OKLAHOMA
State Department
of Health

Delivery via email to: crystalplaceretirement@gmail.com

November 2, 2023

License Number: AL5518

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

RE: Survey Event ID: E56911

Dear Ms. Andrews:

On **October 10, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **October 10, 2023**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Crystal Place, LLC**
Address: **400 SOUTHWEST 79TH STREET**
City, State, Zip: **OKLAHOMA CITY, OK, 73139**
Provider #: **AL5518**
Complaint #: **OK00059919**
Investigation Date(s): **10/10/23**

ALLEGATION(S)

The facility failed to have adequate qualified staff.
The facility failed to protect residents' right to chose and right to self-determination.
The facility failed to provide a sanitary and safe environment.
The facility failed to provide therapeutic diets.
The center failed to ensure food was not expired and was safe for consumption.

An unannounced on-site investigation was initiated 10/10/2023 at 9:05 a.m.

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

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

A Summary of Complaint Investigation:

Observations of the facility were made upon entry and randomly throughout the survey. Staff were observed providing assistance to residents as needed. Residents were observed in their rooms and in common areas during individual pursuits.

Resident records were reviewed including physician orders, medication administration records, assessments, contracts, and progress notes. Facility records were reviewed including staff schedules, staff training and licensing, policies and procedures, and maintenance logs.

Residents and staff were interviewed regarding adequate and qualified staff, rights to choose, environment, diets, and food.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5518	A. BUILDING: _____ B. WING _____	C 10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL PLACE, LLC	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 on 10/10/23. A complaint investigation (#OK00059919) was conducted in conjunction with the survey. The following abbreviations will be used throughout the document. ADL- activity of daily living F - Fahrenheit RCD- Resident Care Director	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was stored in a safe and sanitary manner, the dishes were sanitized, and the kitchen was kept clean and in good repair. The "Assisted Living Resident Condition and Care Overview" documented 13 residents resided in the facility and received meals from the kitchen. Findings: An initial tour of the kitchen was conducted on 10/10/23 at 9:30 a.m. The following was observed during the initial tour: a. an accumulation of black and brown debris and residue under the fryer and cook top,	C 391		

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C 391	Continued From page 1 b. white residue on the flooring to the left of the oven/cook top, c. missing baseboards on the wall to the left of the oven/cook top, d. the Superior two door freezer on the right immediately next to the wall contained an unlabeled and undated bag with a hole in it with hashbrowns exposed to air within the bag and four frozen fish filets without labeling or dates, e. the Superior two door refrigerator to the left of the two door freezer contained a thawed boneless pork loin resting on a serving tray and two gallon sized bags of raw chicken legs and thighs on the same serving tray, f. standing water on the bottom of the Superior two door refrigerator, g. 4 dozen unpasteurized whole eggs, h. the low-temperature dishwasher sanitizing cycle tested at 10 ppm, i. missing base boards below and behind the dishwasher, j. black accumulation on floor and walls below and behind dishwasher. On 10/10/23 at 09:56 a.m., cook #1 stated the raw pork and chicken should have been on separate trays. They stated the standing water was due to the refrigerator being recently defrosted and they had not had a chance to clean it yet. They stated residents were able to order eggs however they liked. They stated they did	C 391		

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C 391	Continued From page 2 not have any pasteurized eggs for preparation of made to order eggs that were not thoroughly cooked. They stated the kitchen was deep cleaned weekly on the weekends. They stated food in the freezer should be labeled. The cook was unable to verbalize what level the sanitizer should be.	C 391		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure water temperatures in bathing rooms were no greater than 115 degrees F. The "Assisted Living Resident Condition and Care Overview" documented 13 residents resided in the facility. Findings: A facility temp log for March 2023, documented the water temperature in room #2 was 120 degrees F. The water temperature in room #20	C 701		

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	AL5518	A. BUILDING: _____ B. WING _____	C 10/10/2023

