3 [Cholecalciferol] 1000U (25MCG) Capsule 1 cap by mouth daily...Losartan Potassium 100MG Tablet D/C'D 07/21/22...Melatonin 10MG Tablet D/C'D [no date]...Metoprolol Tartrate 25MG Tablet 3 tabs (75MG) by mouth twice daily...Oxycodone-Acet 10-325MG Tablet 1 tab by mouth every 6 hrs [changed to PRN- not dated]...Oxycodone Immediate 10MG Tablet 1 tab by mouth every 8 hrs as needed for pain....Actos Tablet 15MG 1 tab po at 8am...Nystatin 100,000unit/GM Cream apply topically to affected area twice daily...Promethazine Gel 25MG every 6 hours PRN nausea...Docusate Sodium Softgel 100MG 1 cap by mouth daily...Cyclobenzaprine Tablet 7.5MG tab 1 tab by mouth as needed...Duloxetine Tablet 30MG 1 capsule po 8am...Hydrochlorthiazide Tablet 25MG 1 tab po 8am...Abilify Tablet 5MG tab po 8am...Labetalol Tablet 200MG 1 tab po BID 8a 8p...Acetaminophen Tablet 500MG tab 1 tab by mouth every 6 hours as needed for pain...Citroma Solution 296ml (1 Bottle) by mouth every day as needed for constipation..."</p> <p>A comparison of the "Medication Review Report" received on admission from discharging facility to the MAR dated October 2022, revealed discrepancies in medications to be administered. The MAR for resident #7, dated Oct 2022, documented that resident #7 had received medications according to those listed on the Oct 2022 MAR.</p> <p>Review of resident #7's clinical record revealed that no medication reconciliation had been</p> | C 921                                                                                                 |                                                                                                                          |                                                                    |



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| C 921                                                         | <p>Continued From page 11</p> <p>completed by the facility registered nurse or consultant pharmacist and faxed to the physician for review and signing when they were admitted to the facility.</p> <p>On 10/12/22 at 12:17 p.m., Owner #2 was asked if the facility employed a registered nurse to perform medication reviews. They replied, "No. All I know is we need an LPN or RN to come once a month and sign forms, and come PRN in case we need them. Not to be here daily." When asked if the registered nurse had been called to perform a medication review for resident #7 on admission, they stated, "No." When asked if resident #7's physician had been notified of their admission, Owner #2 stated, "She was a resident here before." When asked if a medication review had been completed upon re-admission and a reconciled medication list had been sent to resident #7's physician for approval and signing, Owner #2 stated, "No."</p> <p>On 10/12/22 at 3:20 p.m., Owner #1 was asked if the facility currently had a consultant pharmacist on staff or under contract. They stated, "No."</p> <p>On 10/12/22 at 4:29 p.m., Office Assistant was asked for the admission paperwork for Resident # 7. They provided a stack of papers that included a face sheet, medication review report, and progress notes from the previous facility. Office Assistant was asked if the medication orders had been reviewed and faxed to the pharmacy. The Office Assistant requested clarification and was shown an example of the "admission/start-up form" from another chart. They asked, "Isn't that something a nurse does? I'll have to look."</p> | C 921                                                                                                       |                                                                                                                          |                                                                    |

