OKLAHOMA
State Department
of Health

Delivery via email to: KBolino@Sagora.com; kbolino@Lyndalelife.com

May 20, 2024

License Number: AL5525

Ms. Kara Bolino, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event ID: LJQT11

Dear Ms. Bolino:

On **May 1, 2024**, agents from our office concluded a State Licensure survey along with complaint investigations 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 **May 1, 2024**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Lyndale at Edmond**
Address: **1225 Lakeshore Drive**
City, State, Zip: **Edmond, OK, 73013**
Provider #: **AL5525**
Complaint #: **OK00061894**
Investigation Date(s): **04/30/24 and 05/01/24**

ALLEGATIONS
The center failed to ensure food was served under sanitary conditions and food was labeled according to State Law.
The center failed to have and/or implement an effective infection control program for Covid-19.

An unannounced on-site investigation was initiated 04/30/2024 at 5:27 a.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility and kitchen was conducted upon entrance and other various times throughout the survey. Residents and staff were observed for proper infection control prevention.

Resident records were reviewed including assessments, service plans, physician orders, and nursing notes.

Residents were interviewed in regards to meal service and infection prevention.

Staff were interviewed related to facility policy and procedures for proper meal preparation and service.

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: 05/02/2024

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INVESTIGATIVE REPORT

Facility: **Lyndale at Edmond**
Address: **1225 Lakeshore Drive**
City, State, Zip: **Edmond, OK, 73013**
Provider #: **AL5525**
Complaint #: **OK00062106**
Investigation Date(s): **04/30/24**

ALLEGATION
The facility failed to have and/or implement proper food handling procedures, sanitization, and maintenance on kitchen appliances.

An unannounced on-site investigation was initiated 04/30/2023 at 5:27 a.m.

A sample of eight 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:

A tour of the kitchen was conducted upon entrance and other various times throughout the survey.

Kitchen staff were observed for proper technique in cleaning, serving.

Kitchen logs were reviewed.

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: 05/02/2024

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INVESTIGATIVE REPORT

Facility: **Lyndale at Edmond**
Address: **1225 Lakeshore Drive**
City, State, Zip: **Edmond, OK, 73013**
Provider #: **AL5525**
Complaint #: **OK00063838**
Investigation Date(s): **04/30/24**

ALLEGATIONS
The center failed to assess, monitor, and intervene in a timely manner for a change in condition.
The center failed to ensure assistance with incontinent care was provided according to the plan of care and/or the contract.
The center failed to ensure a clean, comfortable, and odor-free environment, failed to ensure residents were treated with respect and failed to ensure residents' representatives were notified of a change in condition.
The center failed to have and/or implement effective pharmacy policies and procedures to ensure medications were provided according to the standard of care.
The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 04/30/2024 at 5:27 a.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls were observed for odors and potential urine saturation of residents. Staff were observed for assisting residents with toileting needs, including providing incontinent care. Common areas were observed for cleanliness and odors. Staff were observed during medication administration.

A visual count of direct care nursing staff on duty was taken and compared to the State mandated staffing requirement. Past facility staffing schedules were reviewed for staffing patters and compared to the State mandated staffing requirements. Grievance reports were reviewed. Staff training records were reviewed.

Resident records including assessments, care plans, physician orders, nursing notes, medication administration

records, and treatment records were reviewed.

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: 05/02/2024

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 _____	C 05/01/2024

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

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C 000	INITIAL COMMENTS Relicensure survey was conducted from 04/30/24 through 05/01/24. Complaint investigations (#OK00061894, OK00062106 and #OK00063838) were conducted in conjunction with the survey. Center Census: 36 Listed below are abbreviations that will be used throughout this document. ACMA - advanced certified medication aide AED - Automated External Defibrillator BLS - basic life support CMA - certified medication aide CNA - certified nurse aide CPR - cardiopulmonary resuscitation DM - dietary manager ED - Executive Director	C 000		
C 391 SS=D	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the center failed to ensure: a. sanitation logs were implemented and kept; b. a clean and sanitary kitchen; and c. food items were closed, dated, and labeled. The Executive Director identified a census of 36 who all ate from the kitchen.	C 391		