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C 701	Continued From page 3 was 118 degrees F. The water temperature in room #28 was 116 degrees F. A facility temp log for April 2023, documented the water temperature in room #3 was 116 degrees F. The water temperature in room #11 was 116 degrees F. The water temperature in room #30 was 116 degrees F. A facility temp log for May 2023, documented the water temperature in room #6 was 118 degrees F. The water temperature in room #32 was 116 degrees F. The water temperature in room #12 was 116 degrees F. A facility temp log for June 2023, documented the water temperature in room #6 was 116 degrees F. The water temperature in room #32 was 116 degrees F. The water temperature in room #29 was 116 degrees F. A facility temp log for August 2023, documented the water temperature in room #38 was 117.9 degrees F. The water temperature in room #11 was 115.1 degrees F. A facility temp log for September 2023, documented the water temperature in room #12 was 119 degrees F. The water temperature in room #32 was 118 degrees F. The water temperature in room #30 was 116.8 degrees F. A facility temp log for October 2023, documented the water temperature in room #11 was 118.8 degrees F. The water temperature in room #26 was 116 degrees F. The water temperature in room #18 was 118.6 degrees F. On 10/10/23 at 10:22 a.m., the water temperature was observed in the bathing room of room #2 as	C 701		

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C 701	Continued From page 4 116.4 degrees F. On 10/10/23 at 10:24 a.m., the water temperature was observed in the bathing room of room #17 as 116.1 degrees F. On 10/10/23 at 10:38 a.m., the water temperature was observed in the bathing room of room #24 as 117.6 degrees F. On 10/10/23 at 1:45 p.m., the administrator stated they were the person doing the temperature checks. They stated the process was to notify the maintenance worker to have the temperatures adjusted if they were out of parameter. They stated they were aware the water was not to exceed 115 degrees F in the resident's bathing rooms.	C 701		
C1326 SS=D	310:663-13-2(6) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (6) charges for services; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure charges for services were included in the contract for one (#6) of six sampled residents whose contracts were reviewed. The "Assisted Living Resident Condition and	C1326		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1326	Continued From page 5 Care Overview" documented 13 residents resided in the facility. Findings: A facility contract, dated 01/07/23, did not document Res #6's charges for services. A "Contract for Enhanced Services" page of the contract was left blank. On 10/10/23 at 3:18 p.m., the administrator was asked to review Res #6's contract. They stated there were no documented charges for services in the contract. They stated the blank page of the contract should have been filled out which would have documented the charges.	C1326		
C5020 SS=D	63 O.S. 1-890.8(F)(3)(a-d) Care and Services - POC and Follow-up 3. The person or persons responsible for performing, monitoring and assuring compliance with the plan of accommodation shall be expressly specified in the plan of accommodation and shall include the assisted living center and any of the following: a. the personal or attending physician of the resident, b. a home care agency, c. a hospice, or d. other designated persons; The plan of accomodation shall be reviewed at least quarterly by a licensed health care professional.	C5020		

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	AL5518	A. BUILDING: _____ B. WING _____	C 10/10/2023

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C5020	Continued From page 6	C5020		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to review a plan of accommodation quarterly for one (#3) of one residents reviewed for plan of accommodation.

The "Assisted Living Resident Condition and Care Overview" form documented 13 residents resided in the facility.

Findings:

Res #3 admitted to the facility with diagnoses of dementia, anxiety, and atrial fibrillation.

A plan of accommodation, signed on 05/28/23, documented Res #3 required two person assist with ADL's.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C5020	Continued From page 7 There was no other plan of accommodation documented in the resident's chart. On 10/10/23 at 2:56 p.m., the RCD stated the plan of accommodation should have been completed quarterly.	C5020		

OKLAHOMA
State Department
of Health

Delivery via email to: crystalplaceretirement@gmail.com

November 17, 2023

License Number: AL5518

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

Survey Event ID: E56911

Dear Ms. Andrews:

On **October 10, 2023,** a Licensure survey and a Complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **November 30, 2023**.

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

Respectfully,

Tempal Killman

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

Enclosure

Oklahoma State Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/9/2023

Facility Name: Crystal Place LLC

License Number: AL5518

Survey Event ID: E56911

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 a.b.j.	Based on: Observation and interview, the facility failed to ensure food was stored in a safe and sanitary manner, the disher were sanitized, and the kitchen was kept clean and in good repair. A. An accumulation of black and brown debris and residue under the fryer and cook top. B. White residue on the flooring to the left of the oven/cook top. J. Black accumulation on floor and walls below and behind dishwasher.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Floors and walls under fryer, cook top, left of oven/cook top and dishwasher were cleaned and scrubbed on 10/12/2023 and 10/13/2023
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community have the potential to be affected
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?	Weekly deep cleaning duties updated to include floors and walls under appliances
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.	Dietary staff in-serviced on state regulations, dietary requirements, and cleaning duties Administrator to do random checks to ensure cleanliness is up to state regulations QA team will recommend and put into place additional interventions if needed Cooks to document daily on cleaning log. Administrator to document PRN on cleaning log. Cleaning and new logs completed on 10/13/2023. QA on 10/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/13/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tomee Andrews** OAC 310:663-25-4(F)	**Date 11/9/2023**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/9/2023

