OKLAHOMA
State Department
of Health

Delivery via email to: danellezemke@southernplaza.net; tonyarideaux@southernplaza.net

July 25, 2023

License Number: AL5549

Ms. Danelle Zemke, Administrator
Southern Plaza Assisted Living And Memory Care
3704 North Asbury
Bethany, OK 73008

RE: Survey Event ID: SB1O11

Dear Ms. Zemke:

On **June 14, 2023**, 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 14, 2023.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Southern Plaza Assisted Living and Memory Care**
Address: **3704 North Asbury**
City, State, Zip: **Bethany, Ok. 73008**
Provider #: **AL5549**
Complaint #: **OK00060455**
Investigation Date(s): **06/12/23 through 06/14/23**

ALLEGATION(S)

The center failed to ensure residents received medications according to the physicians' orders.
The center failed to follow proper pharmacy procedures and ensure medications were administered **according to the physicians' orders.**

An unannounced on-site investigation was initiated 06/12/2023 at 12:00 p.m.

A sample of four 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 Centers for Medicare and Medicaid Services (CMS) 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 brief initial tour of the center was completed. Staff were observed assisting residents. A medication observation pass was completed.

Resident progress notes, medication administration records, physician orders, pharmacy policy and procedures, resident contracts, waivers, and plans of accommodations were reviewed.

Residents or resident representatives, medication staff, and administrative staff were interviewed regarding the process for ensuring medications are ordered and available to administer according to the physician orders.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 06/19/2023

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	AL5549	A. BUILDING: _____ B. WING _____	C 06/14/2023

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 06/12/23 through 06/14/23. A complaint investigation (#OK00060455) was conducted in conjunction with the survey. Listed below are the abbreviations used throughout this document. @ - at AAO - Awake, Alert and Oriented ADK - Vitamin A, Vitamin D, Vitamin K b/p - blood pressure CMA - Certified Medication Aide CKD - Chronic Kidney Disease DX/dx - diagnosis DON - Director of Nursing ED - Executive Director H.S. - hour of sleep MAR - Medication Administration Record MD - Medical Doctor mg - milligram N.O. - new order OTC - over the counter Rec.- received RD - Registered Dietitian RN - Registered Nurse SPR - spray XR - extended release	C 000		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract.	C1304		

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C1304	Continued From page 1	C1304		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the center failed to ensure medications were ordered and available for administration according to the Resident Agreement for one (#6) of nine sampled residents reviewed for provision of services according to the Resident Service Agreement.

The ED identified the census was 93.

Findings:

An "Assistance with Medication" policy, dated 10/19, read in part, "...Designated Community staff will communicate with the pharmacies to order all medications unless other arrangements have been made with the resident/family. All new orders shall be ordered from a local pharmacy in order to expedite the arrival of the medicine. If medications are not in the Community within twelve (12) hours of notification, the medications shall be ordered from the house pharmacy and the resident shall be billed..."

Resident #6's "Resident Admission Agreement," dated 06/10/21, read in part, "...If the Community receives a physician order for a Resident's medication and the Community had not received the medication within twelve (12) hours after notice has been given to the Resident, then the

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C1304	Continued From page 2 Community shall order the medication from the house pharmacy..." A "Physician Orders," dated 05/19/23 read in part, "...melatonin 5mg at bedtime..." A nurse "Progress Notes," dated 05/19/23, read in parts, "...Rec. N.O. from [doctor name]...for melatonin 5 mg @ H.S. for insomnia..." The MAR medication notes, dated May 2023, documented Resident #6 had not received their Melatonin 5 mg on the following days: a. 05/20/23 at 8:00 p.m., Patient unable to take medication, b. 05/21/23 at 8:00 p.m., Patient unable to take medication, c. 05/22/23 at 8:00 p.m., Waiting for med from family, and d. 05/23/23 at 8:00 p.m., medication not available contacted pharmacy. On 06/14/23 at 11:44 a.m., the DON was asked why Resident #6's melatonin had not been started until 05/24/23. They stated they got the order late from the family member who uses a mail order pharmacy. The DON was shown the resident service agreement and asked if contract services had been met. They stated, "No." The DON stated the center received the mail order from Resident #6's family member on 05/24/23.	C1304		
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	C1505		

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C1505	Continued From page 3 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 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. ensure staff maintained infection control measures during the medication pass for two (#11, and #12) of four sampled residents	C1505		