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| C 930                                                         | Continued From page 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | C 930                                                                                                       |                                                                                                                          |                                                                    |
| C 930<br>SS=F                                                 | <p>310:663-9-3(1-3) STAFF QUALIFICATIONS</p> <p>Each assisted living center shall designate an administrator responsible for the operation of the assisted living center. The administrator shall hold at least one (1) of the following credentials:</p> <p>(1) a license issued by the State Board of Examiners for Nursing Home Administrators; or</p> <p>(2) a residential care home administrator's certificate of training from an institution of higher learning whose program has been reviewed by the Department; or</p> <p>(3) a nationally recognized assisted living certificate of training and competency for assisted living administrators that has been reviewed and approved by the Department.</p> <p>This Rule is not met as evidenced by:<br/>Based on record review and interview the facility failed to designate an administrator responsible for the day to day operation of the assisted living center.</p> <p>Findings:</p> <p>On 10/12/22 at 3:20 p.m., Owner #2 was asked who was the administrator of the facility. They stated, "We are the owners." Owner #2 was asked if they or Owner #1 were licensed administrators. Owner #2 stated no. When asked if there was a licensed administrator working at the facility. They stated, "No, I fired [them]." When</p> | C 930                                                                                                       |                                                                                                                          |                                                                    |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CRYSTAL PLACE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 SOUTHWEST 79TH STREET</b><br><b>OKLAHOMA CITY, OK 73139</b> |                                                                                                                          |                                                                    |
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| C 930                                                         | Continued From page 13<br><br>asked what was the last day of work for the previous administrator, Owner #2 stated it may have been 2-2.5 weeks ago. When asked if the facility had hired another administrator, Owner #2 stated, "No, but we have posted the job on sites."                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | C 930                                                                                                       |                                                                                                                          |                                                                    |
| C 940<br>SS=F                                                 | 310:663-9-4 DIETARY CONSULTANT<br><br>Each assisted living center shall use a licensed dietitian or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to employ a licensed dietitian or qualified nutritionist to develop the diet plan and address the needs of individuals with special diets. This failed practice resulted in the risk for more than minimal harm for the 16 residents residing in the facility.<br><br>Findings:<br><br>On 10/12/22 at 11:46 a.m., the CDM was asked for a copy of the menu, both alternative and regular. They stated, "We kinda have one, going week by week because the new owners threw away the previous menus." The CDM provided a handwritten menu for the week of 10/9/22 thru 10/15/22, with blank spaces for dinner on Thursday 10/13/22 and Friday 10/14/22. When asked who was the dietitian, the CDM stated they didn't know when [previous dietitian] was last there. | C 940                                                                                                       |                                                                                                                          |                                                                    |

Oklahoma State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL5518</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CRYSTAL PLACE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 SOUTHWEST 79TH STREET</b><br><b>OKLAHOMA CITY, OK 73139</b> |                                                                                                                          |                                                                    |
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| C 940                                                         | <p>Continued From page 14</p> <p>A review of the current menu contained no documentation they had been reviewed by a dietician or nutritionist.</p> <p>On 10/12/22 at 12:30 p.m., Owner #2 was asked if the facility had a contract with a licensed dietician or qualified nutritionist. They stated, "[Unnamed person] was the dietician for the previous owner, but I never met them. I've been trying to reach them to set up something." Owner #2 was asked who currently makes the menus for the facility. They stated, "The CDM makes weekly menus." When asked if menus for special diets were available, Owner #2 stated, "All diets are exactly the same. For dessert, diabetics probably get no sugar jello." Owner #2 was shown the copy of the facility menu dated for the week of 10/09/22 thru 10/15/22 provided by the CDM. Owner #2 was asked to verify there were no items entered for Thursday (10/13/22) nor Friday (10/14/22), and stated, "I guess [Cert. Dietary Manager] just didn't put it in there." When asked if the facility menus are reviewed by a licensed dietician or qualified nutritionist, Owner #2 stated, "Not at this time."</p> <p>On 10/12/22 at 3:20 p.m., Owner #1 was asked if the facility currently had a licensed dietitian or nutritionist on staff or under contract. They stated, "No."</p> <p>On 10/13/22 at 10:21 a.m., the CDM was asked for a completed copy of the menu for the week of 10/9/22-10/15/22. They provided a menu that was handwritten and contained different meals than the previous menu provided on 10/12/22. The CDM was asked if either menu had been reviewed or developed by a dietician. They stated, "No."</p> | C 940                                                                                                       |                                                                                                                          |                                                                    |

Oklahoma State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL5518</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CRYSTAL PLACE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 SOUTHWEST 79TH STREET</b><br><b>OKLAHOMA CITY, OK 73139</b> |                                                                                                                          |                                                                    |
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| C1507                                                         | Continued From page 15                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | C1507                                                                                                       |                                                                                                                          |                                                                    |
| C1507<br>SS=E                                                 | <p>310:663-15-1 &amp; 63 OS 1-1918(B)(7) RESIDENT RIGHTS - Reasonable Accommodation</p> <p>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</p> <p>63 O.S. 1-1918.(B)(7)<br/>(7) Every resident shall have the right to reside and to receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered;</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review and interview the facility failed to provide reasonable accommodations for three (#3, #5, and #6) of five residents sampled for receiving alternative menu items and food preferences.</p> <p>Facility menu submitted by the CDM for the week of 10/9/22 thru 10/15/22 did not have alternative</p> | C1507                                                                                                       |                                                                                                                          |                                                                    |