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

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C 391	Continued From page 1 Findings: A "Sanitation and Food Safety" policy, undated, read in part, "...all operational documentation is kept for a full calendar year. This documentation includes...sanitation logs ...All areas of the culinary department must always be clean and sanitary..." On 04/30/24 at 7:00 a.m., the following observations were made in the assisted living kitchen and dining room: 1. unlabeled cheese and sour cream in refrigerator, 2. cookies on a rack open to air, 3. peanut butter jar open on counter, 4. refrigerator and freezer doors had greasy residue splattered on them, and 5. cereal spilled under dispenser on cabinet in dining room. On 04/30/24 at 7:20 a.m., the following observations were made in the independent living kitchen, where most of the food is made and then transported to the Assisted Living building: 1. dish storage area next to handwashing station had a saucer with black streaky residue on it, 2. a coffee cup had black residue sprinkles inside of it, 3. bottom shelf of counters had food debris observed on them, 4. food prep counters and oven doors had greasy streaks down the sides, 5. vegetable medley in refrigerator on a shelf with no cover, date, or label, 6. meat patties uncovered on a shelf with no cover, date, or label,	C 391		

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C 391	Continued From page 2 7. pre-made side salads uncovered no label or date, 8. black bananas in an unlabeled box in the freezer, and 9. dry spaghetti package not closed or dated. On 04/30/24 at 7:28 a.m., the DM stated they were hired at the end of February and they were trying to get things in order. They stated cleaning was everyone's responsibility. On 04/30/24 at 8:15 a.m., the DM stated some of the dishes in the dish storage area directly next to the handwashing station were "not at all clean". They were then removed from the area. On 04/30/24 at 8:18 a.m., the DM stated that the vegetable medley was leftovers that were to be used for soup and that the sausage patties were panned up yesterday. The DM stated they should have been covered, dated, and labeled. The DM stated that the "cold line" veggies had no label because they were used daily. On 04/30/24 at 8:20 a.m., the DM asked another kitchen staff when the side salads were prepared and then repeated that they were made yesterday and should have been covered, dated, and labeled. On 04/30/24 at 8:22 a.m., the DM stated that the black bananas were used in banana bread and that they were here when he started working. The DM was unable to locate a label or date on the box and then removed them from the freezer. On 05/01/24 at 7:54 a.m., the DM stated they were not even aware of a certification needed to be dietary manager but provided Safeserv certification. They stated there were no cleaning	C 391		

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C 391	Continued From page 3 logs.	C 391		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure an admission assessment was completed within 30 days before or at the time of admission for two (#1 and #2) of eight sampled residents reviewed for admission assessments. The Executive Director identified 36 residents resided in the center. Findings: 1. Resident #1's "Service Plan", dated 07/15/23 documented the resident was admitted on 06/23/23. The initial assessment was documented as completed on 06/28/23. 2. Resident #2's "Service Plan", dated 02/09/24 documented the resident was admitted on 02/07/24.	C 521		

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C 521	Continued From page 4 Resident #2 had no initial assessment in their chart. On 05/01/24 at 9:15 a.m., the ED stated that initial assessments were to be completed 30 days prior to the admission or the day of admission. They stated the Initial assessments were not completed within that timeframe. They stated they were unable to locate an initial assessment for resident #2.	C 521		
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 a comprehensive assessment was completed within 14 days of admission for one (#1) of eight sampled residents reviewed for 14 day comprehensive assessments. The Executive Director identified 36 residents resided in the center. Findings: 1. Resident #1's "Service Plan", dated 07/15/23	C 522		

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C 522	Continued From page 5 documented the resident was admitted on 06/23/23. The 14 day comprehensive assessment was documented as completed on 07/15/23. On 05/01/24 at 9:15 a.m., the ED stated that 14 day comprehensive assessments were to be completed within 14 days of their admission. They stated the 14 day comprehensive assessment was not completed within that timeframe for resident #1.	C 522		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure direct care staff were trained in CPR and first aid for two (CNA #3 and CNA #4) of five sampled staff reviewed for CPR and first aid training. The Executive Director identified 36 residents resided in the center. Findings:	C 954		