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C1505	Continued From page 4 reviewed during medication observation, and b. ensure medications were available to administer according to the physician order for three (#10, 8, and #14) of ten sampled residents reviewed for physician orders, and c. provide a renal diet as ordered by the physician for one (#1) of ten sampled residents reviewed for diet orders. The ED identified 93 residents resided in the center. Findings: An "Assistance with Medication" policy, updated October 2019, read in parts, "...The Community shall provide or arrange qualified members to administer medications. Medications must be administered according to physician's orders..." 1. Resident #11 had diagnoses which included dementia and high blood pressure. 2. Resident #12 had diagnoses which included high blood pressure and dementia. On 06/13/23 at 7:34 a.m., during a medication administration observation, CMA #1 was observed to obtain a blood pressure on Resident #12. Then placed the b/p wrist cuff on the pole on the medication cart. CMA #1 did not sanitize the blood pressure cuff. CMA #1 continued the medication administration. On 06/13/23 at 8:15 a.m., CMA #1 was observed to remove the b/p wrist cuff from the medication cart pole and put it in their pocket. CMA #1 then	C1505		

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C1505	Continued From page 5 obtained a blood pressure on Resident #11 then returned to the cart. CMA #1 did not sanitize the b/p cuff before they placed it on the medication cart. On 06/13/23 at 2:24 p.m., CMA #1 was asked what should be used to sanitize the blood pressure cuff between residents. They stated the purple wipes. They were asked if they sanitized the b/p cuff between Resident #11 and #12. They stated, "No." On 06/13/23 at 2:47 p.m., Corporate Nurse #1 was asked when a b/p cuff should be sanitized. They stated it should be sanitized before each use and between residents. 3. Resident #10 had diagnoses which included high blood pressure, dementia, and weakness. A "Physician Order," dated 07/20/22, read in parts, " ...IPRATROPIUM SPR 0.06%...ONE SPRAY EACH NOSTRIL THREE TIMES A DAY ..." The "MAR," dated March 2023, documented Resident #10 did not receive their nasal spray on the following days. a. On 03/16/23 at 8:00 p.m., medication out of stock contacted nurse and pharmacy, b. On 03/23/23 at 8:00 a.m., medication out of stock contacted nurse and pharmacy, c. On 03/25/23 at 8:00 p.m., medication out of stock contacted nurse and pharmacy, d. On 03/28/23 at 8:00 p.m., medication out of stock contacted nurse and pharmacy, e. On 03/29/23 at 8:00 p.m., medication out of stock contacted nurse and pharmacy, and f. On 03/30/23 at 8:00 p.m., medication out of	C1505		

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C1505	Continued From page 6 stock contacted nurse and pharmacy. On 06/14/23 at 11:36 a.m., the DON was asked why Resident #10 had gone without their Ipratropium Nasal spray from 03/16/23 through 03/30/23. They stated the family had not brought the medication. The DON was asked what the policy was on ordering medications. They stated staff should contact the family or pharmacy when there is one week left of the medication. 4. Resident #8 had diagnoses which included Alzheimer's disease, dysphagia, and dementia. A "Physician Order," dated October 2022, documented Resident #8's diet as regular mechanical soft diet with nectar thick liquids. The MAR, dated February 2023, documented the thick it powder was not available on the following days: a. On 02/13/23 at 4:00 p.m., on order, b. On 02/14/23 at 4:00 p.m., on order, c. On 02/15/23 at 4:00 p.m., med out of stock contacted nurse and pharmacy, d. On 02/16/23 at 4:00 p.m., med out of stock contacted nurse and pharmacy, and e. On 02/20/23 at 4:00 p.m., med out of stock contacted nurse and pharmacy. On 06/14/23 at 12:38 p.m., Corporate RN #1 was shown the February 2023 MAR and asked why Residents #8's thickening powder was documented as not being used. They stated, "It was clearly out of stock." On 06/14/23 at 3:37 p.m., the ED stated they have had inservice's regarding missed medications and reporting in January by the pharmacist, and had identified the concern in QA.	C1505		

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C1505	Continued From page 7 The ED was asked if all staff who administered medications had been inserviced regarding ordering of medications, and missed medications. They stated they had completed an inservice in April 2023. They were asked to compare the inservice and the staff roster. They were asked if all medication staff had not signed the inservice how could they ensure all staff are aware. They stated, "I am not sure, the documentation is not there." 5. Resident #1 had diagnoses to include acute on chronic metabolic acidosis, severe hyperkalemia, acute kidney injury, chronic kidney disease-stage 4, Diabetes Mellitus-type 2, unintentional weight loss, and protein calorie malnutrition. A "Preadmission Assessment" form, dated 04/06/23, documented Resident #1 had chronic kidney disease-stage five, and was to receive a renal diet. A "Resident Admission Agreement," dated 04/17/23, read in parts, "...Meals and Snacks. Three (3) meals per day are included...Some Modified diets will be provided if prescribed by the Resident's physician as a medical necessity. In such case, the Community requires a written waiver if the Resident wishes to deviate from the diet. Snacks are also available as reasonably requested..." A "Resident Service Plan," dated 04/18/23, documented Resident #1 was cognitive to person, place and time, made sense in conversation. A "Physician Order," dated 04/19/23, documented Resident #1 was to be served a renal diet with no concentrated sweets.	C1505		

