OKLAHOMA
State Department of Health

Delivery via email to: crystalplaceretirement@gmail.com

April 25, 2025

License Number: AL5518

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

RE: Survey Event ID: 692111

Dear Ms. Herring:

On **April 11, 2025**, agents from our office concluded a State Licensure inspection with a complaint investigation 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 **April 11, 2025**.

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

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

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

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to: IDRCoordinator@health.ok.gov

Or mail 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,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Crystal Place
Address: 400 Southwest 79th Street
City, State, Zip: Oklahoma City, OK 73139
Provider #: AL5518
Complaint #: OK00067482
Investigation Date(s): 04/11/25

ALLEGATION(S)
The facility failed to provide palatable meals and failed to honor residents' food choices
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 04/11/2025 at 8:00 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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: Based on observation, record review and interview, the center provides an alternative menu and honors resident choices. Observation of meal times showed appropriate nutrition and portion sizes with a pleasant aroma. All residents ate either most or all of their meals without complaint. Record review showed 8 alternative food options offered besides the regularly planned menu. Record review of resident diets showed no special diets or preferences. Allergies were noted for 3 residents. Interviews with residents were conducted and there were no complaints about the center's food. The residents stated they do have meal alternatives if they choose to deviate from the planned menu items. Interviews with staff were conducted and allergies were observed for the three residents with food allergies. Alternative items are always available.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

OKLAHOMA
State Department
of Health

Date report completed: 04/11/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Crystal Place
Address: 400 Southwest 79th Street
City, State, Zip: Oklahoma City, OK 73139
Provider #: AL5518
Complaint #: OK00074561
Investigation Date(s): 04/11/25

ALLEGATION(S)
The center failed to ensure assistance was provided in a safe manner to prevent injury
The center failed to ensure palatable food was served, food was served according to residents' preference and an alternate menu was available/provided
The center failed to ensure a safe, clean and comfortable environment
enter text
enter text

An unannounced on-site investigation was initiated 04/11/2025 at 8:00 a.m.

A sample of 8 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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: Based on observation, record review, and interview the allegations were not confirmed. There were no resident injuries reported during record review or interview that occurred during assistance given by the staff. During observations of resident assistance the staff demonstrated safety. The residents interviewed denied any injuries during staff assistance. Based on record review and interview the center provides an alternative menu and the residents interviewed were satisfied with the food the center serves. Observation of meal times showed appropriate nutrition and portion sizes with a pleasant aroma. Based on observation and interview the center provides a clean and comfortable environment for the residents in their apartments as well as in common areas. The residents interviewed expressed satisfaction with the cleanliness and schedule of cleaning.

The attached State form, Statement of Deficiencies, 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: 04/11/2025

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 04/11/2025

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 04/11/25. Complaint investigations (#OK00067482 and #OK00074561) were conducted in conjunction with the survey. Facility Census: 32 Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide CVA- cerebral vascular accident DON- director of nursing HIPAA- The Health Insurance Portability and Accountability Act MAR- medication administration record Med- medication	C 000		
C 371 SS=D	310:663-3-6(a) MANAGEMENT OF RISK (a) If a resident's preference or decision places the resident or others at risk or is likely to lead to an adverse consequence, the assisted living center shall advise the resident and the resident's representative of such risk or consequences. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to advise a resident and the resident's representative of the risks associated with the use of a bed rail for 1 (#3) of 8 sampled residents reviewed for risk management.	C 371		

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C 371	Continued From page 1 The administrator identified 32 residents resided in the center. Findings: On 04/11/25 at 2:35 p.m., a half bed rail was observed on the right upper side of Resident #3's bed. A "14-day Comprehensive Assessment," dated 06/07/24, showed resident #3 was admitted to the center on 06/07/24 with diagnoses which included psychomotor deficit (a slowing down or impairment of both mental and physical processes) following CVA (cerebral vascular accident), hemiplegia to left side, Alzheimer's disease, osteoporosis, and osteoarthritis. A "14-day Comprehensive Assessment," dated 06/07/24, showed Resident #3 required the use of a half bed rail. A review of the Resident #3's medical chart did not show the resident or representative were advised of the risks associated with the use of a bed rail. On 04/11/25 at 2:37 p.m., Resident #3 was asked if they used their bed rail. They stated, "Yes." The resident was asked why they used their bed rail. Resident #3 stated, "I don't know." On 04/11/25 at 2:41 p.m., the DON was asked if Resident #3 had a risk agreement, or if a notification of risk related to bed rail use was made to the resident or representative. The DON stated, "I can try to find it." On 04/11/25 at 2:45 p.m., the administrator was	C 371		

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C 371	Continued From page 2 asked if they could show where Resident #3's notification of risk or risk agreement for their bed rail was located. They stated, "It might be on their care plan." The surveyor verified the bed rail was not on the resident's care plan. The administrator stated, "I'll check the desktop." On 04/11/25 at 3:10 p.m., the administrator stated, "I have looked everywhere for the risk agreement and notification and I can't find it."	C 371		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a significant change assessment was completed for 1 (#3) of 8 residents sampled for assessments. The administrator identified 32 residents resided in the center. Findings: A "14-day Comprehensive Assessment," dated	C 522		

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C 522	Continued From page 3 06/07/24, showed resident #3 was admitted to the center on 06/07/24 with diagnoses which included psychomotor deficit (a slowing down or impairment of both mental and physical processes) following CVA (cerebral vascular accident), hemiplegia to left side, Alzheimer's, osteoporosis, and osteoarthritis. A "14-day Comprehensive Assessment," dated 06/06/25, showed Resident #3 required one person to assist with transfers. A "Plan of Accommodation," dated 02/17/25, showed Resident #3 required two people to assist with transfers. A review of the resident's chart did not show a significant change assessment was conducted. On 04/11/25 at 2:02 p.m., CMA #2 was asked how many staff were required to assist Resident #3 with transfers. The CMA stated, "Two." On 04/11/25 at 2:42 p.m., the DON was asked what the policy was for assessments. The DON stated, "We do them at move-in and every year." The DON was asked how a change in resident condition was documented. The DON stated, "We do a new assessment." The DON was asked if a significant change assessment was conducted on Resident #3 for their change from requiring one person to two person assistance with transfers. The DON stated, "If it's not in her chart, then I don't know. I just started working here."	C 522		
C1931 SS=F	310:663-19-2(b)(1) MEDICATION ADMINISTRATION	C1931		

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C1931	Continued From page 4 (b) An assisted living center may maintain nonprescription drugs for dispensing from a common or bulk supply if all of the following are accomplished. (1) The assisted living center shall have and follow a written policy and procedure to assure safety in dispensing and documenting medications given to each resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure: a. unattended medication carts were locked for 2 of 2 medication carts observed; b. HIPAA information and MAR were secured; and c. medications were stored and secured inside of a locked medication cart for 1 of 2 medication carts observed. The administrator identified 32 residents resided in the center. Findings: a. On 04/11/25 at 8:00 a.m., an unattended medication cart was observed in the overflow dining room area where two residents were eating breakfast. The medication cart was unlocked and had a medication cup with medications sitting in it on top of the medication cart. The computer on top of the medication cart was unlocked with resident information and MAR displayed on the screen. On 04/11/25 at 11:30 a.m., an unattended	C1931		

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C1931	Continued From page 5	C1931		

medication cart was observed on the West hall. The medication cart was unlocked. The computer on top of the medication cart was unlocked with resident information and MAR displayed on the screen.

A policy titled, "Policies and Procedures for Medication Administration," dated 05/30/23, showed, "Med [medication] cart to be locked at all times when not in use."

On 04/11/25 at 8:04 a.m., CMA #1 was asked what the policy was for securing unattended medication carts. They stated, "We don't normally leave it unlocked, but we're supposed to lock it."

On 04/11/25 at 11:35 a.m., CMA #2 was asked what the policy was for securing unattended medication carts. They stated, "It's supposed to be locked when we're not at it."

b. On 04/11/25 at 8:00 a.m., an unattended medication cart was observed in the overflow dining room area where two residents were eating breakfast. The medication cart was unlocked and had a medication cup with medications sitting in it on top of the medication cart. The computer on top of the medication cart was unlocked with resident information and MAR displayed on the screen.

On 04/11/25 at 11:30 a.m., an unattended medication cart was observed on the West hall. The medication cart was unlocked. The computer on top of the medication cart was unlocked with resident information and MAR displayed on the screen.

A policy titled, "Policies and Procedures for Medication Administration," dated 05/30/23,

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C1931	Continued From page 6 showed, "All HIPAA information to be covered, MAR closed, etc." On 04/11/25 at 8:05 a.m. CMA #1 was asked what the policy was for securing the computer containing the resident's MAR. They stated, "Cover it or lock the computer." The CMA was asked if the computer containing the residents information and MAR was secured. They stated, "No." On 04/11/25 at 11:36 a.m., CMA #2 was asked what the policy was for securing the computer containing the resident's MAR. They stated, "Make sure it's not showing to everyone like it is right now." The CMA was asked if the computer containing the residents information and MAR was secured. They stated, "No." c. On 04/11/25 at 8:00 a.m., an unattended medication cart was observed in the overflow dining room area where two residents were eating breakfast. The medication cart was unlocked and had a medication cup with medications sitting in it on top of the medication cart. The computer on top of the medication cart was unlocked with resident information and MAR displayed on the screen. On 04/11/25 at 8:02 a.m., CMA #1 was asked what the policy was for storing medications. CMA #1 stated, "Lock it up."	C1931		
C1952 SS=D	310:663-19-3(b) MAINTENANCE OF RECORDS (b) Each resident's records shall be retained for at least five (5) years after the resident's transfer, discharge or death. Destruction of records shall be done in a manner to preserve resident	C1952		

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C1952	Continued From page 7 confidentiality. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure records were retained for 1 (#8) of 8 resident sampled for records. The administrator identified 32 residents resided in the center. A pharmacy consult document titled, "Roster Report," dated 09/04/24, listed Resident #8 as a current resident. On 04/11/25 at 10:10 a.m., the administrator was asked for records regarding Resident #8. The administrator stated, "I will look for it, but that name doesn't sound familiar." On 04/11/25 at 10:20 a.m., the administrator stated, "I called the owners (of the center) and they said the name is not familiar, but I will look for the chart." On 04/11/25 at 12:00 p.m., the administrator stated, "They (the owners of the center) said [Resident #8] was involved in litigation and the records are with their lawyer." The administrator was asked to have those records available for review. The administrator stated, "You can call the lawyer, but we don't have them here."	C1952		
C1953 SS=D	310:663-19-3(c) MAINTENANCE OF RECORDS (C) Records for the previous twelve (12) months of operation, whether original, electronic, or	C1953		

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C1953	Continued From page 8 microfilm copies, shall be maintained in such form as to be legible and readily available upon request of the attending physician, the assisted living center and any person authorized by law to make such a request. Records more than twelve (12) months old, whether original, electronic, or microfilm copies, shall be maintained in such form as to be legible and available within seventy-two (72) hours upon request of the attending physician, the continuum of care facility or assisted living center, and any person authorized by law to make such a request. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure all records were readily available upon request by the Oklahoma State Department of Health for 1 (#8) of 8 residents sampled for records. The administrator identified 32 residents resided in the center. A pharmacy consult document titled, "Roster Report," dated 09/04/24, listed Resident #8 as a current resident. A policy titled, "Retention of Resident Records," dated 06/13/23, showed, "When a resident is no longer at Crystal Place, their resident record will be removed from the 3-ring binder and kept in envelope together. Records will be stored for a minimum of 5 years. Records will be accessible to regulatory agencies as required." On 04/11/25 at 10:10 a.m., the administrator was asked for records regarding Resident #8. The administrator stated, "I will look for it, but that name doesn't sound familiar."	C1953		

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C1953	Continued From page 9 On 04/11/25 at 10:20 a.m., the administrator stated, "I called the owners (of the center) and they said the name is not familiar, but I will look for the chart." On 04/11/25 at 12:00 p.m., the administrator stated, "They (the owners of the center) said [Resident #8] was involved in litigation and the records are with their lawyer." The administrator was asked to have those records available for review. The administrator stated, "You can call the lawyer, but we don't have them here."	C1953		
C1959 SS=F	310:663-19-3(i) MAINTENANCE OF RECORDS (i) Incident reports required in 310:663-19-1. shall be retained, filed and stored to protect against loss, destruction, or unauthorized use for a period of two (2) years. Destruction of incident reports shall be done in a manner to preserve resident confidentiality. This Rule is not met as evidenced by: Based on record review and interview, the center failed to maintain incident reports for a period of two years. The administrator identified 32 residents resided in the center. Findings: A policy titled, "Retention of Resident Records," dated 06/13/23, showed, "Records will be stored for a minimum of 5 years. Records will be accessible to regulatory agencies as required." On 04/11/25 at 8:56 a.m., an Oklahoma State Department of Health document titled, "Entrance	C1959		

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 04/11/2025

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
C1959	Continued From page 10 Conference Checklist," was given to the administrator which included a request for incident and abuse reports from the past 12 months. On 04/11/25 at 1:40 p.m., the administrator provided incident reports from 2025, but no incident reports were given for 2024. On 04/11/25 at 1:45 p.m., the DON was asked for incident reports from 2024. They stated, "Ok." On 04/11/25 at 3:10 p.m., the administrator was asked for incident reports from 2024. They stated, "I know the previous nurse kept them in a binder and she may have taken them with her when she left. I can't find them."	C1959		

OKLAHOMA
State Department of Health

Delivery via email to: reggie@mlcconsult.com

April 30, 2025

License Number: AL5518

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

RE: Survey Event 692111

Dear Ms. Herring:

On **April 11, 2025**, a Licensure inspection with a complaint investigation was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and in a timely manner. **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 have been corrected and you were in substantial compliance by **April 28, 2025**.

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/28/2025** **Facility Name:** Crystal Place Assisted Living **License Number:** AL5518 **Survey Event ID:** 692111 **Date Survey Completed: 4/11/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C371	Based on: Based on observation, record review, and interview, the center failed to advise a resident and the resident's representative of the risks associated with the use of a bed rail for 1 (#3) of 8 sampled residents reviewed for risk management.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Choice of resident or facility to utilize a half bed rail for bed mobility has never been considered an action that required a risk management agreement as it is a piece of equipment which is utilized to enhance the residents mobility; therefore, it has not been this Administrators practice in the last 20 years to perform a risk management agreement on such device. Upon questioning the surveyor as to why this would be required the answer was "this comes from the top at our department". Hence, the managed risk will be put in place for this device as time constraints prevent an IDR event at this time.

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?	A Managed risk will be completed for resident #3 to continue to utilize the half bed rails for her bed mobility.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents that would choose to use half bed rails would not have a managed risk in place therefore not having knowledge of consequential risk for placement of such DME.
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?	Future policy will be interpreted and DON will be educated to include half bed rails as a managed risk requirement.
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.	If a resident chooses or requires half bed rails to assist with mobility, the facility will complete a managed risk agreement. a. A form will be placed in resident chart and resident or responsible party will acknowledge by signature of understanding. b. Managed Risks will be reviewed in QA by administrator and DON. c. QA records are kept in binder by Admininstrator and managed risks are kept and reviewed
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/28/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter date of signature. 4/28/25

10012013

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor:** Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/28/2025** **Facility Name:** Crystal Place Assisted Living **License Number:** AL5518 **Survey Event ID:** 692111 **Date Survey Completed: 4/11/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: Based on record review and interview the facility failed to ensue a significant change assessment was completed for resident #3 of 8 reisents sampled for assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: As per facility policy, a comprehensive assessment is required upon initial admit, significant change and annually. The change of this resident from one assist to two assist was placed on care plan but was not found to have been assessed for significant change. This occurrence was prior to this Administrator and DON's time at the facility.

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?	Policy will be followed to perform a new comprehensive assessment for all significant changes within any residents care requirement.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents would be at risk for not having a comprehensive assessment on file upon a significant change. This could prevent staff from having the knowledge of appropriate care requirements.
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 has discussed the policy and regulation regarding the significant change assessments with DON to ensure acknowledgment and understanding of such policy. Assessment policy was sent to DON via email and reviewed together.
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.	Upon significant change, a resident will receive a comprehensive assessment from the nurse to ensure that any change in condition or care is communicated to staff and documented. a. Significant changes will be reviewed on an ongoing basis by DON through interviews with direct care staff and by visual assessments daily. b. Significant changes will be reviewed during QA. c. QA notes will be kept in a binder in Administrator's office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/14/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4/28/25

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/28/2025** **Facility Name:** Crystal Place Assisted Living **License Number:** AL5518 **Survey Event ID:** 692111 **Date Survey Completed: 4/11/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: CC1931	Based on: Based on observation, record review, and interview, the center failed to ensure unattended medication carts were locked for 2 of 2 medication carts observed; HIPPA information and MAR were secured, and medications were stored and secured inside of a locked medication cart for 1 of 2 medication carts observed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The medication administration policy was not followed by direct care staff at time of observation by this surveyor.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Medication administration policy will be reviewed by all direct care staff members and those whom violated this policy were counseled on survey date and educated on appropriate methods.
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 residents could be affected by the possible HIPPA violation due to leaving MARs open and unattended, as well as the potential risk of resident obtaining unlocked and unattended medication left on cart.
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?	Medication administration policy will be followed by all direct care staff requiring them to lock all unattended carts and to ensure all information is kept secure and out of line of sight if unattended with no medications left out.
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 will monitor medication passes randomly to ensure policy is followed and the medication administration policy will be given to each staff member that passes medication with a signature required for acknowledgment. a. Through the DON evaluation of med passes b. Competency skills checklists are completed annually. c. The skills check lists are reviewed annually and kept in employee binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/24/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature (Administrator signature required.) OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4/28/25

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SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1952	Based on: Based on record, review, and interview, the facility failed to ensure records were retained for #8 of 8 residents sampled for records.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The name initially given to this Administrator for resident # 8 was "Fray". When this Adminstrator stated that she did not think that was a familiar name, the surveyor responded with "we are not certain of name or spelling." This was at approximately 3:30 pm. This Administrator called the owners upon not finding any records with this name and they stated that there was a previous resident by the name of "Ferrer" that was sent to the attorney's office but would have copies at facility. Administrator told surveyor she thought she may be speaking of a "Ferrer" but that she was still searching as the storage area was not a familiar area to her as of yet. Surveyor stated that records must be produced prior to exit. All records requested were found at 4:40 pm behind a locked storage door that owners informed DON and Administrator of and this Administrator attempted to call and text and email surveyor giving them the information that records had been located as this Administrator was new to facilty and DON was also new while owners were out of the country.

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?	DON and Administrator are now aware of where all discharged resident records are stored and filed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	There is no potential of harm to other residents.
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?	Records will be produced in timely manner as the Administrator and DON are now aware of where the locked storage room is located.
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.	No monitoring of performance is required for this tag. a. If records are requested they shall be produced from this storage area. b. Continued storage policy will be followed. c. Any discharged resident files will continue to be stored in appropriate areas and all staff has been made aware of such practice.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/12/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4/28/25

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/28/2025** **Facility Name:** Crystal Place Assisted Living **License Number:** AL5518 **Survey Event ID:** 692111 **Date Survey Completed: 4/11/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1953	Based on: Based on record, review, and interview, the facility failed to ensure records were retained for #8 of 8 residents sampled for records.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: All discharged resdients and charts are kept in storage area upstairs, however; it was not known by this Administrator that the previous Administrator had put all 2024 resident information behind a locked storage area in a different room. Therefore, all requested documentation was found for 2024 were found within one hour of the request; however the surveyor had already exited and this Administrator was unable to reach by cell, email or text upon calling at that time.

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?	DON and Administrator are now aware of where all discharged resident records are stored and filed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	There is no potential of harm to other residents.
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?	Records will be produced in timely manner as the Administrator and DON are now aware of where the locked storage room is located.
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.	No monitoring of performance is required for this tag. a. If records are requested they shall be produced from this storage area. b. Continued storage policy will be followed. c. Any discharged resident files will continue to be stored in appropriate areas and all staff has been made aware of such practice.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/12/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4/28/25

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/28/2025** **Facility Name:** Crystal Place Assisted Living **License Number:** AL5518 **Survey Event ID:** 692111 **Date Survey Completed: 4/11/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1959	Based on: Based on record review and interview, the center ailed to maintain incident reports for a period of two years.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: All discharged resdients and charts are kept in storage area upstairs, however; it was not known by this Administrator that the previous Administrator had put all 2024 resident information behind a locked storage area in a different room. Therefore, the incident reports for 2024 were found within one hour of the request; however the surveyor had already exited and this Administrator was unable to reach by cell, email or text upon calling at that time.

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?	DON and Administrator are now aware of where all discharged resident records are stored and filed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	There is no potential of harm to other residents.
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?	Records will be produced in timely manner as the Administrator and DON are now aware of where the locked storage room is located.
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.	No monitoring of performance is required for this tag. a. If records are requested they shall be produced from this storage area. b. Continued storage policy will be followed. c. Any discharged resident files will continue to be stored in appropriate areas and all staff has been made aware of such practice.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/12/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4/28/25

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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

Delivery via email to: reggie@mlcconsult.com

May 7, 2025

License Number: AL5518

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

RE: Survey Event 692112

Dear Ms. Elmore:

On **May 7, 2025,** an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your survey on **April 11, 2025,** have now been corrected effective **April 28, 2025.**

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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 05/07/2025

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 05/07/25. 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