Oklahoma State Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CRYSTAL PLACE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 SOUTHWEST 79TH STREET</b><br><b>OKLAHOMA CITY, OK 73139</b> |                                                                                                                          |                                                                    |
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| C1507                                                         | <p>Continued From page 16</p> <p>meal options listed on them.</p> <p>On 10/12/22 at 12:30 p.m., Owner #2 was asked if alternative menu items were available during meals. They stated, "Cert. Dietary Manager asks residents daily if they don't want what is being served."</p> <p>On 10/12/22 at 1:59 p.m., resident #3 was asked if they received alternative meal options. They stated, "The food is lousy. They do not have food for diabetic people. They give everyone the same food everyday and if you don't ask for snacks then you won't get any."</p> <p>On 10/12/22 at 6:04 p.m., an anonymous family interview was conducted. They stated that last week they were at the facility visiting a resident during the evening meal when the resident stated they could not eat what was being served and asked for something else. [Anonymous family member] stated Owner #2 told the resident that, "What you see is what you get, either eat it or you don't eat."</p> <p>On 10/13/22 at 10:21 a.m., The CDM was asked if any resident had been told they could not have an alternative meal option. They stated, "Yes. One time." When asked to elaborate on that incident, the CDM stated, "It was one of the owners who told a resident they could not have an alternative meal option."</p> <p>On 10/13/22 at 10:25 a.m., resident #6 was asked how was the food at the facility. They stated, "Sometimes it's way too salty. They have sandwiches a lot and I can't eat sandwiches." When asked if they could make alternate meal selections, resident #6 stated, "No, I don't think so. Nobody gives you a menu."</p> | C1507                                                                                                       |                                                                                                                          |                                                                    |

Oklahoma State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL5518</b>                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>10/13/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CRYSTAL PLACE, LLC</b> |                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>400 SOUTHWEST 79TH STREET</b><br><b>OKLAHOMA CITY, OK 73139</b> |                                                                                                                          |                                                                    |
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| C1507                                                         | Continued From page 17<br><br>On 10/13/22 at 10:57 a.m., Resident #5 was<br>asked if they received alternative meal options.<br>They stated, "No, options are limited." | C1507                                                                                                       |                                                                                                                          |                                                                    |



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**Delivery via email to:** chivari\_ioanmarius@yahoo.com; crystalplaceretirement@gmail.com

November 23, 2022

License Number: AL5518

Ioan Chivari, Owner  
Crystal Place, Llc  
400 Southwest 79th Street  
Oklahoma City, OK 73139

**Survey Event ID: 8RS311**

Dear Ioan Chivari:

On **October 13, 2022**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C0521, C0711, C0911, C0921, C0930, C0940, & C1507:** The correction dates are unacceptably long for all tags. The plan of correction did not describe a reasonable date of correction. In accordance with 310:663-25-4(b)(2)(E) **Notice of violation, plans of correction... A plan of correction shall:** The corrective action completion action dates shall not exceed sixty (60) calendar days from receipt of notice of violation.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

