

Delivery via email to: crystalplaceretirement@gmail.com

July 2, 2025

License Number: AL5518

Ms. Carrie Elmore, Administrator
Crystal Place, LLC
400 Southwest 79th Street
Oklahoma City, OK 73139

Survey Event ID: OCIP11

Dear Ms. Elmore:

On **June 19, 2025**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance

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

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

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

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

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or 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

INVESTIGATIVE REPORT

Facility: Crystal Place Assisted Living

Address: 400 SOUTHWEST 79th St

City, State, Zip: OKC, OK 73139

Provider #: AL5518

Complaint #: OK00083530

Investigation Date(s): 06/18/25-06/19/25

ALLEGATION(S)
The facility failed to ensure water was offered to all residents
The facility failed to ensure residents were free from verbal abuse
The facility failed to ensure medications were secured
enter text
enter text

An unannounced on-site investigation was initiated 06/18/2025 at 6:15 a.m.

A sample of 6 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: Throughout the survey residents were observed for signs of neglect and mental disturbance. Medication carts, medication storage, and medication pass were observed. Records of resident medical charts and the center's policies were reviewed. Interviews were conducted with staff, residents, and families. It was determined by observation, record review and interview that the center failed to secure medications.

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: 06/19/2025

INVESTIGATIVE REPORT

Facility: Crystal Place Assisted Living

Address: 400 SOUTHWEST 79TH ST

City, State, Zip:

Provider #: AL5518

Complaint #: OK00083544

Investigation Date(s): 06/18/25-06/19/25

ALLEGATION(S)
The facility failed to ensure residents were free from self harm
The facility failed to ensure medications were secured
enter text
enter text
enter text

An unannounced on-site investigation was initiated 06/18/2025 at 6:15 a.m.

A sample of 6 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: Throughout the survey residents were observed for signs of neglect and mental disturbance. Medication carts, medication storage, and medication pass were observed. Records of resident medical charts and the center's policies were reviewed. Interviews were conducted with staff, residents, and families. It was determined by observation, record review and interview that the center failed to secure medications and prevent a resident from causing self harm.

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: 06/19/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/19/2025
NAME OF PROVIDER OR SUPPLIER CRYSTAL PLACE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 400 SOUTHWEST 79TH STREET OKLAHOMA CITY, OK 73139		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS Complaint investigations (#OK00083530, OK00079607, and #OK00083544) were conducted on 06/18/25 through 06/19/25. Deficiencies were cited as a result of the survey. The RN consultant identified 33 residents resided in the center. Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide FSBS- finger stick blood sugar IJ- immediate jeopardy MAR- medication administration record ML- milliliters OSDH- Oklahoma State Department of Health RN- registered nurse	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure comprehensive assessments	C 522		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 522	Continued From page 1 were completed every 12 months for 1 (#4) of 6 residents sampled for comprehensive assessments. The RN consultant identified 33 residents resided in the center. Findings: A "14-day Comprehensive Assessment," dated 06/04/24, showed Resident #4 was admitted to the center on 06/04/24 with a diagnosis of diabetes mellitus Type 2. A review of Resident #4's medical record did not show an annual comprehensive assessment had been completed for the year 2025. On 06/18/25 at 1:54 p.m., the RN consultant was asked for Resident #4's annual comprehensive assessment for 2025. The RN consultant stated, "I do not have one for 2025." The RN consultant was asked when Resident #4's annual comprehensive assessment was due and they stated, "By June 4th of this year."	C 522			
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract.	C1304			

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C1304	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure weekly medication counts for residents who self administered medications in accordance with resident service contracts for 2 (#1 and #4) of 2 residents reviewed for self administration of medications. The RN consultant identified 33 residents resided in the center. Findings: 1. A "14-day Comprehensive Assessment," dated 06/04/24, showed Resident #4 was admitted to the center on 06/04/24 with a diagnosis of diabetes mellitus type 2. A document titled, "Resident Contract," dated 09/09/24, read in part, "Personal Care Services Schedule C. Weekly inventory of medication for those who self administer (State law requirement)." A review of Resident #4's MAR did not show any medication counts for February, April, or June of 2025. 2. An "Annual Comprehensive Assessment," dated 10/09/24, showed Resident #1 was	C1304		

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C1304	Continued From page 3 admitted to the center on 08/26/21 with diagnoses to include diabetes mellitus type 2. A review of Resident #1's medical chart showed an untitled document, dated 03/13/25, showed Resident #1's name and apartment number with a list of oral medications. Next to the oral medications were numbers. This document did not show insulin on the list. A review of Resident #1's MAR did not show any medication counts for April, May, or June of 2025. A review of Resident #1's medical chart showed an untitled document, dated 04/03/25, showed Resident #1's name and apartment number with a list of oral medications. Next to the oral medications were numbers. This document did not show insulin on the list. There were no other documents since 04/03/25 indicating any medication counts. On 06/18/25 at 7:20 a.m., CMA #1 was asked if the center monitored or counted medications for residents who self administer medications. They stated, "No." On 06/18/25 at 8:48 a.m., Resident #1's family member was asked if the center assisted the resident in counting or keeping up with medications. They stated, "No." On 06/18/25 at 9:23 a.m., Resident #4 was asked who administered their insulin. Resident #4 stated, "I do." Resident #4 was asked if staff counted their insulin or kept track of their injections in any way. They stated, "No." Resident #4 was asked if they counted their insulin pens. They stated, "I don't count anything. I've never been told to."	C1304		

