OKLAHOMA
State Department
of Health

Delivery via email to: mshrum@homesteadofdelcity.com

June 23, 2023

License Number: AL5520

Ms. Mary Shrum, Administrator
Homestead Of Del City
5020 Southeast 44th Street
Oklahoma City, OK 73135

RE: Survey Event ID: G6QY11

Dear Ms. Shrum:

On **June 13, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on June 13, 2023.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 06/12/23 through 06/13/23. Listed below are abbreviations that will be used throughout this document: BIPAP - Bi-level Positive Airway Pressure CPAP - Continuous Positive Airway Pressure DME - Durable Medical Equipment HH - Home Health LPN- Licensed Practical Nurse MAR- Medication Administration Record MG/DL - Milligrams/Deciliter PCP - Primary Care Physician POA - Power of Attorney PDM - Personal Diabetes Manager RCC - Resident Care Coordinator SN - Skilled Nurse S/S - Signs and Symptoms X- Times	C 000		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to conduct a personal interview between the resident and/or the resident's representative	C 543		

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C 543	Continued From page 1 for four (#5, 6, 7, and #8) of eight residents sampled for assessments. The "Assisted Living Resident Condition and Care Overview," dated 06/12/23, documented 29 residents resided in the center. Findings: The "Comprehensive Assessments" policy, not dated, read in part, "...Prior to admission the nurse will evaluate the ability of the community to meet the functional, medical, nursing, mental and psychosocial needs of the prospective resident...Evaluation will be made based on any of the following...Review of information provided by the potential resident or their family members...Completion of assessments..." 1. Resident #5's assessment diagnosis included Alzheimer's Disease, Bipolar Disorder, Schizoaffective Disorder. On 06/13/23 at 3:20 p.m., the regional clinical consultant was asked if Resident #5's assessment included a personal interview with the resident and/or representative to include their signature. The consultant stated the sister was the resident's representative and they did not sign the assessment. There was no documentation the family or resident signed the assessment. On 06/13/23 at 3:45 p.m., the regional clinical consultant was asked if it was the center's policy to do a personal interview with the resident for comprehensive assessments. The consultant stated they would involve the resident as much as possible, depending on their cognition, and allow the resident the opportunity to ask questions.	C 543		

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C 543	Continued From page 2 2. Resident #6's assessment diagnosis included Type 2 Diabetes Mellitus with diabetic neuropathy, chronic kidney disease, and obstructive sleep apnea. On 06/13/23 at 3:20 p.m., the regional clinical consultant was asked if Resident #6's assessment included a personal interview with the resident and/or their representative to include their signature. The consultant stated the resident was their own POA and would have a POA appointed if needed. They stated the resident did not sign the assessment. There was no documentation the family or resident signed the assessment. 3. Resident #7's assessment diagnosis included unspecified open angle glaucoma, essential hypertension, and selective deficiency of immunoglobulin A. On 06/13/23 at 3:20 p.m., the regional clinical consultant was asked if Resident #7's assessment included a personal interview with the resident and/or their representative to include their signature. The consultant stated the assessment did not contain a signature. There was no documentation the family or resident signed the assessment. 4. Resident #8's assessment diagnosis included essential hypertension, epileptic seizures related to external causes, not intractable, without status epileptics, dementia in other diseases classified elsewhere, unspecified severity without behavioral disturbance. On 06/13/23 at 3:20 p.m., the regional clinical consultant was asked if Resident #8's assessment included a personal interview with	C 543		

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C 543	Continued From page 3 the resident and/or their representative to include their signature. The consultant stated the resident was interviewed, but they did not sign the assessment and preferred the family to sign for them. There was no documentation the family or resident signed the assessment	C 543		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure an accurate individualized plan of care was conducted for a) diabetes management, and b) CPAP/BIPAP, for one (#6) of eight residents sampled for care plans. The "Assisted Living Resident Condition and Care Overview," dated 06/12/23, documented 29 residents resided in the center. Findings: a) Resident #6's "Resident Assessment Form," dated 12/20/22, read in part, ".... Type 2 Diabetes Mellitus with diabetic neuropathy, chronic kidney disease, essential hypertension, obstructive sleep apnea..."	C 552		

