Oklahoma State Department of Health
Creating a State of Health

October 10, 2019

License Number: AL5525

Ms. Brandy Ratcliff, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event ID: S7FD11

Dear Ms. Ratcliff:

On **September 30, 2019**, 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 September 30, 2019.

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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A BUILDING _____ B WING _____	09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

(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
N 000	Initial Comments A re-licensure survey was conducted on 09/25/19, 09/27/19 and 09/30/19. Current census was 41. Deficient practice was cited as follows.	N 000		
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure certified medication aides' (CMA) skills were validated prior to administering medications for 3 (#1 through #3) of three sampled CMAs who were hired since the last survey. This failed practice had the potential for more than minimal harm at a pattern. Findings: The employee files were reviewed and revealed the following CMAs had not had their skills validated prior to administering medications: CMA/employee #1 - hired on 01/20/19; CMA/employee #2 - hired on 04/10/19 and CMA/employee #3 - hired on 02/20/19. On 09/27/19 at 10:46 a.m., the regional director of operations stated she would have the business office manager look to see if the skills validations	N1442		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A. BUILDING _____ B. WING _____	09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N1442	Continued From page 1 were in the employee files. The business office manager stated she could not find them.	N1442		
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 09/25/19, 09/27/19 and 09/30/19. Current census was 41. Deficient practice was cited as follows.	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements; This Rule is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regards to utensils, dishware and kitchen cleanliness: 310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (a) Equipment food-contact surfaces and utensils shall be clean to sight and touch...	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A. BUILDING _____ B. WING _____	09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

(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 391	Continued From page 2 (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulations of dust, dirt, food residue, and other debris. 310:257-7-105 Equipment, utensils, linens, and single-service and single-use articles (a) Except as specified in (d) of this Section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (1) In a clean, dry location 310:257-11-41. Cleaning, frequency and restrictions (a) The physical facilities shall be cleaned as often as necessary to keep them clean. These failed practices had the potential for more than minimal harm for all 41 residents who received their nutrition from the kitchen. Findings: On 09/27/19 at 10:30 a.m., a tour of the serving kitchen was conducted with the following findings: 310:257-7-82 (a) Equipment food-contact surfaces and utensils shall be clean to sight and touch. - three plates and one bowl stacked as clean had dried debris on them. The area where the clean dishes were stacked had an accumulation of food debris. (c) Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils. - an accumulation of dust and debris was located on top of the dish machine.	C 391		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A BUILDING _____ B WING _____	09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 391	Continued From page 3 310.257-7-105 (a) Except as specified in (d) of this Section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (1) In a clean, dry location. - an ice cream scoop was stored in a large container of chocolate ice cream in the freezer. 310:257-11-41 Cleaning, frequency and restrictions (a) The physical facilities shall be cleaned as often as necessary to keep them clean. - Food debris and splatters were on the bottom of the freezer where the ice cream was stored. At 10:35 a.m., the server observed the dirty dishes in the clean area. When asked if the ice cream scoop was stored properly, she stated she did not know. At 10:37 a.m., the culinary director observed the findings found in the assisted living serving kitchen. He agreed the freezer and the area above the dish machine were dirty and the scoop should not have been stored in the ice cream. The culinary director stated the kitchen should be cleaned daily.	C 391		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication.	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A. BUILDING _____ B. WING _____	09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

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C1923	Continued From page 4 (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure medications were signed out by the person who administered the medications for 4 (#2, 6, 9 and #10) of ten sampled residents who were administered medication by the staff. This failed practice had the potential for more than minimal harm at a pattern. Findings: September 2019 medication administration records (MAR) were reviewed. Resident #2, 6, 9 and #10 had several medications not initialed as administered on the MAR. On 09/30/19 at 2:19 p.m., the administrator stated resident #10's new order for antibiotics was not transcribed to the written MAR. She stated the agency staff signed it out on the inventory sheet. The administrator stated the electronic MAR did not allow the agency staff to document in the computer. She stated it was documentation	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A BUILDING _____ B WING _____	09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

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C1923	Continued From page 5 errors.	C1923		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5525	LYNDALE AT EDMOND

Type of Survey (select all that apply)

2				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 36191	09/25/2019	09/30/2019	1.00	0.00	16.00	0.00	6.25	4.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

OCT 10 2019

Oklahoma State Department of Health
Creating a State of Health

October 28, 2019

License Number: AL5525

Ms. Brandy Ratcliff, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event S7FD11

Dear Ms. Ratcliff:

On September 30, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **October 28, 2019**.

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) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/ks