Facility Name: Crystal Place LLC

License Number: AL5518

Survey Event ID: E56911

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 C. I.	Based on: Observation and interview, the facility failed to ensure food was stored in a safe ans sanitary manner, the dishes were sanitized and the kitchen was kept clean and in good repair. C. Missing baseboards on the wall to the left of the oven/cook top. I. Missing baseboards below and behind the dishwasher.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Baseboards replaced.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community have the potential to be affected.
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?	Maintenance to maintain upkeep of building and baseboards.
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.	Administrator to perform random checks to ensure baseboards are intact. Maintenance to maintain upkeep of building QA team will recommend and put in place additional interventions if needed Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/12/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tomee Andrews** **Date 11/9/2023**
OAC 310:663-25-4(F)

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

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Facility Name: Crystal Place LLC

License Number: AL5518

Survey Event ID: E56911

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 D.	Based on: Observation and interview, the facility failed to ensure food was stored in a safe and sanitary manner, the dishes were sanitized, and the kitchen was kept clean and in good repair. D. The superior two door freezer on the right immediately next to the wall contained an unlabeled and undated bag with a hole in it with hashbrowns exposed to air within the bag and four frozen fish filets without labeling or dates.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Food was immediately disposed of. No residents were served potentially hazardus foods.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The community will check for open/exposed/expired/unlabeled food items.
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?	Cooks inserviced on daily checks for food storage, open, exposed, expired or unlabeled food items daily.
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.	Dietary staff in-serviced on state regulations for food storage, dietary requirements, expired items Administrator to perform random checks for dates on food items, expired items, tarnished food products, unlabeled food items. QA team will recommend and put in place additional interventions if needed Completed on 10/13/2023, QA on 10/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/13/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tomee Andrews** **Date 11/9/2023**
OAC 310:663-25-4(F)

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Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/9/2023

Facility Name: Crystal Place LLC

License Number: AL5518

Survey Event ID: E56911

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 E	Based on: Observation and interview, the facility failed to ensure food was stored ina safe and sanitary manner, the dishes were sanitized, and the kitchen was kept clean and in good repair. E. The superior two door refrigerator to the left of the two door freezer contained a thawed bonless pork loin resting on a serving tray and two gallow sized bags of raw chicken legs and thighs on the same serving tray.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The food was disposed of immediately. Potentially hazardous food was not served to the residents.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Cooks to defrost/store meats in separate containers (tubs). Only 1 type of meat to be in each container (tub).
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?	In-serviced dietary staff on state regulations, storage of food, direct and indirect cross contamination, approved defrost methods to ensure safe food consumption
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.	Random check to be completed by Administrator for safe food storage. QA team will recommend and put in place additional interventions if needed. Results to be documented in QA Completed on 10/10/2023, QA on 10/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tomee Andrews** **Date 11/9/2023**
OAC 310:663-25-4(F)

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Oklahoma State Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/9/2023

Facility Name: Crystal Place LLC

License Number: AL5518

Survey Event ID: E56911

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 G.	Based on: Observations and interview, the facility failed to ensure food was stored in a safe and sanitary manner, the dishes were sanitized, and the kitchen was kept clean and in good repair. G. Four dozen unpasteurized whole eggs.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Pasteurized eggs were immediately purchased for cook to order eggs. Cook in-serviced on state regulations on non-pasteurized eggs vs pasteurized eggs
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community have the potential to be affected.
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?	Pasteurized eggs purchased on 10/10/2023. Staff in-serviced on state regulations on eggs, pasteurized vs nonpasteurized eggs. Menus updated to accomadate state regulations
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.	Random monitoring by Administrator QA team will recommend and put in place additional interventions if needed Menus to be reviewed by dietician. Completed 10/13/2023, QA 10/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/13/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tomee Andrews** | **Date 11/9/2023**

OAC 310:663-25-4(F)

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Oklahoma State Department of Health
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/9/2023