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C 552	Continued From page 4 A "Nurses Note," dated 05/29/23, read in part, "[Resident #6] has been utilizing omni-pod and insulin pump per...No issues noted or reported. Both devices are placed by HH x 3 days. Omni-pod is located on back of upper arm and insulin pump is placed on lower abdomen. No s/s or adverse reaction noted..." The blood sugar readings were reviewed with the LPN and there were no blood sugars recorded on 11 separate days from 05/10/23 through 06/13/23. On 06/13/23 at 1:00 p.m., Resident #6 was asked about their fingerstick blood sugars. They stated they used to do fingerstick blood sugars, but not anymore. They were asked about insulin and reported they did not receive insulin. On 06/13/23 at 2:25 p.m., the LPN was asked if the plan of care was an accurate reflection of resident #6's diabetes management. The LPN stated, "Yes, except for the Omnipod." The LPN stated the system would alert for low blood sugars. On 06/13/23 at 3:20 p.m., the regional clinical consultant was asked if Resident #6's plan of care included the care required for the Omnipod [the Pod is a small, tubeless, wearable, and waterproof device filled with insulin and worn directly on the body. The consultant stated, "No." The consultant was asked if they would expect the plan of care to include this type of delivery system and they stated it was somewhat of a new area of focus. They stated the resident's plan of care included diabetes, but was not updated with the new insulin delivery system or glucose monitoring system. They were asked about the center's policy for care plans and reported they did not have a policy for care plans. The regional	C 552		

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C 552	Continued From page 5 float nurse reported the Omnipod information was not on resident's #6's home health recertification plan of care, dated 04/28/23 through 06/26/23, but reported they needed to look for additional orders from the home health agency. On 06/13/23 at 3:45 p.m., the regional clinical consultant was asked if it was the center's policy to do an individualized plan of care for the resident. They stated, "Yes, it is." b) Resident #6's "Plan of Care," dated 07/06/22, read in part, "...Goal...keep oxygen saturation above 90%... Interventions: [Resident #6] is independent with my BiPAP. Please continue to monitor and provide assistance as needed or requested...wears a BiPAP at night and is independent with this...DME...[Resident #6] will utilize DME equipment for CPAP reasons, any issues with equipment will be reported to provider...Interventions: [Resident #6] use a BiPAP independently..." On 06/13/23 at 4:05 p.m., the LPN was asked about the cleaning and the replacement for the mask and tubing for the BiPAP machine. They stated the resident's family provided that. They were asked to notify the family via telephone to find out when the tubing/mask was replaced. They called the family member and they stated, they had changed it but had not changed it recently and they thought it probably needed more and did not know how to get all that. On 06/13/23 at 4:15 p.m., Resident #6 was observed lying in bed taking a nap with the BiPAP in place. On 06/13/23 at 4:15 p.m., the BiPAP tubing had a piece of tape around it with 4/5 written on it.	C 552		

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C 552	Continued From page 6 On 06/13/23 at 4:15 p.m., the LPN was asked what date would 4/5 mean. They stated, "I do not know." On 06/13/23 at 4:39 p.m., the regional clinical consultant was asked if the staff would chart when the resident used the BiPAP. They reported the resident was independent. They were asked if staff charted when the tubing was cleaned. They stated, "No, they do not." They were asked if they had a policy for BiPAP. They stated, "We do not." On 06/13/23 at 4:39 p.m., the regional float nurse was asked if they documented when the tubing/mask was replaced. They stated as far as replacing the tubing, they would have them set up with DME and they would ship it every four weeks, but that was not the case with Resident #6.	C 552		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from	C5010		

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C5010	Continued From page 7 any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to coordinate home health services related to an Omnipod and FreeStyle Libre 2 insulin and glucose monitoring system for one (#6) of one resident sampled for diabetes management. The "Assisted Living Resident Condition and Care Overview," dated 06/12/23, documented 29 residents resided in the center. Findings: Resident #6's "Resident Assessment Form," dated 12/20/22, read in part, ".... Type 2 Diabetes Mellitus with diabetic neuropathy, chronic kidney disease, essential hypertension, obstructive sleep apnea..."	C5010		

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C5010	Continued From page 8 Resident #6's "Plan of Care," dated 07/06/22, read in part, "...Home Health...RCC to coordinate care with services being provided by [name withheld-home health] ..." Resident #6's "Physician Orders," dated 04/28/23 and 05/31/23, read in part, "...Insulin Glargine...inject 5 units subcutaneously in the morning...supervised self-administration...Insulin Glargine inject 20 unit subcutaneously one time a day...unsupervised self-administration [name withheld-home health] with [sic] administer daily..." The 04/28/23 physician orders were signed by the physician and the 05/31/23 orders were pending signature by the physician. The physician orders did not match the Omnipod orders received on the day of survey. Resident #6's "Home Health Certification and Plan of Care," documented certification period, "... 04/28/23-06/26/23...Type 2 Diabetes Mellitus with diabetic chronic kidney disease...SN to assess diabetic status, identify any signs and symptoms of impaired diabetic function, report significant changes to physician...Using aseptic technique, SN to perform/teach caregiver/patient to perform subcutaneous injection of Glargine (Lantus insulin)...5 units daily subcutaneous [injection under the skin]...20 units daily..." The home health orders were created prior to the placement of the Omnipod. Resident #6's "Omnipod Therapy Order," dated 05/15/23, read in part, "... Please fax to home health, facility, and PCP...Facility: Read FreeStyle Libre 2 with patient reader or smart phone 3 [three] times daily. All omnipod PDMs, Freestyle Libre 2 reader or dedicated smart phone and patient information folder should remain in blue...bag in patient room...Omnipod	C5010		