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/24/2019** **Facility Name:** Lyndale Edmond Assisted Living **License Number:** AL5525 **Survey Event ID:** S7FD11 **Date Survey Completed: 9/30/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: observation and interview, it wasdetermined the center failed to ensurecompliance with Chapter 257 Food ServiceEstablishment Regulations in regards to utensils,dishware and kitchen cleanliness:310:257-7-82. Equipment, food-contact surfaces,nonfood-contact surfaces, and utensils(a) Equipment food-contact surfaces and utensilsshall be clean to sight and touch...(c) Nonfood-contact surfaces of equipment shallbe kept free of an accumulations of dust, dirt,food residue, and other debris.310:257-7-105 Equipment, utensils, linens, andsingle-service and single-use articles(a) Except as specified in (d) of this Section,cleaned equipment and utensils, launderedlinens, and single-service and single-use articlesshall be stored: (1) In a clean, dry location310:257-11-41. Cleaning, frequency andrestrictions(a) The physical facilities shall be cleaned asoften as necessary to keep them clean.These failed practices had the potential for morethan minimal harm for all 41 residents whoreceived their nutrition from the kitchen.Findings:On 09/27/19 at 10:30 a.m., a tour of the servingkitchen was conducted with the following findings:310:257-7-82 (a) Equipment food-contactsurfaces and utensils shall be clean to sight andtouch.- three plates and one bowl stacked as clean haddried debris on them. The area where the cleandishes were stacked had an accumulation of fooddebris. (c) Equipment, food-contact surfaces,nonfood-contact surfaces, and utensils.- an accumulation of dust and debris was locatedon top of the dish machine.310:257-7-105 (a) Except as specified in (d) ofthis Section, cleaned equipment and utensils,laundered linens, and single-service andsingle-use articles shall be stored: (1) In a clean,dry location.- an ice cream scoop was stored in a largecontainer of chocolate ice cream in the freezer.310:257-11-41 Cleaning, frequency and restrictions(a) The physical facilities shall be cleaned asoften as necessary to keep them clean.- Food debris and splatters were on the bottom ofthe freezer where the ice cream was stored.At 10:35 a.m., the server observed the dirtydishes in the clean area. When asked if the icecream scoop was stored properly, she stated shedid not know.At 10:37 a.m., the culinary director observed thefindings found in the assisted living servingkitchen. He agreed the freezer and the areaabove the dish machine were dirty and the scoopshould not have been stored in the ice cream.The culinary director stated the kitchen should becleaned daily.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The dishes were immediately removed and the area and dishes cleaned. The ice cream scoop was removed and stored properly; the debris spatters were cleaned. The Dishwasher was wiped down immediately.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All 41 residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Culinary staff will all be re-educated on the cleanliness standards. Culinary staff will be re-educated on proper storage of dishes and utensils. Cleaning of the kitchen will be documented daily. Weekly spot checks by the ED, RSD or designee will occur no fewer than 3 times per week and will be documented for 1 month to monitor and verify compliance.

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.	Monthly audits of the kitchen area will be documented by the ED, RSD or designee. The audit documentation witll become part of our quarterly QA meetings to monitor and verify continued compliance. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/28/2019
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required OAC 310:663-25-4(F)	**Date 10/24/2019**
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: 10/24/2019** **Facility Name:** Lyndale Edmond Assisted Living **License Number:** AL5525 **Survey Event ID:** S7FD11 **Date Survey Completed: 9/30/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1923	Based on: interview and record review, it wasdetermined the center failed to ensuremedications were signed out by the person whoadministered the medications for 4 (#2, 6, 9 and#10) of ten sampled residents who wereadministered medication by the staff. This failedpractice had the potential for more than minimalharm at a pattern. Findings:September 2019 medication administrationrecords (MAR) were reviewed. Resident #2, 6, 9and #10 had several medications not initialed asadministered on the MAR.On 09/30/19 at 2:19 p.m., the administratorstated resident #10's new order for antibioticswas not transcribed to the written MAR. Shestated the agency staff signed it out on theinventory sheet.The administrator stated the electronic MAR didnot allow the agency staff to document in thecomputer. She stated it was documentationerrors.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All contract associates will be added to our EMAR system. All contract associates will be educated on the use of our EMAR system.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All 41 residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All MARS will be reviewed daily via our EMAR dashboard with weekly spot checks of no less than 3 resident records documented by the RSD for a period of 30 days to monitor and verify compliance.
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.	Monthly audits of no fewer than 3 resident records will be documented by the ED, RSD or designee. The audit documentation witll become part of our quarterly QA meetings to monitor and verify continued compliance. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/28/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required.	**Date 10/24/2019**
OAC 310:663-25-4(F)	

10012013

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 10/24/2019** **Facility Name:** Lyndale Edmond Assisted Living **License Number:** AL5525 **Survey Event ID:** S7FD11 **Date Survey Completed: 9/30/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1442	Based on: Interview and record review, it was determined that the center failed to ensure certified medication aides (CMA)skills where validated prior to administering medications for 3 (#1-3) of the three sampled CMA's who were hired since the last survey. The failed practice had the potential for more than minimal harm at a pattern. The employee files were reviewed and revealed the following CMAs had not had their skills validated prior to administering medications: CMA/Employee #1-hired 1/20/2019, CMA/employee #2-hired 04/10/2019, and CMA/employee #3 hired 02/20/2019

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Employee's #1-3 will have their skills verifications completed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All 41 residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	A monthly audit will be completed to monitor and confirm continued compliance.
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.	Monthly Audits will be documented. The audit documentation witll become part of our quarterly QA meetings to monitor and verify continued compliance. Enter methods to evaluate for effectiveness. Enter methods to incorporate into QA system. Enter methods to keep monitoring records.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	10/20/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 10/24/2019**

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

December 13, 2019

License Number: AL5525

Mr. Barry Stone, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event S7FD12

Dear Mr. Stone:

On **November 20, 2019,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **September 30, 2019,** have now been corrected effective **October 28, 2019.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL5525	A. BUILDING _____ B WING _____	R 11/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNDALE AT EDMOND	1225 LAKESHORE DRIVE EDMOND, OK 73013

(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
{N 000}	Initial Comments A follow-up survey was conducted on 11/20/19. Current census was 39. The deficient practice was cleared.	{N 000}		
{C 000}	INITIAL COMMENTS A follow-up survey was conducted on 11/20/19. Current census was 39. All deficient practices were cleared.	{C 000}		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5525	LYNDALE AT EDMOND

Type of Survey (select all that apply)

2	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 35195	11/20/2019	11/20/2019	0.75	0.00	3.00	0.00	2.75	1.25
2. 36191	11/20/2019	11/20/2019	0.00	0.00	0.00	0.00	0.00	0.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**