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C 954	Continued From page 6 A "CPR - Loss of Vital Signs" policy, dated 09/08/15, read in part, "...Resident Services Associates are trained in CPR and AED management by vendors that use the American Heart Association BLS curriculum...Classroom CPR training is required..." 1. CNA #3 was hired on 03/24/23. There was no documentation they were trained in CPR and first aid. 2. CNA #4 was hired on 02/27/24. There was no documentation they were trained in CPR and first aid. On 05/02/24 at 1:09 p.m. the Executive Director stated CNA #3 and CNA #4 had not received CPR training. They stated the center did require CPR training for staff.	C 954		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care 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)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can	C1505		

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C1505	Continued From page 7 understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to: a. provide personal care in a manner that prevented cross-contamination for four (#2, #5, #7, and #9) of four residents observed for personal care, b. ensure proper transfer techniques were used for one (#5) of one resident observed for two person transfer assist, and c. ensure medication carts were secured for one of two medication carts observed. The Executive Director identified 36 residents resided in the center. . Findings: a. A "Handwashing" policy, dated 04/19/21, read	C1505		

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C1505	Continued From page 8 in part, "...a minimum twenty (20) second handwashing should be performed in situations including but not limited to:...before performing dressing care...after offering incontinence care...after contact with blood, urine, feces, oral secressions...the use of gloves does not replace handwashing." On 04/30/24 at 5:42 a.m., CNA #1 wearing new gloves provided personal care to Resident #7 which included incontinet care and changing clothes. CNA #1 then removed the gloves, transported resident to dining room using wheel chair, and continued to the next room. They did not wash their hands or use hand sanitizer. On 04/30/24 at 5:50 a.m., CNA #1 wearing new gloves provided personal care to Resident #9 which included assistance to toilet and changing clothes. CNA #1 then removed the gloves, held hands with resident #9 and walked them to the dining room, and continued to the next room. They did not wash their hands or use hand sanitizer On 04/30/24 at 6:10 a.m., CNA #1 wearing new gloves provided personal care to Resident #2 which included assistance with toileting and changing clothes. CNA #1 removed gloves, wheeled resident #2 to sit in front of their TV, and continued to the next room. They did not wash their hands or use hand sanitizer On 04/30/24 at 6:15 a.m., CNA #1 wearing new gloves provided personal care to Resident #5 which included incontinence care, changing clothes, and stripping "wet" linens. They did not wash their hands or use hand sanitizer On 04/30/24 at 6:38 a.m., CNA #1 stated they	C1505		

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C1505	Continued From page 9	C1505		

are supposed to wash their hands after caring for each resident.

b. A "Lifting and Transferring Residents" policy, undated, read in part, "all residents classified as total dependence or 2-person transfers may be lifted and transferred...by means of a full-sling mechanical lift device...all residents classified as extensive assistance should be lifted and transferred...with the aid of an associate with a transfer belt."

On 04/30/24 at 6:25 a.m., a sit to stand lift was observed in the residents room. ACMA #1 assisted CNA #1 with a two person transfer by grabbing Resident #5 under the arm nearest each of them and grabbing the back of the pants to lift and pivot resident into a geriatric chair next to the bed.

On 04/30/24 at 6:38 a.m., CNA #1 stated the reason the sit to stand lift was not used was because the resident was no longer able to bear weight.

On 04/30/24 at 6:40 a.m., ACMA #1 stated there was not a hoyer lift in the building.

On 04/30/24 at 8:45 a.m., the ED stated a sit to stand would be "not good" for a resident unable to bear weight and a gait belt should have been used. The ED stated there are no longer any hoyer lifts in the building.

On 05/01/24 at 10:55 a.m., CNA #2 with the help of a hospice nurse, transferred Resident #5 from recliner into the bed. They lifted recliner to almost standing, then hooked resident under her arms and pivoted her to the bed for wound care and incontinence care.