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C1304	Continued From page 4 On 06/18/25 at 10:25 a.m., the RN consultant stated, "There's no self administration policy (for resident self administration of medications)." The RN consultant was asked how the center monitored medications for residents who self administer medications. The RN consultant stated, "I believe there is a count on the MAR. I'd have to look. I know on [Resident #1] [they] turned in their own count sheets weekly."	C1304		
C1512 SS=G	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;	C1512		

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C1512	Continued From page 5 Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the center failed to ensure residents were free from neglect for 1 (#2) of 3 residents sampled for assistance with activities of daily living. This failed practice resulted in actual harm at an isolated pattern.	C1512		

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C1512	Continued From page 6 The RN consultant identified 33 residents resided in the center. Findings: On 06/18/25 at 7:32 a.m., CMA #1 entered Resident #2's apartment to assist with toileting and dressing assistance. The resident had been asleep, but awoke upon staff entry into apartment. A strong odor of urine was present in Resident #2's bedroom. CMA #1 assisted Resident #2 to a sitting position on the bed and it was observed Resident #2's bed pad and sheets were soiled with urine. It was further observed Resident #2 was saturated with urine from their shins to the back of their neck. Resident #2 did not have any under garments on. As CMA #1 assisted Resident #2 to stand and walk to the toilet, the resident's bed sheets were noted to have smeared bowel movement where they were sitting. An "Annual Comprehensive Assessment," dated 09/04/24, showed Resident #2 was admitted to the center on 08/11/14 with diagnoses to include dementia, osteoarthritis, cerebral vascular accident, and chronic pain. The assessment showed Resident #2 was incontinent of bowel and bladder and required the assistance of one staff member for toileting and dressing. A review of Resident #2's "Individual Care Plan," dated 09/04/24, read in part, "Toileting schedule: 2 hour. Resident encouraged to assist with brief changes. Incontinent of bowel and bladder, toileting schedule/pericare." On 06/18/25 at 7:42 a.m., CMA #1 was asked how often Resident #2 was soiled in urine in the	C1512		

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C1512	Continued From page 7 morning. They stated, "Night shift usually gets [them] up before we get here in the morning, so I'm not sure. You can tell [Resident #2] has been laying in [their] urine a long time. We have to help [them] in the bathroom." On 06/18/25 at 7:47 a.m., Resident #2 was asked how often they woke up soiled in urine. They stated, "Nearly every morning." Resident #2 was asked if anyone helped them to the bathroom during the night. They stated, "No." Resident #2 was asked how it made them feel to wake up soiled in their urine. They stated, "I need help. Someone should be taking care of me, it makes me very upset. It's degrading. I'm 97 years old and I need help." On 06/18/25 at 2:20 p.m., CMA #2 was asked via telephone what Resident #2's toileting abilities were. CMA #2 stated, "[They] used it by themselves, but sometimes we help." CMA #2 was asked if Resident #2 was on a toileting schedule. CMA #2 stated, "We go in there when we think [they] need to go and encourage [them] to go." CMA #2 was asked what time they last checked on Resident #2 last night. CMA #2 stated, "Probably about 11:30 p.m. or 12 midnight. CMA #2 was asked if Resident #2 went to the bathroom at that time. CMA #2 stated, "No. I took [them] to the toilet when [they] went to bed between about 9:00 p.m. and 9:30 p.m. last night." CMA #2 was asked if any staff had taken Resident #2 to the bathroom between 9:30 p.m. and 7:00 a.m. when their shift ended. CMA #2 stated, "No." On 06/18/25 at 2:40 p.m., the administrator was asked what Resident #2's toileting ability was. The administrator looked at Resident #2's care plan and stated, "[They] need one staff to assist	C1512		

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C1512	Continued From page 8 to the toilet every two hours." The administrator was asked if they could say why the overnight shift did not assist the resident to the bathroom on their shift. The administrator stated, "No, I cannot." The administrator was asked if not assisting a dependent resident to the toilet, which caused the resident to wake up saturated in their own urine, constitutes neglect. The administrator stated, "Absolutely."	C1512		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		

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C1911	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the center failed to submit an incident report to the department within 1 business day of the incident's discovery for 1 (#1) of 6 sampled residents reviewed for incident reports. The RN consultant identified 33 residents resided in the center. Findings: A policy titled "Incident Reporting," dated 09/01/22, read in part, "Incidents involving residents will be reported to the State Health Department as stated in their rules and regulations." An "Annual Comprehensive Assessment," dated 10/09/24, showed Resident #1 was admitted to the center on 08/26/21 with diagnoses to include diabetes mellitus type 2 and hypertension. A review of Resident #1's medical chart showed an "Incident Report Form," dated 06/13/25, read in part, "Death by unnatural causes. On 06/13/25 at 8:00 a.m., home health nurse went in to resident's apartment to do resident's blood sugar and administer his twice daily insulin. Resident was unresponsive upon arrival. FSBS was 23. Resident was transported to [name-deleted hospital]. Family arrived to facility on 06/14/25 and informed facility staff that resident expired in the hospital."	C1911		

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C1911	Continued From page 10 A review of OSDH's incident report system did not show this incident report form was received by OSDH. On 06/18/25 at 12:45 p.m., the RN consultant was asked for the fax confirmation showing the incident report form for Resident #2 was sent and received by OSDH. The RN consultant provided the fax confirmation which read in part, "Transmission error." On 06/18/25 at 12:48 p.m., the administrator was asked to show the Incident Report Form was received by OSDH. The administrator pointed to the fax confirmation sheet. They were shown the fax confirmation read in part, "Transmission error." The administrator stated, "I see what I did. I transposed the fax number, so of course it didn't go through." The administrator was asked what the policy is for reporting resident incidents to OSDH. They stated, "One business day." On 06/18/25 at 12:51 p.m., OSDH received the Incident Report Form for Resident #1.	C1911		
C1920 SS=J	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: On 06/18/25, an immediate jeopardy situation was determined to exist when the center failed to develop and implement medication policies and procedures for self administration of medications	C1920		

Oklahoma State Department of Health

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C1920	Continued From page 11 to ensure the safe self administration of medications. On 06/18/25 at 12:44 p.m., OSDH was notified and verified the existence of the IJ situation. On 06/18/25 at 12:51 p.m., the owner, administrator and RN consultant were notified of the IJ situation related to the death of Resident #1. On 06/18/25 at 3:46 p.m., the RN consultant submitted an acceptable plan of removal. The plan of removal, read in part, "Crystal Place Plan of Removal, 06/18/25 1. All insulin was removed from the resident's rooms and stored in facility medication room on 06/18/25 at 13:25 [1:35 p.m.]. 2. Facility has developed and implemented a Self-Administration policy for residents who self-administer medications on 06/18/25 at 13:25 [1:35 p.m.]. 3. The facility will evaluate residents who self-administer medications and complete a self-administration test on 06/18/25 by 17:00 [5:00 p.m.]. 4. The facility's nurse will be educated on the Self-Administration policy for residents on 6/18/25 by 1700 [5:00 p.m.]. 5. The facility's nurse will be educated on performing accurate and proper medication counts for residents who self administer medications on 6/18/25 by 1700 [5:00 p.m.]. 6. A current medication count will be obtained on 6/18/25 by 1700 [5:00 p.m.]. 7. All staff will be educated on which residents can safely self-administer medications. Staff will be educated on signs and symptoms of medication overdose, what types of medication	C1920		

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C1920	Continued From page 12 each resident may have in their apartment, and when to report concerns to the nurse. This education will be completed by 6/19/25 at 1500 [3:00 p.m.]." The IJ was removed on 06/19/25 at 3:29 p.m., when all components of the plan of removal had been verified as completed. Observation and interview of Resident #4, verified insulin had been removed from their apartment. An undated policy titled, "Self Administration of Medication by Residents," was presented to be adopted by the center. Documents titled, "Self Administration of Medication," dated 06/18/25 and signed by the RN consultant verified all residents who self administered medications were reassessed for safe ability to self administer medications. Attached to the self administration tests were medication counts for all residents who self administer. Interviews with staff and a document titled "Crystal Place Retirement Inservice," dated 06/18/25, with all staff signatures verified all staff had been educated on the Self-Administration policy, signs and symptoms of medication overdose, and when to report concerns to the nurse. Interviews with the administrator and RN consultant as well as a document titled, "Crystal Place Retirement Inservice: Medication Reconciliation, Self-Administration policy, Proper med storage," dated 06/18/25 verified the RN consultant was educated on proper medication counts and the center's newly adopted Self-Administration policy. Based on observation, record review, and interview, the center failed to develop and implement medication policies and procedures for self administration of medications to ensure the safe self administration of medications resulting in the death of 1 (#1) of 2 residents reviewed for	C1920		

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C1920	Continued From page 13 self administration of medications. The administrator identified 33 residents resided in the center. Findings: 1. On 06/18/25 at 9:25 a.m., 5 Levemir (insulin for diabetes mellitus) Flextouch 100 unit/ml (similar to vials) were observed unsecured inside Resident #4's apartment refrigerator. There was no lock on the refrigerator. A "14-day Comprehensive Assessment," dated 06/04/24, showed Resident #4 was admitted to the center on 06/04/24 with diagnosis of diabetes mellitus type 2. A review of Resident #4's MAR did not show any medication counts for February, April, or June of 2025. A document titled "Physicians Orders Routine Medications," dated 06/02/25, showed Resident #4 was prescribed Levemir Flextouch 100 unit/ml, "Inject 22 units SQ (subcutaneously) daily." On 06/18/25 at 9:23 a.m., Resident #4 was asked who administered their insulin. Resident #4 stated, "I do." Resident #4 was asked if staff counted their insulin or kept track of their injections in any way. They stated, "No." They were asked if they counted their insulin pens. They stated, "I don't count anything. I've never been told to." Resident #4 was asked where their insulin was stored. The resident stated, "In the refrigerator." Resident #4 was asked if they ever kept their insulin behind a lock. Resident #4 stated, "I've never been asked to."	C1920		

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C1920	Continued From page 14 2. An "Annual Comprehensive Assessment," dated 10/09/24, showed Resident #1 was admitted to the center on 08/26/21 with a diagnosis of diabetes mellitus type 2. A review of Resident #1's medical chart showed an untitled document, dated 03/13/25, showed Resident #1's name and apartment number with a list of oral medications. Next to the oral medications were numbers. This document did not show insulin on the list. A review of Resident #1's MAR did not show any medication counts for April, May, or June of 2025. A document titled "Physicians Orders Routine Medications," dated 05/01/25 showed Resident # 1 was prescribed Insulin Degludec Pen (U-100) 100 unit/ml Insulin Pen (similar to vials) "Inject 25 units subcutaneously every morning." The document also showed Resident #1 was prescribed Insulin Degludec Pen (U-100) 100 unit/ml Insulin Pen "Inject 15 units subcutaneously every night at bedtime." A review of Resident #1's medical chart showed an untitled document, dated 04/03/25, showed Resident #1's name and apartment number with a list of oral medications. Next to the oral medications were numbers. This document did not show insulin on the list. There were no other documents since 04/03/25 indicating any medication counts. A document titled "Crystal Place Communication Form," dated 06/12/25 at 5:30 p.m., and signed by Resident #1's home health nurse, read in part, "[Resident #1] FSBS 100 insulin held due to [patient] decreased appetite."	C1920		

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C1920	Continued From page 15 A review of Resident #1's medical chart showed an "Incident Report Form," dated 06/13/25, read in part, "Death by unnatural causes. On 06/13/25 at 8:00 a.m., home health nurse went in to resident's apartment to do resident's blood sugar and administer his twice daily insulin. Resident was unresponsive upon arrival. FSBS was 23. Resident was transported to [name-deleted hospital]. Family arrived to facility on 06/14/25 and informed facility staff that resident expired in the hospital." On 06/18/25 at 7:20 a.m., CMA #1 was asked where residents who self administer medications kept their medications, specifically insulin. CMA #1 stated, "In their room." CMA #1 was asked if the residents who self administer medications were kept locked in their room or if they were out in the open. CMA #1 stated, "Just out." CMA #1 was asked how Resident #1 passed away. CMA #1 stated, "I heard home health found [them] after [they] injected [them]self with insulin and [they] passed at the hospital." CMA #1 was asked if the center monitored or counted medications for residents who self administered medications. They stated, "No." On 06/18/25 at 8:48 a.m., Resident #1's family member was asked about the death of Resident #1. They stated, "[Another family member] got a call from the home health nurse stating when they came in [Resident #1] was passed out, non responsive, FSBS was 30 or something. The home health nurse called an ambulance and when they arrived they gave glucose. EMSA able to rouse [Resident #1] and transported to the hospital." The family member was asked if they were aware of why Resident #1's FSBS was low. The family member stated, "The doctor said they found insulin pens in bed with [Resident #1]."	C1920		

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C1920	Continued From page 16 [Resident #1] insisted on doing their own medications but usually the home health nurse gave insulin, so I have no idea why it was in the bed with [Resident #1]. The doctor stated he was surprised insulin was kept in [Resident #1's] room." The family member was asked how Resident #1 stored medications in their room. The family member stated, "The insulin was kept in [their] refrigerator and a basket had other medications. [Resident #1] also kept a sheet with a list of meds so [they] could mark it off when [they] took them." The family member was asked if the center assisted the resident in counting or keeping up with medications. They stated, "No." The family member was asked if any of the medications in Resident #1's apartment were locked up. They stated, "No, just in there." On 06/18/25 at 9:58 a.m., the RN consultant was asked what the policy was for resident self administration of medications. They stated, "I don't know anything about the policies." The RN consultant was asked about the death of Resident #1. They stated, "[They] did [their] own medications. Home health came twice daily for insulin. I don't remember the day, but home health called EMSA because FSBS was like 23 or something. [Resident #1] went to the hospital and he passed away in the hospital." The RN consultant was asked if Resident #1 gave their own insulin. They stated, "No, but I know all meds were in there [Resident #1's apartment]. I don't know the whole set up about [their] medications." The RN consultant was asked for the center's resident self administration of medications policy. On 06/18/25 at 10:25 a.m., the RN consultant stated, "There's no self administration policy [for resident self administration of medications]." The RN consultant was asked how the center	C1920		

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C1920	Continued From page 17 monitored medications for residents who self administer medications. The RN consultant stated, "I believe there is a count on the MAR. I'd have to look. I know on [Resident #1] [they] turned in their own count sheets weekly." On 06/18/25 at 1:45 p.m., the administrator for Resident #1's home health company was interviewed via telephone. They were asked about the morning Resident #1's home health nurse arrived at the center to see Resident #1. They stated, "The home health nurse got there (to the center) in the morning, found [Resident #1] was unresponsive in bed. There were 2 insulin pens and 1 had no insulin. There were about 5 needles in the bed as well. [Resident #1's] FSBS was 23. The nurse called 911 and then we were notified [Resident #1] passed away at the hospital."	C1920		
C1931 SS=F	310:663-19-2(b)(1) MEDICATION ADMINISTRATION (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 1 of 2 medication carts observed;	C1931		

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C1931	Continued From page 18 b. medications were stored and secured inside of a locked medication room for 1 (East hall) of 1 medication rooms. The RN consultant identified 33 residents resided in the center. Findings: On 06/18/25 at 6:25 a.m., an unattended medication cart on the East hall was observed to be unlocked. Four residents were observed sitting in the dining room unattended, approximately 12 feet from the medication cart. On 06/18/25 at 6:26 a.m., a closed door marked "Storage Room," was noted to be unlocked. Upon entry, there were observed medications for the residents in the facility. On 06/18/25 at 6:33 a.m., CMA #2 locked the medication storage room. A document titled, "Policies and Procedures for Medication Administration," dated 05/30/23, read in part, "Med cart to be locked at all times when not in use." On 06/18/25 at 6:26 a.m., CMA #2 was asked what the policy was on locking medication carts. CMA #2 stated, "It's supposed to be locked." On 06/18/25 at 6:29 a.m., CMA #2 was what the policy was on locking the medication storage room. They stated, "It's supposed to be locked."	C1931		

Delivery via email to: crystalplaceretirement@gmail.com

July 16, 2025

License Number: AL5518

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

Survey Event ID: 0CIP11

Dear Ms. Bell:

On **June 19, 2025**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1931** - There is no remedy to ensure the medication aides are trained appropriately to keep medication carts locked.

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

Respectfully,

Tempal Killman

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

Enclosure

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C 000	INITIAL COMMENTS Complaint investigations (#OK00083530, OK00079607, and #OK00083544) were conducted on 06/18/25 through 06/19/25. Deficiencies were cited as a result of the survey. The RN consultant identified 33 residents resided in the center. Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide FSBS- finger stick blood sugar IJ- immediate jeopardy MAR- medication administration record ML- milliliters OSDH- Oklahoma State Department of Health RN- registered nurse 310:663-5-2(b) ASSESSMENT TIMEFRAMES	C 522	It is the policy of Crystal Place Retirement to comply with Assessment Timeframes Step 1 Comprehensive Assessment was completed on Resident #4. Step 2 An audit was conducted of all residents to ensure up to date comprehensive assessment completed, any assessments found out of date will be completed. Step 3 The Administrator will educate the RN Consultant on comprehensive assessment timing.	7/30/2025
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Oklahoma State Department of Health
LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 522	Continued From page 1 were completed every 12 months for 1 (#4) of 6 residents sampled for comprehensive assessments. The RN consultant identified 33 residents resided in the center. Findings: A "14-day Comprehensive Assessment," dated 06/04/24, showed Resident #4 was admitted to the center on 06/04/24 with a diagnosis of diabetes mellitus Type 2. A review of Resident #4's medical record did not show an annual comprehensive assessment had been completed for the year 2025. On 06/18/25 at 1:54 p.m., the RN consultant was asked for Resident #4's annual comprehensive assessment for 2025. The RN consultant stated, "I do not have one for 2025." The RN consultant was asked when Resident #4's annual comprehensive assessment was due and they stated, "By June 4th of this year." 310:663-13-1(d) RESIDENT SERVICE CONTRACT SS=E	C 1304	It is the policy of Crystal Place Retirement to comply with Resident Service Contract Step 1 Resident #1 no longer self-administers medications. Resident #4 no longer self-administers medications.	7/30/2025

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C1304	Continued From page 2	C1304	Step 2 An audit of resident who self-administer medications was conducted to ensure weekly medication counts in place Step 3 The RN consultant will educate the Director of Nursing and medication aide staff on self-administration weekly count. Step 4 Director of Nursing or designee will perform Quality Assurance by audit of self-administration counts. This review will occur weekly for four weeks, then monthly. Areas of concern will be addressed immediately. Findings will be reported to Administrator weekly and to the Quality Assurance committee monthly.	
C1304	This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure weekly medication counts for residents who self administered medications in accordance with resident service contracts for 2 (#1 and #4) of 2 residents reviewed for self administration of medications. The RN consultant identified 33 residents resided in the center. Findings: 1. A "14-day Comprehensive Assessment," dated 06/04/24, showed Resident #4 was admitted to the center on 06/04/24 with a diagnosis of diabetes mellitus type 2. A document titled, "Resident Contract," dated 09/09/24, read in part, "Personal Care Services Schedule C. Weekly inventory of medication for those who self administer (State law requirement)." A review of Resident #4's MAR did not show any medication counts for February, April, or June of 2025. 2. An "Annual Comprehensive Assessment," dated 10/09/24, showed Resident #1 was			

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C1304	Continued From page 3	C1304		
admitted to the center on 08/26/21 with diagnoses to include diabetes mellitus type 2. A review of Resident #1's medical chart showed an untitled document, dated 03/13/25, showed Resident #1's name and apartment number with a list of oral medications. Next to the oral medications were numbers. This document did not show insulin on the list. A review of Resident #1's MAR did not show any medication counts for April, May, or June of 2025. A review of Resident #1's medical chart showed an untitled document, dated 04/03/25, showed Resident #1's name and apartment number with a list of oral medications. Next to the oral medications were numbers. This document did not show insulin on the list. There were no other documents since 04/03/25 indicating any medication counts. On 06/18/25 at 7:20 a.m., CMA #1 was asked if the center monitored or counted medications for residents who self administer medications. They stated, "No." On 06/18/25 at 8:48 a.m., Resident #1's family member was asked if the center assisted the resident in counting or keeping up with medications. They stated, "No." On 06/18/25 at 9:23 a.m., Resident #4 was asked who administered their insulin. Resident #4 stated, "I do." Resident #4 was asked if staff counted their insulin or kept track of their injections in any way. They stated, "No." Resident #4 was asked if they counted their insulin pens. They stated, "I don't count anything. I've never been told to."				

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STREET ADDRESS, CITY, STATE, ZIP CODE 400 SOUTHWEST 79TH STREET OKLAHOMA CITY, OK 73139				

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C1304	Continued From page 4 On 06/18/25 at 10:25 a.m., the RN consultant stated, "There's no self administration policy (for resident self administration of medications)." The RN consultant was asked how the center monitors medications for residents who self administer medications. The RN consultant stated, "I believe there is a count on the MAR. I'd have to look. I know on [Resident #1] [they] turned in their own count sheets weekly." C1512 310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;	C1304 C1512	It is the policy of Crystal Place Retirement to comply with Resident Rights-Abuse/Neglect Step 1 Resident #2 received ADL care immediately including toileting assistance and dressing Step 2 Facility will ensure residents are free from abuse/neglect. Facility will ensure that employees are educated on abuse/neglect policy. Step 3 Facility staff educated on resident rights, abuse and neglect and providing ADL care timely. Step 4 The Director of Nursing or designee will perform Quality Assurance by surveillance rounds of ADL Care. This review will occur 3-5 times weekly for four weeks then weekly for 4 weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to Administrator weekly and to Quality Assurance Performance Improvement Committee monthly.	7/30/2025

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C1512	Continued From page 5	C1512					
Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the center failed to ensure residents were free from neglect for 1 (#2) of 3 residents sampled for assistance with activities of daily living. This failed practice resulted in actual harm at an isolated pattern.							

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C1512	Continued From page 6	C1512		
The RN consultant identified 33 residents resided in the center. Findings: On 06/18/25 at 7:32 a.m., CMA #1 entered Resident #2's apartment to assist with toileting and dressing assistance. The resident had been asleep, but awoke upon staff entry into apartment. A strong odor of urine was present in Resident #2's bedroom. CMA #1 assisted Resident #2 to a sitting position on the bed and it was observed Resident #2's bed pad and sheets were soiled with urine. It was further observed Resident #2 was saturated with urine from their shins to the back of their neck. Resident #2 did not have any under garments on. As CMA #1 assisted Resident #2 to stand and walk to the toilet, the resident's bed sheets were noted to have smeared bowel movement where they were sitting. An "Annual Comprehensive Assessment," dated 09/04/24, showed Resident #2 was admitted to the center on 08/11/14 with diagnoses to include dementia, osteoarthritis, cerebral vascular accident, and chronic pain. The assessment showed Resident #2 was incontinent of bowel and bladder and required the assistance of one staff member for toileting and dressing. A review of Resident #2's "Individual Care Plan," dated 09/04/24, read in part, "Toileting schedule: 2 hour. Resident encouraged to assist with brief changes. Incontinent of bowel and bladder, toileting schedule/pericare." On 06/18/25 at 7:42 a.m., CMA #1 was asked how often Resident #2 was soiled in urine in the				

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C1512	Continued From page 7	C1512		
morning. They stated, "Night shift usually gets [them] up before we get here in the morning, so I'm not sure. You can tell [Resident #2] has been laying in [their] urine a long time. We have to help [them] in the bathroom." On 06/18/25 at 7:47 a.m., Resident #2 was asked how often they woke up soiled in urine. They stated, "Nearly every morning." Resident #2 was asked if anyone helped them to the bathroom during the night. They stated, "No." Resident #2 was asked how it made them feel to wake up soiled in their urine. They stated, "I need help. Someone should be taking care of me, it makes me very upset. It's degrading. I'm 97 years old and I need help." On 06/18/25 at 2:20 p.m., CMA #2 was asked via telephone what Resident #2's toileting abilities were. CMA #2 stated, "[They] used it by themselves, but sometimes we help." CMA #2 was asked if Resident #2 was on a toileting schedule. CMA #2 stated, "We go in there when we think [they] need to go and encourage [them] to go." CMA #2 was asked what time they last checked on Resident #2 last night. CMA #2 stated, "Probably about 11:30 p.m. or 12 midnight. CMA #2 was asked if Resident #2 went to the bathroom at that time. CMA #2 stated, "No. I took [them] to the toilet when [they] went to bed between about 9:00 p.m. and 9:30 p.m. last night." CMA #2 was asked if any staff had taken Resident #2 to the bathroom between 9:30 p.m. and 7:00 a.m. when their shift ended. CMA #2 stated, "No." On 06/18/25 at 2:40 p.m., the administrator was asked what Resident #2's toileting ability was. The administrator looked at Resident #2's care plan and stated, "[They] need one staff to assist				

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C1512	Continued From page 8	C1512		
C1911	SS=D 310:663-19-1(a) INCIDENT REPORT TIMELINES	C1911	It is the policy of Crystal Place Retirement to comply with Incident Report Timelines 7/30/2025	
to the toilet every two hours." The administrator was asked if they could say why the overnight shift did not assist the resident to the bathroom on their shift. The administrator stated, "No, I cannot." The administrator was asked if not assisting a dependent resident to the toilet, which caused the resident to wake up saturated in their own urine, constitutes neglect. The administrator stated, "Absolutely." (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.				
Step 1 Incident report sent into OSDH, did not verify fax went through. Incident report refaxed to OSDH on 6/19/2025 Step 2 Facility will ensure resident incident reports are sent to OSDH within one day of incident discovery. Step 3 The facility Administrator/DON were educated on the regulatory requirements for reporting incident and timeline of reporting to Oklahoma State Department of Health. Step 4 Director of Nursing or designee will perform audits of 24-hour shift reports to ensure incidents are properly reported. This review will occur 3-5 times weekly for four weeks, then weekly for four weeks, then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Administrator weekly and to the Quality Assurance Performance Improvement committee monthly				

OKLAHOMA STATE DEPARTMENT OF HEALTH		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5518		(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2025		NAME OF PROVIDER OR SUPPLIER CRYSTAL PLACE, LLC 400 SOUTHWEST 79TH STREET OKLAHOMA CITY, OK 73139	
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Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the center failed to submit an incident report to the department within 1 business day of the incident's discovery for 1 (#1) of 6 sampled residents reviewed for incident reports. The RN consultant identified 33 residents resided in the center. Findings: A policy titled "Incident Reporting," dated 09/01/22, read in part, "Incidents involving residents will be reported to the State Health Department as stated in their rules and regulations." An "Annual Comprehensive Assessment," dated 10/09/24, showed Resident #1 was admitted to the center on 08/26/21 with diagnoses to include diabetes mellitus type 2 and hypertension. A review of Resident #1's medical chart showed an "Incident Report Form," dated 06/13/25, read in part, "Death by unnatural causes. On 06/13/25 at 8:00 a.m., home health nurse went in to resident's apartment to do resident's blood sugar and administer his twice daily insulin. Resident was unresponsive upon arrival. FSBS was 23. Resident was transported to [name-deleted hospital]. Family arrived to facility on 06/14/25 and informed facility staff that resident expired in the hospital."											

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C1911	Continued From page 10 A review of OSDH's incident report system did not show this incident report form was received by OSDH. On 06/18/25 at 12:45 p.m., the RN consultant was asked for the fax confirmation showing the incident report form for Resident #2 was sent and received by OSDH. The RN consultant provided the fax confirmation which read in part, "Transmission error." On 06/18/25 at 12:48 p.m., the administrator was asked to show the Incident Report Form was received by OSDH. The administrator pointed to the fax confirmation sheet. They were shown the error." The administrator stated, "I see what I did. I transposed the fax number, so of course it didn't go through." The administrator was asked what the policy is for reporting resident incidents to OSDH. They stated, "One business day." On 06/18/25 at 12:51 p.m., OSDH received the Incident Report Form for Resident #1. 310:663-19-2(a) MEDICATION ADMINISTRATION SS=J	C1920	It is the policy of Crystal Place Retirement to comply with Medication Administration Crystal Place Retirement completed an immediate removal plan for the jeopardy citation issued on 6/18/2025, T 1244. This credible removal plan has been submitted and accepted per SOD. The removal of the jeopardy status was completed on 6/19/2025 at T 1509	7/30/2025

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C1920	to ensure the safe self administration of medications. On 06/18/25 at 12:44 p.m., OSDH was notified and verified the existence of the 1J situation. On 06/18/25 at 12:51 p.m., the owner, administrator and RN consultant were notified of the 1J situation related to the death of Resident #1. On 06/18/25 at 3:46 p.m., the RN consultant submitted an acceptable plan of removal. The plan of removal, read in part, "Crystal Place Plan of Removal, 06/18/25 1. All insulin was removed from the residents rooms and stored in facility medication room on 06/18/25 at 13:25 [1:35 p.m.]. 2. Facility has developed and implemented a Self-Administration policy for residents who self-administer medications on 06/18/25 at 13:25 [1:35 p.m.]. 3. The facility will evaluate residents who self-administer medications and complete a self-administration test on 06/18/25 by 17:00 [5:00 p.m.]. 4. The facility's nurse will be educated on the Self-Administration policy for residents on 6/18/25 by 1700 [5:00 p.m.]. 5. The facility's nurse will be educated on performing accurate and proper medication counts for residents who self administer medications on 6/18/25 by 1700 [5:00 p.m.]. 6. A current medication count will be obtained on 6/18/25 by 1700 [5:00 p.m.]. 7. All staff will be educated on which residents can safely self-administer medications. Staff will be educated on signs and symptoms of medication overdose, what types of medication	C1920	Step 1 Resident #1 No longer resides in facility. Step 2 Per plan of correction All insulins removed from Resident's room, Facility has developed and implemented a Self-Administration policy for residents who self-administer medications, facility evaluated residents who self-administer medications and complete a self-administration test. Step 3 Facility's nurse educated on performing accurate and proper medication counts for residents who self-administer medications, staff educated on which residents can safely self-administer medications. Staff educated on signs and symptoms of medication overdose, what types of medication each resident may have in their apartment, and when to report concerns to the nurse. Step 4 Director of Nursing or designee will perform Quality Assurance by audit of self-administration counts, medication storage in resident rooms to ensure proper storage, medication self-administration test This review will occur weekly for four weeks, then monthly. Areas of concern will be addressed immediately. Findings will be reported to Administrator weekly and to the Quality Assurance Performance Improvement committee monthly.	

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C1920	Continued From page 12 each resident may have in their apartment, and when to report concerns to the nurse. This education will be completed by 6/19/25 at 1500 [3:00 p.m.]." The 1J was removed on 06/19/25 at 3:29 p.m., when all components of the plan of removal had been verified as completed. Observation and interview of Resident #4, verified insulin had been removed from their apartment. An undated policy titled, "Self Administration of Medication by Residents," was presented to be adopted by the center. Documents titled, "Self Administration of Medication," dated 06/18/25 and signed by the RN consultant verified all residents who self administered medications were reassessed for safe ability to self administer medications. Attached to the self administration tests were medication counts for all residents who self administer. Interviews with staff and a document titled "Crystal Place Retirement Inservice," dated 06/18/25, with all staff signatures verified all staff had been educated on the Self-Administration policy, signs and symptoms of medication overdose, and when to report concerns to the nurse. Interviews with the administrator and RN consultant as well as a document titled, "Crystal Place Retirement Inservice: Medication Reconciliation, Self-Administration policy, Proper med storage," dated 06/18/25 verified the RN consultant was educated on proper medication counts and the center's newly adopted Self-Administration policy. Based on observation, record review, and interview, the center failed to develop and implement medication policies and procedures for self administration of medications to ensure the safe self administration of medications resulting in the death of 1 (#1) of 2 residents reviewed for	C1920			

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C1920		Continued From page 13		C1920		
The administrator identified 33 residents resided in the center. Findings: 1. On 06/18/25 at 9:25 a.m., 5 Levemir (insulin for diabetes mellitus) Flextouch 100 unit/ml (similar to vials) were observed unsecured inside Resident #4's apartment refrigerator. There was no lock on the refrigerator. A "14-day Comprehensive Assessment," dated 06/04/24, showed Resident #4 was admitted to the center on 06/04/24 with diagnosis of diabetes mellitus type 2. A review of Resident #4's MAR did not show any medication counts for February, April, or June of 2025. A document titled "Physicians Orders Routine Medications," dated 06/02/25, showed Resident #4 was prescribed Levemir Flextouch 100 unit/ml, "Inject 22 units SQ (subcutaneously) daily." On 06/18/25 at 9:23 a.m., Resident #4 was asked who administered their insulin. Resident #4 stated, "I do." Resident #4 was asked if staff counted their insulin or kept track of their injections in any way. They stated, "No." They were asked if they counted their insulin pens. They stated, "I don't count anything. I've never been told to." Resident #4 was asked where their insulin was stored. The resident stated, "In the refrigerator." Resident #4 was asked if they ever kept their insulin behind a lock. Resident #4 stated, "I've never been asked to."						

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C1920	Continued From page 14 2. An "Annual Comprehensive Assessment," dated 10/09/24, showed Resident #1 was admitted to the center on 08/26/21 with a diagnosis of diabetes mellitus type 2. A review of Resident #1's medical chart showed an untitled document, dated 03/13/25, showed Resident #1's name and apartment number with a list of oral medications. Next to the oral medications were numbers. This document did not show insulin on the list. A review of Resident #1's MAR did not show any medication counts for April, May, or June of 2025. A document titled "Physicians Orders Routine Medications," dated 05/01/25 showed Resident #1 was prescribed Insulin Degludec Pen (U-100) 100 unit/ml Insulin Pen (similar to vials) "Inject 25 units subcutaneously every morning." The document also showed Resident #1 was prescribed Insulin Degludec Pen (U-100) 100 unit/ml Insulin Pen "Inject 15 units subcutaneously every night at bedtime." A review of Resident #1's medical chart showed an untitled document, dated 04/03/25, showed Resident #1's name and apartment number with a list of oral medications. Next to the oral medications were numbers. This document did not show insulin on the list. There were no other documents since 04/03/25 indicating any medication counts. A document titled "Crystal Place Communication Form," dated 06/12/25 at 5:30 p.m., and signed by Resident #1's home health nurse, read in part, "[Resident #1] FSBS 100 insulin held due to [patient] decreased appetite."	C1920			
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