OKLAHOMA
State Department
of Health

Delivery via email to: marsha.triplett@jasmineestatesedmond.com;
violet.Mast@jasmineestatesedmond.com

July 3, 2024

License Number: AL5543

Ms. Marsha Triplett, Administrator
Jasmine Estates Of Oklahoma City
2232 Southwest 104th Street
Oklahoma City, OK 73159

RE: Survey Event ID: X01S11

Dear Ms. Triplett:

On **June 25, 2024**, agents from our office concluded a State Licensure survey with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **June 25, 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: Jasmine Estates of Oklahoma City
Address: 2232 Southwest 104th Street
City, State, Zip: Oklahoma City, OK., 73159
Provider #: AL5543
Complaint #: OK00062457
Investigation Date(s): 06/24/24 through 0626/24

ALLEGATION(S)
1.The center failed to provide adequate supervision to prevent elopement.

An unannounced on-site investigation was initiated 06/06/2024 at 09:00a.m.

A sample of three 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 facility was conducted. Residents were observed for medication administration. Observations were made of resident's rooms for medication. Resident records including physician orders, contracts, service plans, medication administration records, grievances, incident reports, and nurse's notes were reviewed. Staff were interviewed about policies for medication administration and drug use concerns by employees. The center's policies 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: 06/26/2024

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
	AL5543	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 06/24/24 through 06/26/24. A complaint investigation (#OK00062547) was conducted in conjunction with the survey. Facility Census: 38 Listed below are abbreviations that will be used throughout this document. CDM- Certified Dietary Manager CNA- Certified Nurse Aide DON- Director of Nursing RN -Registered Nurse	C 000		
C 391 SS=F	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: Base on observation, record review and interview, the center failed to: a. ensure staff in the kitchen were wearing hair nets during two of two observations in the kitchen: and b. ensure food items were labeled with the date in the refrigerator during one of two kitchen observations. The DON identified 38 residents resided in the center and received nutrition from the kitchen. Findings:	C 391		

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C 391	Continued From page 2 wearing a hair net. On 06/25/24 at 11:46 a.m., CNA #1 stated they forgot to wear a hair net and should of been wearing one. On 06/25/24 at 12:20 p.m., the CDM was asked what the policy was for labeling items in the refrigerator. The CDM stated all items should be labeled with the date item was opened. The CDM was asked what the policy was for wearing hair nets in the kitchen. They stated a hair net should be worn in the kitchen at all times.	C 391		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure assessments were coordinated by a physician or RN for three (#2, 5, and #6) of eight sampled Residents reviewed for assessments coordinated by an RN or physician. The DON identified 38 Residents resided in the center. Findings: The center's "Admission, Appropriate Placement, and Assessment" policy, dated 04/30/23, read in part, "... A registered nurse or the resident's personal physician must coordinate and sign	C 542		

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C 542	Continued From page 3 each resident assessments..." 1. Resident #2 was admitted on 01/02/24 with diagnoses which included hypertension and dementia. The center's "Resident Asessments Form", dated 01/16/24, did not document an RN or Physician coordinated and signed the asessment. 2. Resident #5 was admitted on 02/24/23 with diagnoses which included dementia and psychosis. The center's "Resident Asessments Form", dated 05/31/24, did not document an RN or Physician coordinated and signed the asessment. 3. Resident #6 was admitted on 01/12/24 with diagnoses which included dementia and anxiety disorder. The center's "Resident Asessments Form", dated 01/24/24, did not document an RN or Physician coordinated and signed the asessment. On 6/24/24 at 10:00 a.m., the DON was asked why the RN or physician never signed the assessments. The DON stated that the assessments never got emailed to the RN.	C 542		
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	C 543		

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C 543	Continued From page 4 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 ensure assessments were signed by a resident and/or resident representative for four (#2, 5,6 and #7) of eight sampled Residents reviewed for assessments signed by a resident and/or resident representative. The DON identified 38 Resident resided in the center. Findings: The center's "Admission, Appropriate Placement, and Assessment" policy, dated 04/30/23, read in part, "... Each resident assessment must include a personal interview between the resident and the person completing the form. The resident is mentally impaired, the facility must include the resident, personal physician or personal representative...." 1. Resident #2 was admitted on 01/02/24 with diagnoses which included hypertension and dementia. The center's "Resident Asessments Form", dated 01/16/24, did not document the resident, personal physician or personal representative signed the assessment. 2. Resident #5 was admitted on 02/24/23 with diagnoses which included dementia and	C 543		