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 _____	C 05/01/2024

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
C1505	Continued From page 10 On 05/01/24 at 11:04 a.m., CNA #2 stated a gait belt should have been used so that grabbing under the arms could be avoided, but was not provided. CNA #2 stated they were agency staff. On 05/01/24 at 11:10 a.m., the ED stated gait belts are on the medication carts and in the medication room. They stated the center is currently using about 50% agency staff. The ED stated agency staff would have to ask core staff where items were located. c. A "Medication Assistance and MARs/MORs" policy, revised 04/23/15, read in part, "If carts are utilized, clean and lock the cart after each use (per regulatory requirements)" On 05/01/24 at 6:56 a.m., a medication cart was observed to be unlocked and unsupervised on resident hall 200. In the top drawer there were several nasal sprays, the second and third drawers contained blister packs of medications, and the fourth drawer contained bottles of bulk medications. On 05/01/24 at 6:57 a.m., ACMA #1 stated the medication cart had not been locked. They stated the policy for securing medications was to pull medications, lock cart, and give medications.	C1505		
C1951 SS=D	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with	C1951		

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 _____	C 05/01/2024

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
C1951	Continued From page 11 professional standards of practice. This Rule is not met as evidenced by: Based on record review and interview, the center failed to maintain accurate clinical records for one (#5) of eight residents sampled for accurate records. The Executive Director identified 36 residents resided in the center. Findings: A nursing note dated 05/30/23, documented Resident #5 had returned from the hospital and their code status was changed to a DNR with family present. A "Durable Power of Attorney" dated 12/27/21, was located in the hard chart. An "Oklahoma Do Not Resuscitate (DNR) Consent Form", dated 05/30/23, was observed in hard chart signed by the power of attorney. On 05/01/24 at 12:56 p.m., the ED stated FULL CODE is documented in the electronic profile, but a DNR is in the hard chart.	C1951		

OKLAHOMA
State Department
of Health

Delivery via email to: kbolino@Lyndalelife.com; KBolino@sagora.com

June 18, 2024

License Number: AL5525

Kara Bolino, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event LJQT11

Dear Ms. Bolino:

On **May 1, 2024**, a Licensure inspection with complaint investigations 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 **July 31, 2024**.

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,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/4/2024** **Facility Name:** Lyndale Edmond **License Number:** AL5525 **Survey Event ID:** LJQT11 **Date Survey Completed: 5/1/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: record review, observation and interview, the center failed to ensure: a. sanitation logs were implemented and kept; b. a clean and sanitary kitchen; and c. food items were closed, dated, and labeled.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community regarding the alleged statements or conclusion set forth in the statement of deficiencies. The Plan of Corrections is prepared soley as a matter of compliance with State Law.

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?	Sanitation logs will be implemented and kept and Culinary Director and/or designee will ensure a weekly check and review of the logs, review the kitchen cleanliness and check that food items are closed, dated and labled.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Sanitiation logs, cleaning schedules and food items being closed, dated and labeled will be monitored on a weekly basis for thirty days to ensure on-going compliance by Culinary Director and/or designee.
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?	Sanitation logs and cleaning schedules to be brought for review to the monthly QA meeting along with random spot checks for food items being closed, dated and labeled.
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.	Enter methods to ensure corrections are sustained: a. Culinary Director and/or designee to bring sanitation logs, cleaning schedules and the random checks for food items being closed, dated and labeled to monthly QA to review and discuss at monthly QA meeting. b. Reviews of sanitation logs, cleaning schedules and random checks for food items being closed, dated and labeled to be reviewed and discussed at monthly QA meeting for on-going compliance. c. Sanitiation logs, cleaning schedules and random checks for food items being closed, dated and labeled to be kept in a monthly binder and reviewed during monthly QA meeting.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		7/31/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Kara Robins			**Date 6/4/2024**
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: 6/4/2024** **Facility Name:** Lyndale Edmond **License Number:** AL5525 **Survey Event ID:** LJQT11 **Date Survey Completed: 5/1/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C521	Based on: record review and interview, the center failed to ensure an admission assessment was completed within 30 days before or at the time of admission for two (#1 and #2) of eight sampled residents reviewed for admission assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community regarding the alleged statements or conclusion set forth in the Statement of Deficiencies. The plan of correction is prepared soley as a matter of compliance with State Law.