*Lisa Calvin*

Lisa Calvin, Enforcement Analyst  
Long Term Care  
Protective Health Services

Enclosure

|                                                                                                                                                                                                                                                                                                                                                      |                                                    |                                                                                                                                                                                                                                                         |                                           |
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|  <p>Oklahoma State<br/>Department of Health<br/>Creating a State of Health</p> <p>Protective Health Services<br/>Long Term Care Service</p>                                                                                                                         | <b>OPTIONAL PLAN OF CORRECTION TEMPLATE</b>        |                                                                                                                                                                                                                                                         |                                           |
|                                                                                                                                                                                                                                                                                                                                                      | <b>Current Date:</b> 11/15/2022                    |                                                                                                                                                                                                                                                         |                                           |
|                                                                                                                                                                                                                                                                                                                                                      | <b>Facility Name:</b> Crystal Place Retirement INC |                                                                                                                                                                                                                                                         |                                           |
|                                                                                                                                                                                                                                                                                                                                                      | <b>License Number:</b> AL5518                      |                                                                                                                                                                                                                                                         |                                           |
|                                                                                                                                                                                                                                                                                                                                                      | <b>Survey Event ID:</b> 8R5311                     |                                                                                                                                                                                                                                                         |                                           |
| <b>Date Survey Completed:</b> 10/13/2022                                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| <b>SUMMARY OF DEFICIENCY CITED BY OSDH</b>                                                                                                                                                                                                                                                                                                           |                                                    |                                                                                                                                                                                                                                                         |                                           |
| ID Prefix Tag: C521                                                                                                                                                                                                                                                                                                                                  |                                                    | Based on: record review and interview the facility failed to have a registered nurse to complete an admission assessment within the 30 days before or at the time of admission for one (#7) of two sampled residents reviewed for admission assessments |                                           |
| <b>ASSISTED LIVING CENTER'S PLAN OF CORRECTION</b>                                                                                                                                                                                                                                                                                                   |                                                    |                                                                                                                                                                                                                                                         |                                           |
| Assisted Living Center's Comments:                                                                                                                                                                                                                                                                                                                   |                                                    |                                                                                                                                                                                                                                                         |                                           |
| <b>REQUIRED ELEMENTS OF A PLAN</b>                                                                                                                                                                                                                                                                                                                   |                                                    | <b>ASSISTED LIVING CENTER'S PLAN ELEMENTS</b>                                                                                                                                                                                                           |                                           |
| 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?                                                                                                                                                                                                                         |                                                    | #7 has an updated Comprehensive assessment sign by the Medical Director.                                                                                                                                                                                |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified?                                                                                                                                                                                                                                        |                                                    | All current residents will have an updated comprehensive assessment sign by either an RN or the Medical Director.                                                                                                                                       |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?                                                                                                                                                                                                                               |                                                    | All new admissions will have a comprehensive assessment completed 30day prior or on date of move in and signed by the RN or Medical Director.                                                                                                           |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained?<br>Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. |                                                    | The staff will be inserviced on the aspects of the comprehensive assessment and the accuracy of the assessment.<br>The QA team will review the chart of all new move ins to ensure the Comprehensive Assessment is completed.                           |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| 5. On what date will corrective action be completed?                                                                                                                                                                                                                                                                                                 |                                                    | 1/9/2023                                                                                                                                                                                                                                                |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| <b>Administrator's Signature</b> Teri Ellis<br>OAC 310:663-25-4(F)                                                                                                                                                                                                                                                                                   |                                                    |                                                                                                                                                                                                                                                         | <b>Date</b> 11/15/2022                    |
| 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.                                                                                                                                                                                                |                                                    |                                                                                                                                                                                                                                                         |                                           |
| <b>Addendum Date</b>                                                                                                                                                                                                                                                                                                                                 | Enter a date of addendum.                          | <b>Submitted by</b>                                                                                                                                                                                                                                     | Enter name of person submitting addendum. |
| <b>Items Below Are For OSDH Use Only</b>                                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable Date: <a href="#">Click here to enter a date.</a> Surveyor: Surveyor                                                                                                                                                                                   |                                                    |                                                                                                                                                                                                                                                         |                                           |
| If Plan of Correction is unacceptable, the reasons are as follows: <a href="#">Click here to enter text.</a>                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                                                                         |                                           |
| Facility in Compliance by: <a href="#">Click here to enter a date.</a>                                                                                                                                                                                                                                                                               |                                                    |                                                                                                                                                                                                                                                         |                                           |





Oklahoma State  
Department of Health  
Creating a State of Health

Protective Health Services  
Long Term Care Service

## OPTIONAL PLAN OF CORRECTION TEMPLATE

**Current Date:** 11/15/2022

**Facility Name:** Crystal Place Retirement INC

**License Number:** AL5518

**Survey Event ID:** 8R5311

**Date Survey Completed:** 10/13/2022

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C711

Based on: Observation and interview the facility failed to provide a safe, home like environment during construction in the facility

### ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

#### 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 ☐

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

Unoccupied rooms #23 and 40 that contain storage for construction will remain locked at all times. Only the Maintenance Supervisor and the owners will have access to the keys.  
The rubbish bin located in the hallway across from room #6 has been removed.  
Painting in the front near the dining area has been completed.  
Construction hours have been changed

Staff will monitor construction areas and interview residents to ensure safety of the residents

A total of 4 unoccupied rooms will be used for paint and tool storage during the construction period.

All rubbish containers will be stored in unoccupied rooms any used construction material will be disposed of immediately and the rubbish container stored in the unoccupied rooms.

Any painting in the front area near the dining room will stop 1 hour before each meal service and residents will have an option to have meals delivered to their rooms. Construction hour will be from AM to PM. With the exception of stopping 1 hour before meals when painting the front area or dining area.