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C5010	Continued From page 9	C5010		

new start or change (circle one) ... New Omnipod order (include bolus): Lantus U-100 New setting 7 units 08:00, 5 units 17:00 [5:00 p.m.] % change: 25% change... Docusign by [name withheld-Physician] ...Previous glucose readings: *24 hour glucose high: 149 mg/dl @13:30 [at 1:30 p.m.] 05/11/23 *24 hour glucose low: 68 mg/dl @ 08:30 05/11/23..." This physician order was obtained by the center on 06/13/23 at 3:51 p.m., [on the day of survey] for documentation for Resident #6's Omnipod and FreeStyle Libre 2 system.

A "Nurses Note," dated 05/29/23, read in part, "[Resident #6] has been utilizing omni-pod and insulin pump. No issues noted or reported. Both devices are placed by HH x 3 days. Omni-pod is located on back of upper arm and insulin pump is placed on lower abdomen. No s/s or adverse reaction noted..." The blood sugar readings were reviewed with the LPN and there were 11 days with no blood sugars recorded from 05/10/23 through 06/13/23.

Resident #6's "Medication Administration Record," dated June 2023, read in part, "...Glargine...inject 5 unit subcutaneously in the morning...supervised self-administration...Glargine... inject 20 unit subcutaneously one time a day...unsupervised self-administration...will administer daily..." The June MAR documented the insulin was administered, but did not indicate the insulin was administered through the Omnipod.

On 06/13/23 at 1:00 p.m., Resident #6 was asked about their fingerstick blood sugars. They stated they used to do fingerstick blood sugars, but not anymore. They were asked about insulin and reported they did not receive insulin. The

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C5010	Continued From page 10 Omnipod device was observed in place on the resident's abdomen and Freestyle Libre 2 was in place on the resident's arm. On 06/13/23 at 3:20 p.m., the regional clinical consultant was asked if Resident #6's plan of care included the care required for the Omnipod [the Pod is a small, tubeless, wearable, and waterproof device that is filled with insulin and worn directly on the body. They stated the resident's plan of care included diabetes, but was not updated with the new insulin delivery system or glucose monitoring system. They were asked about the center's policy for care plans and reported they did not have a policy for care plans. On 06/13/23 at 5:30 p.m., the clinical regional consultant was asked if the center's physician orders matched the home health orders for insulin. They stated they did not, but they did not have the home health order. They were asked when they received the physician orders for the Omnipod, and stated, "3:51 p.m. today." They were asked who was coordinating care with the home health agency, and stated, "the LPN." They were asked how often the order stated to obtain readings, and stated, "three times daily." They were asked if the center did that, and stated, "No, we did not because we did not have the order." They were asked if the center had a policy for Omnipod Freestyle Libre system. They stated, "No." They were asked to provide a policy for third party providers and reported they did not have a policy. They were asked if they or the staff had received in-services related to the Omnipod, and stated, "No, we did not." On 06/13/23 at 6:05 p.m., the clinical regional consultant was asked if the center failed to coordinate services with the home health agency.	C5010		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF DEL CITY	5020 SOUTHEAST 44TH STREET OKLAHOMA CITY, OK 73135

(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
C5010	Continued From page 11 The consultant stated they felt it was the other way around, that the home health agency had failed to coordinate with the center in a timely manner. On 06/13/23 at 6:10 p.m., the LPN was asked why they had waited to obtain the physician order for the Omnipod and Freestyle Libre 2. They stated they did not have a reason for that but were trying to obtain an order for the Omnipod. The LPN stated they should have received a physician order the day it was started. They were asked what day the system was ordered, and stated, "05/13/23."	C5010		

OKLAHOMA
State Department
of Health

Delivery via email to: mshrum@homesteadofdelcity.com

June 29, 2023

License Number: AL5520
Survey Event ID: G6QY11

Ms. Mary Shrum, Administrator
Homestead Of Del City
5020 Southeast 44th Street
Oklahoma City, OK 73135

Dear Ms. Shrum:

On **June 13, 2023**, a Licensure inspection was conducted at your Adult Day Care 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 timely. Our acceptance does not absolve the facility's responsibility** for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited will be corrected on **July 30, 2023**. We will conduct a revisit at your facility to verify that all violations have been corrected.