Facility Name: Crystal Place LLC

License Number: AL5518

Survey Event ID: E56911

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391 H.	Based on: Observation and interview, facility failed to ensure food was stored in a safe and sanitary manner, the dishes were sanitized, and the kitchen was kept clean and in good repair. H. The low-temperature dishmachine sanitizing cycle tested at 10 ppm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Obtained new bottle of low-temperature test strips. Sanitizing cycle tested at 50 ppm on 10/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community have the potential to be affected.
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?	Cook to obtain the low-temperature dishmachine sanitizing cycle test daily at 50 ppm. Cook to notify MD if results less than 50 ppm.
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.	MD to provide random checks to ensure within range QA team will recommend and put in place additional interventions if needed. Cook to document daily when testing sanitizing cycle.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tomee Andrews** OAC 310:663-25-4(F)	**Date 11/9/2023**

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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/9/2023

Facility Name: Crystal Place LLC

License Number: AL5518

Survey Event ID: E56911

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C701	Based on: Observation, record review, and interview, the facility failed to ensure water temperatures in bathing room were no greater than 115 degrees F. As observed Room #2 of 116.4 degrees, Room # 17 of 116.1 degrees, Room # 24 of 117.6 degrees.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Water heaters for resident room were lowered to the lowest setting at 115 degrees Obtained new theromometer for accuracy of temperature findings
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community have the potential to be affected
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?	Maintenance to log 3 random bathing room temperatures monthly Maintenance to install a temperature regulator on water heaters for resident rooms
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.	Maintenance to obtain temperatures monthly and adjust as needed Results of the documentation will be reviewed in QA meetings QA committee to recommend and put in place additional interventions if needed Records of the temperatures to be kept in temp log book
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	11/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tomee Andrews** **Date 11/9/2023**

OAC 310:663-25-4(F)

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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/9/2023

Facility Name: Crystal Place LLC

License Number: AL5518

Survey Event ID: E56911

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1326	Based on: Record review and interview, the facility failed to ensure charges for services were included in the contract for one of six sample residents-Resident #6. Contract dated 01/07/2023 did not document charges for services. A contract for Enhanced Services page of the contract was left blank.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #6, a new resident contract signed with power of attorney on 10/12/2023 with charges for services included. Enhanced services page was completed
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All contracts reviewed by Administrator for charges for services. Any services required will be listed on the Enhanced Services page
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?	Administrator to list all charges for services included. Administrator to ensure Enhanced Services page complete at time of contract signing
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.	Administrator to list all charges for services included. Administrator to ensure Enhanced Services page complete at time of contract signing QA team will recommend and put in place additional interviention if needed Record of documentation will be on each resident contract Corrected on 10/12/2023. QA on 10/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/12/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tomee Andrews** **Date 11/9/2023**
OAC 310:663-25-4(F)

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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/9/2023

Facility Name: Crystal Place LLC

License Number: AL5518

Survey Event ID: E56911

Date Survey Completed: 10/10/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C5020	Based on: Record review and interview, the facililty failed to review a plan of accommodation quarterly for one (Resident #3) of the reviewed for plan of accommodation. A plan of accommodation signed on 05/28/2023, documented Resident #3, required two person assist with ADLs.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	An updated plan of accommodation for Resident #3 was signed by POA, DON, Hospice CM and PCP on 10/10/2023
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Residents residing in the community have the potential to be affected.
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?	Calendar alerts for quarterly reviews have been added to ensure quarterly plans get reviewed and updated by DON
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.	DON to utilize calendar alerts for due dates. DON/Administrator to review all plan of accommodations DON/Administrator to review all plan of accommodations quartely QA team will recommend and put in place additional interventions if needed Records of review by DON/Administrator will be documented on resident plan of accommodations. Completed on 10/11/2023, QA on 10/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/11/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Tomee Andrews** **Date 11/9/2023**

OAC 310:663-25-4(F)

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OKLAHOMA
State Department
of Health

Delivery via email to: crystalplaceretirement@gmail.com

December 8, 2023

License Number: AL5518

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

RE: Survey Event E56912

Dear Ms. Andrews:

On **December 7, 2023,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 10, 2023,** have now been corrected effective **November 30, 2023.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5518	A. BUILDING: _____ B. WING _____	R-C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL PLACE, LLC	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 An offsite/paper revisit was conducted on 12/07/23. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE