
Delivery via email to: chivari_ianmarius@yahoo.com; crystalplaceretirement@gmail.com

November 22, 2022

License Number: AL5518

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

RE: Survey Event ID: R74E11

Dear Ioan Chivari:

On **November 8, 2022**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance.

However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

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

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

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

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

- Remedy(ies) imposed by the Department,

- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure



INVESTIGATIVE REPORT

Facility: Crystal Place, LLC
Address: 400 SW 79th Street
City, State, Zip: Oklahoma City, OK 73139
Provider #: AL5518
Complaint #: OK00058557
Investigation Date(s): 11/02/22 through 11/08/22

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The facility failed to provide a clean, homelike environment.	US
☒ Violation (s) unrelated to this complaint were also cited during the investigation.	

An unannounced on-site investigation was initiated 11/02/2022 at 3:57 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 a clean, homelike environment was conducted.

The dining room tables and floors were observed clean. Resident room floors were observed clean.

No resident complained about dining room tables or floors not being clean. No resident complained about their room floor not being clean.

Staff stated they swept and mopped the dining room floors after each meal. They stated the dining room tables were wiped down after each meal. Staff stated the room floors were swept and mopped by housekeeping each day.

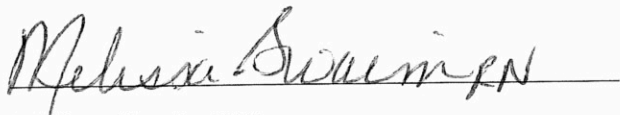
At the time of the survey, there was no deficient practice related to a clean, homelike environment.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script, reading "Melissa Swaim RN", is written over a horizontal line.

Melissa Swaim RN

Date report completed: 11/10/2022



INVESTIGATIVE REPORT

Facility: Crystal Place, LLC
Address: 400 SW 79th St
City, State, Zip: Oklahoma City, OK 73139
Provider #: AL5518
Complaint #: OK00059525
Investigation Date(s): 11/02/22 through 11/08/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to have licensed nursing personnel on staff.	S
2. The center failed to provide alternative meal choices for residents.	US

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

An unannounced on-site investigation was initiated 11/02/2022 at 3:57 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C0911 for details.

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

An investigation specific to alternative meal choices was conducted.

The alternative meal choices were observed posted for residents to view.

No resident complained about the food, at the time of the survey.

Staff stated residents received food preferences of their choice.

At the time of the survey, there was no deficient practice related to alternative meal choices.

Determination Summary and Follow-Up Action:

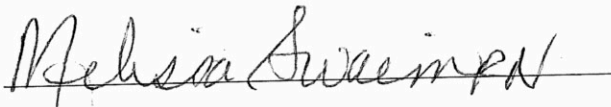
Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation #2. No further action is required.

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

Thank you for bringing these concerns to our attention.



Melissa Swaim RN

Date report completed: 11/10/2022

INVESTIGATIVE REPORT

Facility: Crystal Place, LLC
Address: 400 SW 79th Street
City, State, Zip: Oklahoma City, OK 73139
Provider #: AL5518
Complaint #: OK00059550
Investigation Date(s): 11/02/22 through 11/08/22

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The facility failed to have and/or implement fall precautions.	US
☒ Violation (s) unrelated to this complaint were also cited during the investigation.	

An unannounced on-site investigation was initiated 11/02/2022 at 3:57 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 have and/or implement fall precautions.

A review of records documented residents were provided with means to call for assistance. Incident reports provided documented residents had fall precautions in place as needed.

Residents were observed with a call alert necklace. Staff were observed assisting residents with transfers as needed.

Residents stated staff assisted them when needed.

Staff stated if a resident fell they would check to make sure they weren't injured, take their blood pressure, and call the nurse or hospice. They stated they would document the fall on an incident report. Staff stated if they needed assistance getting someone off the floor, they would call 911.

At the time of the investigation, there was no deficient practice related to the facility failing to have and/or implement fall precautions.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.

____ *Rae Belt, RN* _____

Rae Belt, RN, CHFS

Date report completed: 11/10/2022



INVESTIGATIVE REPORT

Facility: Crystal Place, LLC
Address: 400 SW 79th Street
City, State, Zip: Oklahoma City, OK 73139
Provider #: AL5518
Complaint #: OK00059635
Investigation Date(s): 11/02/22 through 11/08/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed provide physician ordered specialty diets.	US
☒ Violation (s) unrelated to this complaint were also cited during the investigation.	

An unannounced on-site investigation was initiated 11/02/2022 at 3:57 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 physician ordered diets was conducted.

No diabetic resident complained about the food during the survey. They liked the dietary staff and could make requests.

Staff stated alternatives to the menu were offered.

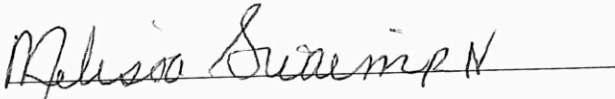
At the time of the survey, there was no deficient practice related to physician ordered diets.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script, reading "Melissa Swaim RN", written over a horizontal line.

Melissa Swaim RN

Date report completed: 11/10/2022

INVESTIGATIVE REPORT

Facility: Crystal Place, LLC
Address: 400 SW 79th Street
City, State, Zip: Oklahoma City, OK 73139
Provider #: AL5518
Complaint #: OK00059666
Investigation Date(s): 11/02/22 through 11/08/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to ensure residents were not verbally or psychosocially abused.	US
2. The facility failed to ensure medications were administered according to physician's orders.	S
3. The facility failed to ensure adequate staff to provide care to dependent residents.	US

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

An unannounced on-site investigation was initiated 11/02/2022 at 3:57 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 verbally or psychosocially abused was conducted.

A review of records documented no concerns with residents being verbally or psychosocially abused.

Staff were observed interacting with residents throughout the survey. There were no observations of staff being verbally or psychosocially abusive towards residents.

A review of records contained no documentation of reports of abuse.

Residents stated they had no concerns with staff being abusive.

Staff stated they had no knowledge of any resident reporting allegations of abuse.

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

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

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

An investigation specific to the facility failing to ensure adequate staff to provide care to dependent residents.

A review of records was conducted. There was no documentation dependent residents were not provided care.

Observations were made throughout the survey of staff assisting residents as needed.

Residents stated staff assisted them as needed.

Staff stated they assisted residents as needed.

At the time of the investigation, there was no deficient practice related to the facility failing to ensure adequate staff to provide care to dependent residents.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation #1 and #3. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Rae Belt, RN

Rae Belt, RN, CHFS

Date report completed: 11/10/2022

INVESTIGATIVE REPORT

Facility: Crystal Place, LLC
Address: 400 SW 79th Street
City, State, Zip: Oklahoma City, OK 73139
Provider #: AL5518
Complaint #: OK00059703
Investigation Date(s): 11/02/22 through 11/08/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to ensure residents were not endangered by on-going construction.	US
2. The center failed to prevent new or worsening pressure wounds.	US
3. The center failed to ensure resident safety and privacy.	US
4. The center failed to ensure qualified staff to provide care for dependent residents.	S
5. The center failed to ensure resident medication was not misappropriated.	US
6. The center failed to have qualified dietary staff, follow physician ordered diets and provide meals according to the menu.	US

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

An unannounced on-site investigation was initiated 11/02/2022 at 3:57 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 center failing to ensure residents were not endangered by on-going construction was conducted.

A review of records contained no documentation residents had been affected by the construction.

Observations were made throughout the survey. There were no observations of residents being affected by the construction.

Residents stated they had not been negatively affected by the construction.

Staff stated no residents had complained of being affected by the construction.

At the time of the investigation, there was no deficient practice related to the center failing to ensure residents were not endangered by on-going construction.

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

An investigation specific to the center failing to prevent new or worsening pressure wounds was conducted.

Resident records were reviewed. There was no documentation residents had new or worsening pressure wounds. Residents had preventative measures in place.

Residents stated they did not have new or worsening pressure wounds.

Staff stated there were no residents with new or worsening pressure wounds.

At the time of the investigation, there was no deficient practice related to the center failing to prevent new or worsening pressure wounds.

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

An investigation specific to the center failing to ensure residents' safety and privacy was conducted.

A review of records had no documentation of a construction crew living in the facility.

Observations were made throughout the survey. There observations of a construction crew living in the facility.

Residents stated they had no concerns with anyone in the facility.

Staff stated a construction crew had never stayed in the facility.

At the time of the investigation, there was no deficient practice related to the center failing to ensure residents' safety and privacy.

Allegation #4: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C0911 for details.

Allegation #5: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the center failed to ensure residents' medications were not misappropriated was conducted.

A review of records was conducted. There was no documentation medications had been misappropriated.

Observations were made of staff signing out narcotic medications when they were administered.

No residents complained of not getting their medications.

Staff stated they counted narcotics at shift change. They stated there had been no concerns with misappropriation.

At the time of the investigation, there was no deficient practice related to the center failing to ensure residents' medications were not misappropriated.

Allegation #6: Deficient practice was unsubstantiated related to this allegation.

An investigate specific to the center failing to have qualified dietary staff, followed physician ordered diets, and provided meals according to the menu was conducted.

A review of records documented was conducted. The center had weekly menus and an always available menu.

Observations were made of meal services throughout the survey. Residents were observed to pick foods of choice. Diets were provided per physician orders.

Residents stated they had no concerns with meals.

Staff stated they followed a menu and had an always available menu.

At the time of the investigation, there was no deficient practice related to the center failing to have qualified dietary staff, following physician ordered diets, and providing meals according to menus.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #4. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation #1, 2, 3, 5, and #6. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Rae Belt, RN

Rae Belt, RN, CHFS

Date report completed: 11/10/2022

INVESTIGATIVE REPORT

Facility: Crystal Place, LLC
Address: 400 SW 79th Street
City, State, Zip: Oklahoma City, OK 73139
Provider #: AL5518
Complaint #: OK00059717
Investigation Date(s): 11/02/22 through 11/08/22

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The center failed to ensure residents were not neglected.	US
2. The center failed to ensure residents were not neglected.	US
3. The center failed to ensure resident's received care according to contracts and standards of practice.	US
4. The center failed to ensure residents' safety and privacy.	US

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

An unannounced on-site investigation was initiated 11/02/2022 at 3:57 a.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 diets and neglect was conducted.

Physician ordered diets and incident reports were reviewed.

No resident complained about the food or alternative menu at the time of survey.

Staff stated palatable food was offered to residents as were physician ordered diets.

At the time of the investigation, there was no deficient practice related to physician ordered diets or neglect.

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

An investigation specific to staffing and neglect was conducted.

No resident complained about staffing, housekeeping, or neglect, at the time of the survey.

Staff stated they provided physician ordered care to the residents.

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

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

An investigation specific to care, contracts, and standards of practice.

No resident complained of difficulty breathing due to construction or painting.

Staff stated no resident had any negative outcome due to remodeling.

At the time of the survey, there was no deficient practice related to care according to contracts or standards of practice.

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

An investigation specific to residents' safety and privacy was conducted.

At the time of the survey, no resident complained about their safety or privacy.

At the time of the survey, staff stated they provided resident privacy.

No family was living in the upstairs of the center.

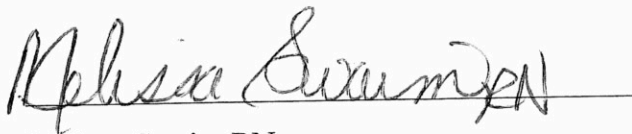
At the time of the survey, there was no deficient practice related to safety or privacy.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1-#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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Melissa Swaim RN

Date report completed: 11/10/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/08/2022
NAME OF PROVIDER OR SUPPLIER CRYSTAL PLACE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 400 SOUTHWEST 79TH STREET OKLAHOMA CITY, OK 73139		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted 11/02/22 through 11/08/22. Complaint investigations (#OK00058557, OK00059525, OK00059550, OK00059635, OK00059666, OK00059703 and #OK00059717) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. BP-blood pressure CHF-congestive heart failure CNA-certified nurse aide COPD-chronic obstructive pulmonary disease hr-hour HS-hour of sleep HTN-hypertension (elevated blood pressure) IJ-immediate jeopardy LPN-licensed practical nurse LTCA-long term care aide MAR-medication administration record MAT-medication administration technician mcg-micrograms meq-millequivalent mg-milligrams Q-every RN-registered nurse	C 000		
C 911 SS=L	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged:	C 911		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/08/2022
NAME OF PROVIDER OR SUPPLIER CRYSTAL PLACE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 400 SOUTHWEST 79TH STREET OKLAHOMA CITY, OK 73139		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 911	Continued From page 1 (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: On 11/04/22, an Immediate Jeopardy (IJ) situation was determined to exist related to the center's failure to employ an RN for staff oversight and to conduct comprehensive assessments and monthly medication reviews. An RN was not available to ensure resident and staff oversight. On 11/04/22 at 12:36 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. On 11/04/22 at 1:05 p.m., owner #1 was notified of the IJ situation. On 11/07/22 at 12:10 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The hand written plan of removal documented: "Being new owners at [facility name deleted], we didn't know we need to hire a RN for staff oversight (sic) and to conduct comprehensive resident assessments and monthly medication reviews. We were told to have a LPN. I just called the Administrator to help me find to hire a RN. We are in process of finding one ASAP. Until we will be able to hire a RN. We will use an agency RN	C 911		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/08/2022
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C 911	Continued From page 2 monthly and prn. Starting today 11/04/22 by midnight." The IJ was lifted, effective 11/07/22 at 12:10 p.m., when all components of the plan of removal had been completed. The deficiency remained at a level of actual harm at a pattern. Based on record review, observation, and interview, the center failed to provide registered nurse supervision and intervention for: a. Resident #3 who had elevated blood pressures, b. All residents who received November medications; and c. Resident #11 who complained of pain with only one unqualified staff at the center. Findings: A "Medication Administration" policy, dated 10/07/19, documented, "...Medication shall be administered on a physician's order...The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medications, and record the medications...An accurate written record of medications shall be maintained ...The medication record shall include...The identity and signature of the person administering the medication...The physician's written order shall be maintained in the resident's clinical record..." An "Emergency" policy, dated 12/15/05, documented, "...In the event of a critical episode involving a resident such as any abnormal...Vitals...the resident's physician will be notified for consultation..."	C 911		

Oklahoma State Department of Health

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C 911	Continued From page 3 A "Pain Management" policy, dated January 2022, documented, "...Assess the area...Find out the severity of pain...See if resident has pain med...Contact the Nurse..." a. Resident #3 had ongoing elevated blood pressures which went unmonitored and no physician notified. Resident #3 had diagnoses which included hypertension. A "Care Plan" sheet, dated 09/01/22, read in part, "...Hypertension...Hypertension symptoms will be reported immediately...administer medications as ordered...check blood pressure as ordered..." An October 2022 MAR documented Resident #3's blood pressure was to be taken daily in the morning. The MAR was blank 11 out of 31 opportunities. Blood pressure readings: 10/16/22 - 209/88, 10/25/22 - 203/87, 10/26/22 - 210/98, 10/27/22 - 209/112, and 10/28/22 - 222/101. There was no documentation the physician had been notified. The October MAR documented Carvedilol 12.5 mg (blood pressure medication) was to be administered twice daily. The MAR for the medication was blank 14 out of 62 opportunities. On 11/02/22 at 6:52 a.m., MAT #1 was asked who the administrator was. They stated there was no administrator, but that a nurse would be in today. They stated it was someone new they had	C 911		

Oklahoma State Department of Health

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C 911	Continued From page 4 not yet met. On 11/02/22 at 7:40 a.m., MAT #1 was observed to take Resident #3's blood pressure with a battery operated device. The blood pressure reading was 221/91. MAT #1 stated, "It's always high in the mornings." MAT #1 stated the physician had been notified of the elevated blood pressures about a week ago. On 11/02/22 at 8:25 a.m., MAT #1 was asked when they would notify a residents' physician. They stated if a blood pressure was too high or too low. MAT #1 was asked who they would notify the owner and call 911. The MAT stated they would notify hospice if the resident was on service. The MAT was asked if they had notified anyone of Resident #3's elevated blood pressure. They stated, "No." On 11/07/22 at 10:20 a.m., MAT #1 was asked how they documented medication administration. They stated they documented on the med pass sheets. They were asked what blanks in the MARs indicated. They stated, "If it's blank, you can't tell if it was given." b. MAT #1 stated a nurse had not completed the October to November monthly medication review of physician orders and MAR reconciliation. When they administered medications on 11/01/22 and 11/02/22 the November MAR had not been initialed by the medication aide administering medication. They used the previous months (October 2022) MAR to administer resident medications without knowing if there had been a change in the physician ordered medications. On 11/02/22 at 7:20 a.m., MAT #1 was observed to start medication pass. MAT #1 stated, "I'm	C 911			