Cones will be placed to mark off areas that are under construction and well as signs to detour residents from construction areas.

|                                                                                                                                                                                                                                                                                                                                                                                                              |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: <ul style="list-style-type: none"> <li>a. How the correction will be evaluated for effectiveness;</li> <li>b. How the correction will be incorporated into the center's quality assurance system; and</li> <li>c. How monitoring records will be kept to evidence the correction.</li> </ul> |                           | Inservice staff and owners to observe cones and signs to ensure they are in place around construction area. Also to observe building for and rubbish or construction debris and to remove it immediately, and report any items found or any residents around the construction area.<br><br>a.) Daily rounds by owner or designee to monitor construction area, and document on Construction monitor log.<br><br>QA team will review construction monitor log |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |
| 5. On what date will corrective action be completed?                                                                                                                                                                                                                                                                                                                                                         |                           | 1/9/2023                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                     |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |
| <b>Administrator's Signature</b> Teri Ellis<br><small>OAC 310:663-25-4(F)</small>                                                                                                                                                                                                                                                                                                                            |                           | <b>Date</b> 11/15/2022                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                           |
| 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.                                                                                                                                                                                                                                                        |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |
| <b>Addendum Date</b>                                                                                                                                                                                                                                                                                                                                                                                         | Enter a date of addendum. | <b>Submitted by</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          | Enter name of person submitting addendum. |
| Items Below Are For OSDH Use Only                                                                                                                                                                                                                                                                                                                                                                            |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable Date: <a href="#">Click here to enter a date.</a> Surveyor: Surveyor                                                                                                                                                                                                                                           |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |
| If Plan of Correction is unacceptable, the reasons are as follows: <a href="#">Click here to enter text.</a>                                                                                                                                                                                                                                                                                                 |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |
| Facility in Compliance by: <a href="#">Click here to enter a date.</a>                                                                                                                                                                                                                                                                                                                                       |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                           |

|                                                                                                                                                                                                                              |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
|  <p>Oklahoma State<br/>Department of Health<br/>Creating a State of Health</p> <p>Protective Health Services<br/>Long Term Care Service</p> | <b>OPTIONAL PLAN OF CORRECTION TEMPLATE</b>         |                                                                                                                                                                                                                                                                                       |                                           |
|                                                                                                                                                                                                                              | <b>Current Date:</b> 11/15/2022                     |                                                                                                                                                                                                                                                                                       |                                           |
|                                                                                                                                                                                                                              | <b>Facility Name:</b> Crystal Place Retirement INC. |                                                                                                                                                                                                                                                                                       |                                           |
|                                                                                                                                                                                                                              | <b>License Number:</b> AL5518                       |                                                                                                                                                                                                                                                                                       |                                           |
|                                                                                                                                                                                                                              | <b>Survey Event ID:</b> 8R5311                      |                                                                                                                                                                                                                                                                                       |                                           |
| <b>Date Survey Completed:</b> 10/13/2022                                                                                                                                                                                     |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
| <b>SUMMARY OF DEFICIENCY CITED BY OSDH</b>                                                                                                                                                                                   |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
| ID Prefix Tag: C911                                                                                                                                                                                                          |                                                     | Based on: Record review and interview the facility failed to provide or arrange registered nurse supervision of skilled nursing interventions for one #3 of one sampled residents self administering for insulin and blood sugar.                                                     |                                           |
| <b>ASSISTED LIVING CENTER'S PLAN OF CORRECTION</b>                                                                                                                                                                           |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
| Assisted Living Center's Comments:                                                                                                                                                                                           |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
| <b>REQUIRED ELEMENTS OF A PLAN</b>                                                                                                                                                                                           |                                                     | <b>ASSISTED LIVING CENTER'S PLAN ELEMENTS</b>                                                                                                                                                                                                                                         |                                           |
| 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?                                                                                                 |                                                     | #3 has moved from the community.                                                                                                                                                                                                                                                      |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                     |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified?                                                                                                                |                                                     | All residents self administering insulin and blood sugars will have an updated Plan of Care in the chart.                                                                                                                                                                             |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                     |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?                                                                                                       |                                                     | Nursing staff will monitor each Plan of care monthly and update any Significant Change immediately. And document each updated Plan of Care on the POC log.                                                                                                                            |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                     |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:                                                                                                              |                                                     | Nursing staff will be inservice on how to complete and update Plan of Care.<br>All nursing staff will be inserviced on the location of Plan of Care.<br>A temporary Plan of Care will be in place with 1 hour of move in for staff to review.<br><br>QA team will review all POC logs |                                           |
| 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 <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                     |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
| 5. On what date will corrective action be completed?                                                                                                                                                                         |                                                     | 1/9/2023                                                                                                                                                                                                                                                                              |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                     |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
| <b>Administrator's Signature</b> Teri Ellis<br>OAC 310:663-25-4(F)                                                                                                                                                           |                                                     |                                                                                                                                                                                                                                                                                       | <b>Date</b> 11/15/2022                    |
| 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.                                                                        |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
| <b>Addendum Date</b>                                                                                                                                                                                                         | Enter a date of addendum.                           | <b>Submitted by</b>                                                                                                                                                                                                                                                                   | Enter name of person submitting addendum. |
| <b>Items Below Are For OSDH Use Only</b>                                                                                                                                                                                     |                                                     |                                                                                                                                                                                                                                                                                       |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable Date: <a href="#">Click here to enter a date.</a> 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.](#)