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C 543	Continued From page 5 psychosis. The center's "Resident Asessments Form", dated 05/31/24, did not document the resident, personal physician or personal representative signed the assessment. 3. Resident #6 was admitted on 01/12/24 with diagnoses which included dementia and anxiety disorder. The center's "Resident Asessments Form", dated 01/24/24, did not document the resident, personal physician or personal representative signed the assessment. 4. Resident #7 was admitted on 12/29/19 with diagnoses which included bipolar disorder and dementia. The center's "Resident Asessments Form", dated 04/05/24, did not document the resident, personal physician or personal representative signed the assessment. On 06/24/24 at 10:00 a.m., the DON was asked why the resident and/or resident representative or physician never signed the assessments. The DON stated that the assessments never got signed because the residents cognition was impaired and a family representative was unavailable.	C 543		

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July 10, 2024

License Number: AL5543

Ms. Marsha Triplett, Administrator
Jasmine Estates Of Oklahoma City
2232 Southwest 104th Street
Oklahoma City, OK 73159

RE: Survey Event X01S11

Dear Ms. Triplett:

On **June 25, 2024**, a Licensure inspection with a complaint investigation was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and 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 **August 15, 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

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 06/24/24 through 06/26/24. A complaint investigation (#OK00062547) was conducted in conjunction with the survey. Facility Census: 38 Listed below are abbreviations that will be used throughout this document. CDM- Certified Dietary Manager CNA- Certified Nurse Aide DON- Director of Nursing RN -Registered Nurse	C 000	C 391 On 6/25/2024, relicensure survey (ID X01S11) found all staff were not wearing hair nests while serving meals and all food items in the refrigerator were not labeled with date. This has the potential to affect all residents. This deficiency will be corrected by August 15, 2024. This facility will ensure all kitchen and all staff serving meals will be wearing hair nets. The Executive Director will in-service all staff members regarding mandatory compliance of wearing hair nets in the kitchen at all times and when directly involved with the serving of meals.	
C 391 SS=F	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: Base on observation, record review and interview, the center failed to: a. ensure staff in the kitchen were wearing hair nets during two of two observations in the kitchen: and b. ensure food items were labeled with the date in the refrigerator during one of two kitchen observations. The DON identified 38 residents resided in the center and received nutrition from the kitchen. Findings:	C 391	Training for the Dietary Manager will be provided. The Dietary Manager will successfully complete the Safe Serve coarse, The Dietary Manager will provide periodic training to all kitchen staff. The Maintenance Director or designee will place holders for boxes of hair nets in several areas of easy access to both kitchen staff and dietary aids and servers. To ensure 'hair net" education has been successful, the Kitchen Manager or designee and the Executives Director or Designee will conduct random audits for hair nets during meals, to include weekends,. Audits will be reviewed in Quartly QA meetings This facility will ensure all food in refrigerator will be labeled with the date. The Executive Director will in-service all kitchen staff regarding the labeling and dating of all food in the refrigerator. The Dietary Manager will conduct periodic training to all kitchen staff. M Luptek 7/8/24	8/15/24

			Training for the Dietary Manager will be provided. The Dietary will successfully complete the Safe Serve coarse, The Dietary Manager will provide periodic training to all kitchen staff. To ensure "date labeling" education has been successful, the Kitchen Manager or Designee and the Executive Director or Designee will conduct random audits of all refrigerated food for date labels. Audits will be reviewed in QA meeting.	8-15-24

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C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure assessments were coordinated by a physician or RN for three (#2, 5, and #6) of eight sampled Residents reviewed for assessments coordinated by an RN or physician. The DON identified 38 Residents resided in the center. Findings: The center's "Admission, Appropriate Placement, and Assessment" policy, dated 04/30/23, read in part, "... A registered nurse or the resident's personal physician must coordinate and sign	C 542	C542 On 6/25/2024, relicensure survey (ID X01S11) found that this facility failed to ensure assessments were coordinated by a physician or RN for three of the eight sampled Residents reviewed.,This has the potential to affect all residents. This deficiency will be corrected by August 15, 2024. This facility will ensure that all assessments be coordinated and signed by a registered nurse or the resident's personal physician. The Executive Director, RN or Facility Physcian will in-service the Health and Wellness Director regarding the necessity of having all assessments signed by the registered nurse or the resident's physician. The Wellness Director will audit Pre-Admit, 14 Day, Significant Changes and Annual Assessments for RN signature or Physician signature.	8-15-24

			Audit will be reviewed in QA meeting.	