Oklahoma State Department of Health

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C 911	Continued From page 5 going by the old MARs." The MAT stated a nurse had not been in the facility to review the November MARs and that some orders needed to be added to the MARs. The MAT stated, "This is the only thing I know to do." On 11/02/22 at 7:25 a.m., MAT #1 was observed to prepare Resident #12's medications by looking at the October 2022 MARs. MAT #1 did not initial the MAR. On 11/02/22 at 7:33 a.m., MAT #1 was observed to prepare Resident #5's medications by looking at the October 2022 MARs. MAT#1 did not initial the MAR. On 11/02/22 at 7:40 a.m., MAT #1 was observed to prepare Resident #3's medications by looking at the October 2022 MARs. MAT#1 did not initial the MAR. On 11/02/22 at 7:45 a.m., MAT #1 was asked how they administered medications on 11/01/22. They stated, "Off of the old MARs." On 11/07/22 at 10:20 a.m., MAT #1 was asked how they documented medication administration. They stated they documented on the medication pass sheet. c. Resident #11 complained of pain and no qualified staff was available to access for pain or administer medication. Resident #11 was admitted on 11/01/22 at 4:30 p.m. On 11/02/22 at 5:10 a.m., CNA #1 (agency) stated, "I really can't do anything if they want a pain pill, can I." The CNA was asked who was	C 911		

Oklahoma State Department of Health

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C 911	Continued From page 6 requesting something for pain. They stated Resident #11. On 11/02/22 at 5:21 a.m., Resident #11 was asked if they were having any pain. They stated, "Yes, generalized pain in my back, shoulders, arms, and feet." Resident #11 was asked if they usually took anything for pain. They stated, "Tylenol." Resident #11 was asked the last time they had anything for pain. They stated yesterday morning. Resident #11 was asked to rate their pain on a scale of one to ten. They stated their pain was a six or seven out of ten. Resident #11 was asked if they had asked anyone for pain medications. They stated they had asked CNA #1. On 11/02/22 at 5:35 a.m., CNA #1 was asked how, as agency staff, the facility informed them to care for the residents. They stated, "They didn't." CNA #1 stated they had been told there were three residents who would need changed in the night and one resident to administer Morphine to. The CNA stated her medication aide certificate had expired, so they told the facility staff they would not be giving any medications. CNA #1 was asked if they knew who to call if a resident asked for pain medications. They stated, "No." On 11/07/22 an agency RN stated they had signed into the center at 10:05 a.m. On 11/07/22 at 12:00 p.m., owner #1 stated they had hired the agency RN to be permanent staff at the center.	C 911		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be	C 954		

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

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C 962	Continued From page 8 direct-care staff member on duty. This Rule is not met as evidenced by: On 11/02/22, an Immediate Jeopardy (IJ) situation was determined to exist related to the center's failure to staff only one agency direct care staff member on duty who had no knowledge of who to contact in case of an urgent or emergent situation with residents. This resulted in resident #11 complaining of pain, but no staff familiar or oriented to the center's emergency plan or who to contact in case of an emergency with only one direct care staff on duty. On 11/02/22 at 12:30 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. At 12:36 p.m., owner #1 was notified of the IJ situation. On 11/03/22 at 1:55 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The hand written plan of removal documented: "Regarding the staff member who did not have the proper orientation was from an agency used for the first time. She was insubordinate when my staff tried to educate her on our policies and	C 962		

Oklahoma State Department of Health

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C 962	Continued From page 9 emergency procedures. It was the first and last time that I will use this agency. All my employees have CNA/MAT certification to make sure all residents are getting pain meds during the night. I called the agency last night and made a complain (sic) against that employee I also told them that I won't use their company anymore. A binder was put in place with a roster with all resident's needs, and the staff list with all emergency's contacts. The in service will be conducting (sic) with all staff on 11/3/2022 by midnight tonight." The IJ was lifted, effective 11/07/22 at 12:10 p.m., when all components of the plan of removal had been completed. The deficiency remained at a level of actual harm at a pattern. On 11/04/22 at 11:46 a.m. interviews were completed with staff regarding education and in-service information pertaining to the immediate jeopardy plan of removal. The staff stated they had been in-serviced and were able to verbalize understanding of the information provided in the in-service pertaining to the plan of removal. Based on record review, observation, and interview, the center failed to ensure one person staffing and a plan to deal with urgent and emergent situations was disclosed to residents and their representatives. Findings: A "One Direct Care Staff on Duty" policy, dated 11/17/01, documented, "...It is the policy of...to ensure the safety, security, and well being of all residents and staff...When there is an emergency. Call 911...Contact the nurse immediately..."	C 962		