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?	Assessment to be completed for resident # 2 immediately and noted as initial assessment. Resident # 1 is no longer a resident of the community.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Resident Services Director and/or designee to ensure community resident chart checklist is used for all new move-in's with an emphasis on the admission assessment completed within 30 days before or at the time of admission for all new residents. ED and/or designee to sign off on checklist as an additional check/review to ensure on going compliance.
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?	Resident Services Director and/or designee to ensure community resident chart checklist is used for all new move-in's with an emphasis on the admission assessment completed within 30 days before or at the time of admission for all new residents. ED and/or designee to sign off on checklist as an additional check/review to ensure on going 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.	Enter methods to ensure corrections are sustained: a. RSD will discuss all new move-in's at monthly QA meeting, specifically focusing on the completion of the admission assessment. b. All Resident Chart Checklist for new residents will be reviewed during QA meeting to ensure ongoing compliance. c. QA meeting minutes to record all new move-in's and a review of their resident chart checklist,

		including their admission assessment.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/31/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Kara Bolins			**Date 6/4/2024**
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: 6/4/2024** **Facility Name:** Lyndale Edmond **License Number:** AL5525 **Survey Event ID:** LJQT11 **Date Survey Completed: 5/1/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C522	Based on: record review and interview, the center failed to ensure a comprehensive assessment was completed within 14 days of admission for one (#1) of eight sampled residents reviewed for 14 day comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community regarding the alleged statements or conclusion set forth in the Statement of Deficiciencies. The Plan of Correction is prepared soley as a matter of compliance with State Law.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident # 1 is no longer a resident of the community.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Audit to be conducted of all of the resident charts to ensure all assessments are comprehensive assessments are completed as required. Resident Services Director and/or designee to run monthly report to ensure all required assessments are completed in a timely manner. Monthly report to be reviewed at QA meeting to ensure on-going compliance.
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?	Monthly report to be run at the beginning of each month by Resident Services Director and/or designee to ensure a comprehensive assessments is completed for all new move-in's within 14 day of admission. List to be reviewed at QA meeting and ED and/or designee to ensure completion of comprehensive assessments.
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.	Enter methods to ensure corrections are sustained: a. RSD will discuss all new move-in's at monthly QA meeting, specifically focusing on the completion of a comprehensive assessment being completed within 14 days of admission. b. New move-in's list to be reviewed with an emphasis on ensuring the completion of the comprehensive assessment within 14 days of admission. c. QA meeting minutes to record all new move-in's and a review of their resident chart checklist and

		specifically ensuring they have their comprehensive assessment completed within 14 days of admission.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/31/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Kara Bdine			**Date 6/4/2024**
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.			
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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: 6/4/2024** **Facility Name:** Lyndale Edmond **License Number:** AL5525 **Survey Event ID:** LJQT11 **Date Survey Completed: 5/1/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C954	Based on: record review and interview, the center failed to ensure direct care staff were trained in CPR and First Aid for two (CNA # 3 and CNA # 4) of five sampled staff reviewed for CPR and First Aid training.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community regarding the alleged statements or conclusion set forth in the Statement of Deficiciencies. The Plan of Correction is prepared soley as a matter of compliance with State Law.