M Supplet ED 7-8-24 8-13-24

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C 542	Continued From page 3 each resident assessments..." 1. Resident #2 was admitted on 01/02/24 with diagnoses which included hypertension and dementia. The center's "Resident Asessments Form", dated 01/16/24, did not document an RN or Physician coordinated and signed the asessment. 2. Resident #5 was admitted on 02/24/23 with diagnoses which included dementia and psychosis. The center's "Resident Asessments Form", dated 05/31/24, did not document an RN or Physician coordinated and signed the asessment. 3. Resident #6 was admitted on 01/12/24 with diagnoses which included dementia and anxiety disorder. The center's "Resident Asessments Form", dated 01/24/24, did not document an RN or Physician coordinated and signed the asessment. On 6/24/24 at 10:00 a.m., the DON was asked why the RN or physician never signed the assessments. The DON stated that the assessments never got emailed to the RN.	C 542		
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	C 543	M Lyght, ED 7-8-24	8-15-24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5543	A. BUILDING: _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

(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 543	Continued From page 4 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 ensure assessments were signed by a resident and/or resident representative for four (#2, 5,6 and #7) of eight sampled Residents reviewed for assessments signed by a resident and/or resident representative. The DON identified 38 Resident resided in the center. Findings: The center's "Admission, Appropriate Placement, and Assessment" policy, dated 04/30/23, read in part, "... Each resident assessment must include a personal interview between the resident and the person completing the form. The resident is mentally impaired, the facility must include the resident, personal physician or personal representative.... " 1. Resident #2 was admitted on 01/02/24 with diagnoses which included hypertension and dementia. The center's "Resident Asessments Form", dated 01/16/24, did not document the resident, personal physician or personal representative signed the assessment. 2. Resident #5 was admitted on 02/24/23 with diagnoses which included dementia and	C 543	C 543 On 6/25/2024, relicensure survey (ID X01S11) found that this facility failed to ensure assessments were signed by a resident and/or resident representative for four of the eight sampled Residents reviewed. This has the potential to affect all residents. This deficiency will be corrected by August 15, 2024. This facility will ensure that all assessments be by resident and/or resident representative. The Executive Director, RN or Facility Physician will in-service the Health and Wellness Director regarding the necessity of having all assessments signed by the resident and/or resident representative. The Wellness Director will audit required facility assessments for resident and/or resident representative signature. Audit will be reviewed in QA meeting. m Lupkt/ ED 7-X-24	8-15-24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

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C 543	Continued From page 5 psychosis. The center's "Resident Asessments Form", dated 05/31/24, did not document the resident, personal physician or personal representative signed the assessment. 3. Resident #6 was admitted on 01/12/24 with diagnoses which included dementia and anxiety disorder. The center's "Resident Asessments Form", dated 01/24/24, did not document the resident, personal physician or personal representative signed the assessment. 4. Resident #7 was admitted on 12/29/19 with diagnoses which included bipolar disorder and dementia. The center's "Resident Asessments Form", dated 04/05/24, did not document the resident, personal physician or personal representative signed the assessment. On 06/24/24 at 10:00 a.m., the DON was asked why the resident and/or resident representative or physician never signed the assessments. The DON stated that the assessments never got signed because the residents cognition was impaired and a family representative was unavailable.	C 543	M Ingalls, ED 7-8-24	8-15-24

OKLAHOMA
State Department
of Health

Delivery via email to: marsha.triplett@jasmineestatesedmond.com;
violet.Mast@jasmineestatesedmond.com

September 3, 2024

License Number: AL5543

Ms. Marsha Triplett, Administrator
Jasmine Estates Of Oklahoma City
2232 Southwest 104th Street
Oklahoma City, OK 73159

RE: Survey Event X01S12

Dear Ms. Triplett:

On **August 30, 2024,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your re-licensure survey with complaint investigation on **June 15, 2024,** have now been corrected effective **August 15, 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
	AL5543	A. BUILDING: _____ B. WING _____	R-C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASMINE ESTATES OF OKLAHOMA CITY	2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159

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{C 000}	INITIAL COMMENTS A revisit was conducted on 08/30/24. All deficiencies from the 06/25/24 survey were cleared.	{C 000}		

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