Oklahoma State Department of Health

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C 962	Continued From page 10 On 11/02/22 at 3:57 p.m., an agency staff identified themselves as a LTCA (#1). They stated, "This is my first night here." They stated they were the only staff in the center. When asked what they did if a resident called and needed an as needed medication they stated, "They haven't called tonight." On 11/03/22 at 5:10 a.m., LTCA #1 stated their CMA had expired, but Resident #5 complained about pain and they had no access to the medication cart and did not know who to notify.	C 962		
C1505 SS=K	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 11 informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: On 11/02/22, Immediate Jeopardy (IJ) situations were determined to exist related to: a. the facility's failure to ensure a resident with ongoing hypertensive blood pressure readings was assessed, monitored, or intervened for. There was no documentation the resident's physician had been notified, and b. the facility's failure to ensure qualified staff was available to administer pain medications for a resident with complaints of pain rated at 7 out of 10. The resident had pain to his back, shoulders, arms, and feet. On 11/02/22 at 12:30 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. At 12:36 p.m., the owner was notified of the IJ situation. On 11/03/22 at 1:55 p.m., an acceptable plan of	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 12 removal was submitted to the Oklahoma State Department of Health. The plan of removal documented: a. "Regarding the hypertension resident. My staff is been taking daisy blood pressure readings. Even twice a day. For [Resident #3].. Last week my staff called [resident #3's] doctor [name and phone numbers deleted. Notified her of [resident #3's] hypertension reading. They also contacted [resident #3's] family member [name deleted] to let him now about [resident #3] hypertension, and if he would take [resident #3] to the doctor. From now on all the B/P readings are going to be written on a specific sheet for vital signs, and we will make sure we monitor, assess, intervene and notify physician regarding abnormal readings. Above 180/100 or below 90/60. Nov 2nd, 2022 2:50 PM. This morning [11/03/22] [Resident #3's] BP was very high again 213/82 at 8 AM. After 2 hrs it was taken again at 10 AM. It was still high at 185/81. I just called [doctor] and send her vitals to him. He contacted the nurse [name deleted] that we have on staff, and ordered Norvasc 5mg QHS. For the future when this happens again, I told my CNA/MAT to call [doctor name deleted] right away to let him know, so we can take immediate action the the right medication. A physician was here yesterday 11/2/22. Reviewed [resident #3's] meds and the BP's, and he implemented a new order and perimeters [sic] all staff will be inserviced by 11/3/22 by 6PM. Any staff that was not able to be reached will be preserviced [sic]. also includes [sic] agency staff." b. "Regarding the staff member who did not have the proper orientation was from an agency used for the first time. She was insubordinate when my staff tried to educate her on our policies and	C1505			

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C1505	Continued From page 13 emergency procedures. It was the first time and the last time I will use this agency. All my employees have CNA/MAT certification to make sure all residents are getting pain meds during the night. I called the agency last night and made a complain [sic] against that employee. I also told them that I won't use their company anymore. A binder was put in place with a roster, with all resident's needs, and the staff list with all emergency's contacts. The inservice will be conducting with all staff on 11/3/2022 by midnight tonight. Nov. 2, 2022 2:50 PM." The IJ was lifted, effective 11/07/22 at 12:10 p.m., when all components of the plan of removal had been completed. The deficiency remained at a level of actual harm at a pattern. On 11/04/22 at 11:46 a.m. interviews were completed with staff regarding education and in-service information pertaining to the immediate jeopardy plan of removal. The staff stated they had been in-serviced and were able to verbalize understanding of the information provided in the in-service pertaining to the plan of removal. Based on record review, observation, and interviews, the facility failed to ensure: a. a resident with ongoing hypertensive blood pressure readings was assessed, monitored, or intervened for one (#3) five sampled residents reviewed for blood pressure monitoring, b. qualified staff was available to administer pain medications for one (#11) of one sampled residents reviewed for pain, and c. physician's orders were followed for medication administration for one (#12) of three sampled	C1505		

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C1505	Continued From page 14 residents reviewed during a medication administration pass. Owner #1 identified 14 resident resided in the facility. Findings: An "Emergency" policy, dated 12/15/05, documented, "...In the event of a critical episode involving a resident such as any abnormal...Vitals...the resident's physician will be notified for consultation..." A "Medication Administration" policy, dated 10/07/19, documented, "...Medication shall be administered on a physician's order...The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medications, and record the medications...An accurate written record of medications shall be maintained...The medication record shall include...The identity and signature of the person administering the medication...The physician's written order shall be maintained in the resident's clinical record..." A "Move - in Orders" policy, dated 12/10/08, documented, "When a new resident who needs assistance with medication administration moves to the Community, all medications and treatments currently required by the resident must be confirmed by the Physician..." a. Resident #3 had diagnoses which included hypertension. A "Care Plan" sheet, dated 09/01/22, read in part, "...Hypertension...Hypertension symptoms will be reported immediately...administer medications as	C1505		

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C1505	Continued From page 15 ordered...check blood pressure as ordered..." An October 2022 MAR documented Resident #3's blood pressure was to be taken daily in the morning. The MAR was blank 11 out of 31 opportunities. Blood pressure readings: 10/16/22 - 209/88, 10/25/22 - 203/87, 10/26/22 - 210/98, 10/27/22 - 209/112, and 10/28/22 - 222/101. There was no documentation the physician had been notified. The October MAR documented Carvedilol 12.5 mg (blood pressure medication) was to be administered twice daily. The MAR for the medication was blank 14 out of 62 opportunities. On 11/02/22 at 6:52 a.m., MAT #1 was asked who the administrator was. They stated there was no administrator, but that a nurse would be in today. They stated it was someone new they had not yet met. On 11/02/22 at 7:40 a.m., MAT #1 was observed to take Resident #3's blood pressure with a battery operated device. The blood pressure reading was 221/91. MAT #1 stated, "It's always high in the mornings." MAT #1 stated the physician had been notified of the elevated blood pressures about a week ago. On 11/02/22 at 8:25 a.m., MAT #1 was asked when they would notify a residents' physician. They stated if a blood pressure was too high or too low. MAT #1 was asked who they would notify the owner and call 911. The MAT stated	C1505		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/08/2022
NAME OF PROVIDER OR SUPPLIER CRYSTAL PLACE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 400 SOUTHWEST 79TH STREET OKLAHOMA CITY, OK 73139		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 16 they would notify hospice if the resident was on service. The MAT was asked if they had notified anyone of Resident #3's elevated blood pressure. They stated, "No." On 11/07/22 at 10:20 a.m., MAT #1 was asked how they documented medication administration. They stated they documented on the med pass sheets. They were asked what blanks in the MARs indicated. They stated, "If it's blank, you can't tell if it was given." b. Resident #11 was admitted on 11/01/22 at 4:30 p.m. On 11/02/22 at 5:10 a.m., CNA #1 (agency) stated, "I really can't do anything if they want a pain pill, can I." The CNA was asked who was requesting something for pain. They stated Resident #11. On 11/02/22 at 5:21 a.m., Resident #11 was asked if they were having any pain. They stated, "Yes, generalized pain in my back, shoulders, arms, and feet." Resident #11 was asked if they usually took anything for pain. They stated, "Tylenol." Resident #11 was asked the last time they had anything for pain. They stated yesterday morning. Resident #11 was asked to rate their pain on a scale of one to ten. They stated their pain was a six or seven out of ten. Resident #11 was asked if they had asked anyone for pain medications. They stated they had asked CNA #1. On 11/02/22 at 5:35 a.m., CNA #1 was asked how, as agency staff, the facility informed them to care for the residents. They stated, "They didn't." CNA #1 stated they had been told there were three residents who would need changed in the	C1505		

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C1921	Continued From page 18 On 11/02/22, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to obtain physician orders on admission for a new resident. This resulted in resident #11 being administered pre-punched medications without physician orders. On 11/02/22 at 12:30 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. At 12:36 p.m., the owner was notified of the IJ situation. On 11/03/22 at 1:55 p.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented: "The resident in room NR5 is a new resident who just moved in last night. From next door rehab. I am calling and trying to get a physician to write med. orders today. From now on all meds will be not pre-punched and all regulations concerning med pass will be monitored. I already reached out to the physician, and they will be out coming to the facility this afternoon. I will make sure he will give us physician orders and also write the MARs to identify what medications were administered. From now on when a new resident moves in, I will have physician orders upon admission to the facility. The physician was in the facility on 11/02/22 and physician's orders were obtained at that time. An in service will be conducted on 11/3/22 by midnight with the nurse and MATs to ensure physician orders were obtained prior to admission. To be inserviced not to administer pre-punched meds and to administer medication only when psysician [sic] orders."	C1921		