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?	Employees 3 and 4 received CPR Training on 5-16-2024.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	List of all Care Staff with CPR training added to the Nurse Aide Checklist and given to RSD and/or designee to complete upon hire. Business Director and/or designee to track and monitor checklist for completion and on-going compliance.
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?	List of all Care Staff with CPR training added to the Nurse Aide Checklist and given to RSD and/or designee to complete upon hire. Business Director and/or designee to track and monitor checklist for completion and on-going 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.	Enter methods to ensure corrections are sustained: a. Business Director will discuss all new hires at monthly QA meeting, specifically focusing on the completion of CPR training. b. All checklists to be reviewed during QA meeting to ensure on-going compliance. c. QA meeting minutes to record all new hires and a review of their checklists, including the completion of CPR training.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/31/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Lara Bolins			**Date 6/4/2024**
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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: 6/4/2024** **Facility Name:** Lyndale Edmond **License Number:** AL5525 **Survey Event ID:** LJQT11 **Date Survey Completed: 5/1/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: observation, record review and interview, the center failed to: a. provide personal care in a manner that prevented cross-contamination for four (#2, # 5, #7, and #9) of four residents observed for personal care. b. ensure proper transfer techniques were used for one (#5) of one resident observed for two person transfer assist, and c. ensure medication carts were secured for one of two medication carts observed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community regarding the alleged statements or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared soley as a matter of compliance with State Law.

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?	In service training to be held with all care staff on practices to prevent cross-contamination, proper transfer techniques and with Medication Aides on securing the medication carts.
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 care staff to receive training upon hire in the practices to prevent cross-contamination, proper transfer techniqures and with the Medication Aides training on securing the medication carts. These items will be highlighted on nursing skills checklist to ensure on-going compliance.
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 care staff to receive training upon hire in the practices to prevent cross-contamination, proper transfer techniqures and with the Medication Aides training on securing the medication carts. In addition, random checks to be conducted by Resident Services Director and/or designee over a 30-day period to ensure on-going compliance of received training.
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.	Enter methods to ensure corrections are sustained: a. Resident Services Director to hold monthly in-service as needed for new hires to review all of the above practices. b. QA meeting to review employee checklist noting skills checklists with an emphasis on all of the above practices.

	c. QA meeting minutes to record a review of employee skills checklist with the emphasis on all of the above practices.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/19/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Kara Bolin	**Date 6/4/2024**

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.

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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: 6/4/2024

Facility Name: Lyndale Edmond

License Number: AL5525

Survey Event ID: LJQT11

Date Survey Completed: 5/1/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1951	Based on: record review and interview, the center failed to maintain accurate clincal records for one (#5) of eight residents sampled for accurate records.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community regarding the alleged statements or conclusion set forth in the statement of deficiencies. The Plan of Corrections is prepared soley as a matter of compliance with State Law.

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?	Correction made in the electronic profile for resident #5 with updated coded status to match the hard copy in the resident chart made immediately on 5-1-2024.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Resident Services Director and/or designee to conduct a full audit on all of the resident's Code Status to ensure that the hard copy in the residents chart matches what is listed on the residents electronic chart.
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?	Resident Services Director and/or designee to highlight Code Status on resident chart record checklist and for resident chart record checklist to be reviewed for all new residents at monthly QA meeting.
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.	Enter methods to ensure corrections are sustained: a. Resident Services Director to discuss/review all resident's Code Status and that the resident hard copy chart matches the resident electronic chart. b. Resident Code Statuses, both hard copy and electronic copy to be reviewed during QA meeting to ensure they match and on-going compliance. c. QA meeting to record resident Code Statuses and that they match.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/31/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Lara Bolino	**Date 6/4/2024**

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.

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

OKLAHOMA
State Department of Health

Delivery via email to: kbolino@Lyndalelife.com; KBolino@sagora.com

August 2, 2024

License Number: AL5525

Ms. Kara Bolino, Administrator
Lyndale At Edmond
1225 Lakeshore Drive
Edmond, OK 73013

RE: Survey Event LJQT12

Dear Ms. Bolino:

On **July 31, 2024,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 1, 2024,** have now been corrected effective **July 31, 2024.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5525	A. BUILDING: _____ B. WING _____	R-C 07/31/2024

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 000}	INITIAL COMMENTS A follow up visit was conducted on 07/31/24. All deficiencies from the 05/01/24 survey have been corrected. Facility census: 33	{C 000}		

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