If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

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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: 6/28/2023** **Facility Name:** Homestead of Del City **License Number:** AL 5520 **Survey Event ID:** G6QY11 **Date Survey Completed: 6/13/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C543	Based on: Record review and interview, the center failed to conducgt a personal interview between the resident and/or the resident's representative for four (#5,6,7 and #8) of eight residents sampled for assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The center will include the resident and /or the resident's representative in each assessment and will be verified by the resident's or representatives signature. This will be ongoing practice. The RCC will receive re-training on completion of assessments and inclusion of the resident or resident's representative by 7/1/23.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The center will complete an audit of all resident's assessments to ensure that the resident and/ or the resident's representative have been signed. This will be completed by 7/30/23.
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?	The center will conduct periodic audits to ensure that the deficient practice has not continued. This will be completed by 7/30/23.
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.	a.The center will complete an audit of all resident's assessments to ensure tha the resident aasnd/or the resident's representative have been signed. Ongoing practice. Enter methods to evaluate for effectiveness: b. The logs of the audits will be entered into QA and trended for necessary improvements. This will be ongoing practice. c. The logs of the audits will be entered into the QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.
Mary Allen	6/28/2023

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 6/28/2023
	Facility Name: Homestead of Del City
	License Number: AL 5520
	Survey Event ID: G6QY11
	Date Survey Completed: 6/13/2023

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C552	Based on: observation, record review, and interview, the center failed to ensure an accurate individualized plan of care was conducted for a: diabetes management, and b) CPAP/BIPAP, for one (#6) of eight residents sampled for care plans.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The center will ensure that each plan of care is updated and individualized for each resident receiving diabetes management and/or CPAP/BIPAP care. The RCC will receive re-training on completion of plans of care by 7/1/23.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The center will complete an audit of all resident's plans of care to ensure that they are updated and individualized for residents receiving diabetes management, CPAP/BIPAP care. This will be completed by 7/30/23.
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?	The center will conduct periodic audits to ensure that the deficient practice has not continued. This will be completed by 7/30/23.
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.	a.The center will complete an audit of all resident's plans of care to ensure that the deficient practice is corrected. By 07/30/23 and ongoing practice. Enter methods to evaluate for effectiveness: b. The logs of the audits will be entered into QA and trended for necessary improvements. This will be ongoing practice. c. The logs of the audits will be entered into the QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.
Mary Shinn	6/28/2023

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

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/28/2023** **Facility Name:** Homestead of Del City **License Number:** AL 5520 **Survey Event ID:** G6QY11 **Date Survey Completed: 6/13/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C5010	Based on: observation, record review and interview, the center failed to coordinate home health services related to an Omnipod and FreeStyle Libre2 insulin and glucose monitoring system for on (#6) of one resident sampled for diabetes management.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The center will ensure that Home Health is coordinating care with the center and the center is coordinating care with the Home Health through care conferences, home health visit documentation and having current 485 on resident chart to reflect most current orders for diabetes management. The RCC will receive re-training on completion of plans of care by 7/1/23.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The center will complete an audit of the Home Health visit documentation, 485, and care conferences pertaining to diabetes management. This will be completed by 7/30/23.
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?	The center will conduct periodic audits to ensure that the deficient practice has not continued. This will be completed by 7/30/23.
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.	a. The center will complete an audit of the Home Health visit documentation, 485, and care conferences pertaining to diabetes management to ensure that the deficient practice is corrected by 07/30/23 and ongoing practice. Enter methods to evaluate for effectiveness: b. The logs of the audits will be entered into QA and trended for necessary improvements. This will be ongoing practice. c. The logs of the audits will be entered into the QA binder.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required.	**Date** Enter a date of signature.
Mary Shu	6/28/2023

OAC 310:663-25-4(F)

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

OKLAHOMA
State Department
of Health

Delivery via email to: mshrum@homesteadofdelcity.com

August 25, 2023

License Number: AL5520

Ms. Mary Shrum, Administrator
Homestead Of Del City
5020 Southeast 44th Street
Oklahoma City, OK 73135

RE: Survey Event G6QY12

Dear Ms. Shrum:

On **August 23, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 13, 2023,** have now been corrected effective **July 30, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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
	AL5520	A. BUILDING: _____ B. WING _____	R 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF DEL CITY	5020 SOUTHEAST 44TH STREET OKLAHOMA CITY, OK 73135

(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 08/22/23 and 08/23/23. The facility was in substantial compliance.	{C 000}		

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