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Long Term Care Service

## OPTIONAL PLAN OF CORRECTION TEMPLATE

**Current Date:** 11/15/2022

**Facility Name:** Crystal Place Retirement INC

**License Number:** AL5518

**Survey Event ID:** 8R5311

**Date Survey Completed:** 10/13/2022

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921

Based on: Record review and interview the facility failed to a.) ensure the medication review was completed on admission for one(#7) of two sampled resident newly admitted to the facility, and b) provide or arrange for a registered nurse, pharmacist, or consultant pharmacist to preform routine medication reviews for 16 of the 16 residents residing in the facility.

### ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

#### 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 ☐

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

RN to complete medication review on #7

RN to preform medication reviews for all current residents

RN or Designee will preform weekly Mar review per Policy And document on Medication review log

Inservice Nurses and medication aides on weekly audits

QA team will review medication review log

1/9/2023

**Administrator's Signature** Teri Ellis

OAC 310:663-25-4(F)

**Date** 11/15/2022

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.





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|  <p>Oklahoma State<br/>Department of Health<br/>Creating a State of Health</p> <p>Protective Health Services<br/>Long Term Care Service</p> | <b>OPTIONAL PLAN OF CORRECTION TEMPLATE</b>        |                                                                                                                                                                  |                                           |
|                                                                                                                                                                                                                              | <b>Current Date:</b> 11/15/2022                    |                                                                                                                                                                  |                                           |
|                                                                                                                                                                                                                              | <b>Facility Name:</b> Crystal Place Retirement INC |                                                                                                                                                                  |                                           |
|                                                                                                                                                                                                                              | <b>License Number:</b> AL5518                      |                                                                                                                                                                  |                                           |
|                                                                                                                                                                                                                              | <b>Survey Event ID:</b> 8R5311                     |                                                                                                                                                                  |                                           |
| <b>Date Survey Completed:</b> 10/13/2022                                                                                                                                                                                     |                                                    |                                                                                                                                                                  |                                           |
| <b>SUMMARY OF DEFICIENCY CITED BY OSDH</b>                                                                                                                                                                                   |                                                    |                                                                                                                                                                  |                                           |
| ID Prefix Tag: C930                                                                                                                                                                                                          |                                                    | Based on: Record review and interview the facility failed to designate and administrator responsible for the day to day operation of the assisted Living center. |                                           |
| <b>ASSISTED LIVING CENTER'S PLAN OF CORRECTION</b>                                                                                                                                                                           |                                                    |                                                                                                                                                                  |                                           |
| Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).                                                                                                   |                                                    |                                                                                                                                                                  |                                           |
| <b>REQUIRED ELEMENTS OF A PLAN</b>                                                                                                                                                                                           |                                                    | <b>ASSISTED LIVING CENTER'S PLAN ELEMENTS</b>                                                                                                                    |                                           |
| 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?                                                                                                 |                                                    | The Assisted Living Center has an Licensed Adminstrator                                                                                                          |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                     |                                                    |                                                                                                                                                                  |                                           |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified?                                                                                                                |                                                    | The Assisted Living Center will employ a Licensed Adminstrator                                                                                                   |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                     |                                                    |                                                                                                                                                                  |                                           |
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?                                                                                                       |                                                    | The Assisted Living Center will Employ a Licensed Adminstrator                                                                                                   |                                           |
| OSDH Response: Element accepted Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                                                          |                                                    |                                                                                                                                                                  |                                           |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:                                                                                                              |                                                    | An Adminstrator will remain employed at the Community.                                                                                                           |                                           |
| 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 <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                     |                                                    |                                                                                                                                                                  |                                           |
| 5. On what date will corrective action be completed?                                                                                                                                                                         |                                                    | 1/9/2023                                                                                                                                                         |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                     |                                                    |                                                                                                                                                                  |                                           |
| <b>Administrator's Signature</b> Teri Ellis<br>OAC 310:663-25-4(F)                                                                                                                                                           |                                                    |                                                                                                                                                                  | <b>Date</b> 11/15/2022                    |
| 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.                                                                        |                                                    |                                                                                                                                                                  |                                           |
| <b>Addendum Date</b>                                                                                                                                                                                                         | Enter a date of addendum.                          | <b>Submitted by</b>                                                                                                                                              | Enter name of person submitting addendum. |
| <b>Items Below Are For OSDH Use Only</b>                                                                                                                                                                                     |                                                    |                                                                                                                                                                  |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable Date: <a href="#">Click here to enter a date.</a> Surveyor: Surveyor                                                           |                                                    |                                                                                                                                                                  |                                           |
| If Plan of Correction is unacceptable, the reasons are as follows: <a href="#">Click here to enter text.</a>                                                                                                                 |                                                    |                                                                                                                                                                  |                                           |
| Facility in Compliance by: <a href="#">Click here to enter a date.</a>                                                                                                                                                       |                                                    |                                                                                                                                                                  |                                           |



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## OPTIONAL PLAN OF CORRECTION TEMPLATE

**Current Date:** 11/15/2022

**Facility Name:** Crystal Place Retirement INC

**License Number:** AL5518

**Survey Event ID:** 8R5311

**Date Survey Completed:** 10/13/2022

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C940

Based on: record review and interview the facility failed to employ a licensed dietitian or qualified nutritionist to develop the diet plan and address the needs of the individuals with special diets.

### ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

#### 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 facility will contract a dietitian to develop a diet plan and address the needs of special diets.  
A menu will be available for all residents and alternative meal options will be given

The facility will contract a dietitian to develop a diet plan and address the needs of special diets.  
The dietitian will review each resident chart and direct the facility of any nutritional concerns.

All menus will be available for each resident. The dietitian will review menus and discuss any changes needed with staff.  
A copy of the sign dietitian review will be kept in a binder in the front office.  
All dietary staff will be inserviced on the menu and any menu change must be documented and the residents notified. Menus will be kept on file.

The QA team will review all dietitian recommendations at each meeting.

1/9/2023

**Administrator's Signature** Teri Ellis

**Date** 11/15/2022

|                                                                                                                                                                    |                           |                     |                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------|-------------------------------------------|
| 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.              |                           |                     |                                           |
| <b>Addendum Date</b>                                                                                                                                               | Enter a date of addendum. | <b>Submitted by</b> | Enter name of person submitting addendum. |
| Items Below Are For OSDH Use Only                                                                                                                                  |                           |                     |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable Date: <a href="#">Click here to enter a date.</a> Surveyor: Surveyor |                           |                     |                                           |
| If Plan of Correction is unacceptable, the reasons are as follows: <a href="#">Click here to enter text.</a>                                                       |                           |                     |                                           |
| Facility in Compliance by: <a href="#">Click here to enter a date.</a>                                                                                             |                           |                     |                                           |



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## OPTIONAL PLAN OF CORRECTION TEMPLATE

**Current Date:** 11/15/2022

**Facility Name:** Crystal Place Retirement INC

**License Number:** AL5518

**Survey Event ID:** 8R5311

**Date Survey Completed:** 10/13/2022

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1507

Based on: review and interview the facility failed to provide reasonable accommodations for three (#3, #5 and #6) of five residents sampled for receiving alternative menu items and food preferences.

### ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

#### 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 ☐

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident #3, #5 and #6 will have an access to meal alternatives.

The facility will provide alternate meal alternatives.

All menu will be available for each resident. The dietitian will review menus and meal alternatives and discuss any changes needed with staff.  
All dietary staff will be inserviced on the menu and any menu change must be document and the residents notified. Menus will be kept on file.

The QA team will review all dietitian recommendations at each meeting.

1/9/2023

**Administrator's Signature** Teri Ellis

OAC 310:663-25-4(F)

**Date** 11/15/2022

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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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.](#)

**Delivery via email to:** ioan <crystalplaceretirement@gmail.com>

January 5, 2023

License Number: AL5518

Ms. Ioan Chivary, Administrator  
Crystal Place, Llc  
400 Southwest 79th Street  
Oklahoma City, OK 73139

**Survey Event ID: 8RS311**

Dear Ms. Chivary:

On **October 13, 2022**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The AMENDED plan of correction you submitted is not acceptable for the following reasons:

- **C521:** This POC has been rejected due to the correction date of 12/26/2023 for tag C521. In accordance with 310:663-25-4(b)(2)(E) Notice of violation, **plans of correction...A plan of correction shall: The corrective action completion action dates shall not exceed sixty (60) calendar days from receipt of notice of violation.**

Please provide a 2<sup>nd</sup> Amended plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

*Lisa Calvin*

Lisa Calvin, Enforcement Analyst  
Long Term Care  
Protective Health Services

Enclosure

|                                                                                                                                                                                                                                                                                                                                                      |                                                    |                                                                                                                                                                                                                                                         |                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
|  <p>Oklahoma State<br/>Department of Health<br/>Creating a State of Health</p> <p>Protective Health Services<br/>Long Term Care Service</p>                                                                                                                         | <b>OPTIONAL PLAN OF CORRECTION TEMPLATE</b>        |                                                                                                                                                                                                                                                         |                                           |
|                                                                                                                                                                                                                                                                                                                                                      | <b>Current Date:</b> 11/15/2022                    |                                                                                                                                                                                                                                                         |                                           |
|                                                                                                                                                                                                                                                                                                                                                      | <b>Facility Name:</b> Crystal Place Retirement INC |                                                                                                                                                                                                                                                         |                                           |
|                                                                                                                                                                                                                                                                                                                                                      | <b>License Number:</b> AL5518                      |                                                                                                                                                                                                                                                         |                                           |
|                                                                                                                                                                                                                                                                                                                                                      | <b>Survey Event ID:</b> 8R5311                     |                                                                                                                                                                                                                                                         |                                           |
| <b>Date Survey Completed:</b> 10/13/2022                                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| <b>SUMMARY OF DEFICIENCY CITED BY OSDH</b>                                                                                                                                                                                                                                                                                                           |                                                    |                                                                                                                                                                                                                                                         |                                           |
| ID Prefix Tag: C521                                                                                                                                                                                                                                                                                                                                  |                                                    | Based on: record review and interview the facility failed to have a registered nurse to complete an admission assessment within the 30 days before or at the time of admission for one (#7) of two sampled residents reviewed for admission assessments |                                           |
| <b>ASSISTED LIVING CENTER'S PLAN OF CORRECTION</b>                                                                                                                                                                                                                                                                                                   |                                                    |                                                                                                                                                                                                                                                         |                                           |
| Assisted Living Center's Comments:                                                                                                                                                                                                                                                                                                                   |                                                    |                                                                                                                                                                                                                                                         |                                           |
| <b>REQUIRED ELEMENTS OF A PLAN</b>                                                                                                                                                                                                                                                                                                                   |                                                    | <b>ASSISTED LIVING CENTER'S PLAN ELEMENTS</b>                                                                                                                                                                                                           |                                           |
| 1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?                                                                                                                                                                                                                         |                                                    | #7 has an updated Comprehensive assessment sign by the Medical Director.                                                                                                                                                                                |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified?                                                                                                                                                                                                                                        |                                                    | All current residents will have an updated comprehensive assessment sign by either an RN or the Medical Director.                                                                                                                                       |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?                                                                                                                                                                                                                               |                                                    | All new admissions will have a comprehensive assessment completed 30day prior or on date of move in and signed by the RN or Medical Director.                                                                                                           |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained?<br>Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. |                                                    | The staff will be inserviced on the aspects of the comprehensive assessment and the accuracy of the assessment.<br>The QA team will review the chart of all new move ins to ensure the Comprehensive Assessment is completed.                           |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| 5. On what date will corrective action be completed?                                                                                                                                                                                                                                                                                                 |                                                    | 12/26/2023                                                                                                                                                                                                                                              |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| <b>Administrator's Signature</b> Teri Ellis<br>OAC 310:663-25-4(F)                                                                                                                                                                                                                                                                                   |                                                    |                                                                                                                                                                                                                                                         | <b>Date</b> 11/15/2022                    |
| 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.                                                                                                                                                                                                |                                                    |                                                                                                                                                                                                                                                         |                                           |
| <b>Addendum Date</b>                                                                                                                                                                                                                                                                                                                                 | Enter a date of addendum.                          | <b>Submitted by</b>                                                                                                                                                                                                                                     | Enter name of person submitting addendum. |
| <b>Items Below Are For OSDH Use Only</b>                                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                                                                                         |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> Unacceptable Date: <a href="#">Click here to enter a date.</a> Surveyor: <a href="#">Surveyor</a>                                                                                                                                                                   |                                                    |                                                                                                                                                                                                                                                         |                                           |
| If Plan of Correction is unacceptable, the reasons are as follows: <a href="#">Click here to enter text.</a>                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                                                                         |                                           |
| Facility in Compliance by: <a href="#">Click here to enter a date.</a>                                                                                                                                                                                                                                                                               |                                                    |                                                                                                                                                                                                                                                         |                                           |