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C1505	Continued From page 8 A "Chronic Renal Failure" care plan, dated 04/19/23, read in parts, "...Approach...Encourage resident to eat foods per their MD orders...Encourage proper nutrition..." The "Resident Service Plan," dated 04/19/23, did not address the order for a renal diet. A "Progress Note," dated 04/19/23 was untimed, and read in parts, "...is AA0x3...Primary dx of stage 4 - 5 renal failure...is on a diabetic, renal diet..." "Hospital Discharge Instructions," dated 05/29/23, read in parts, "...Dietary Instructions...Renal (Non-Dialysis) Diet..." An untimed, "Progress Note," dated 05/29/23, read in parts, "...return from...hospital...renal diet...is AAOx3...have requested that dietician visit with resident regarding renal diet since we do not offer this as a diet...meeting is pending..." "Progress Notes," dated 06/01/23, documented the facility received a new order to change Resident #1's diet to no added salt and no concentrated sweets. The physician requested a dietary consultation to be arranged with the resident. The clinical record did not contain a physician order to change the diet to no added salt and no concentrated sweets. There was no documentation Resident #1 had been offered a renal diet, as ordered, from 04/19/23 to 06/01/23. No information was provided the Resident or representative had been counseled for a waiver or a plan of	C1505		

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C1505	Continued From page 9 accommodation to be placed regarding a renal diet not offered. On 06/12/23 at 2:53 p.m., Resident #1 was observed in their apartment. Two ripe bananas were on the kitchen countertop. Resident #1 stated they did not go to lunch today due to being on a special diet and there was not much to eat. They stated they had food restrictions and then there was not much left to choose from. Resident #1 stated they had picked up a few bananas from the snack area, but was aware bananas were not on their diet. Resident #1 stated even if it is not on the diet, sometimes a person needs something to eat. On 06/13/23 at 11:33 a.m., the dietary manager was asked when Resident #1 had received the order for a renal diet to be provided. They stated the resident did not have the order for a renal diet until they returned from the hospital on 05/29/23. On 06/13/23 at 1:19 p.m., the ED was asked when the facility addressed Resident #1's physician order for a renal diet. The ED stated a conversation at the time of admit had addressed the medical concerns for a diagnoses of end stage renal disease and the disease process. The diet was mentioned but were more concerned with the medical interventions. They stated the resident was not provided a renal diet when ordered at the time of admission to the facility. They were asked if Resident #1 was currently being offered the Renal (Non-Dialysis) diet ordered on 05/29/23, when Resident #1 returned from the hospital. They stated we discussed it and are waiting on the RD for a consult with the resident. They stated the RD could be called and in the building the following day.	C1505		

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C1505	Continued From page 10 7. Resident #14 had diagnoses to include abnormal gait, impaired balance, cognitive disorder, osteoarthritis and hypertension. Physician Orders, reviewed by the RN, dated 05/09/22, documented the resident was to be administered: a. Ferrous Gluconate OTC daily; b. B-Complex OTC daily; c. Memantine 5 mg daily; and d. ADK supplement daily. The "MAR," dated June 2022, documented: a. Ferrous Gluconate was not administered two of 30 days; and b. ADK supplement was not administered three of 30 days due to the facility was waiting for the medication to be delivered. The "MAR," dated July 2022, documented: a. Ferrous Gluconate was not administered one of 31 days; b. B-Complex OTC was not administered three of 31 days; and c. Memantine was not administered two of 31 days due to waiting for medication to be delivered. The "MAR," dated August 2022, documented B-Complex OTC was not administered two of 31 days due to waiting for medication to be delivered. The "MAR," dated October 2022, documented Ferrous Gluconate was not administered four of 30 days due to the facility was waiting for the medication to be delivered. On 06/14/23 at 3:05 p.m., the DON and ED were	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5549	A. BUILDING: _____ B. WING _____	C 06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN PLAZA ASSISTED LIVING AND MEMORY	3704 NORTH ASBURY BETHANY, OK 73008

(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 11 asked if the facility ensured medications were available to be administered. They stated there had been a lot of issues to obtain medications for this resident and at times the medications were not available.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: danellezemke@southernplaza.net; tonyarideaux@southernplaza.net

August 9, 2023

License Number: AL5549

Ms. Danelle Zemke, Administrator
Southern Plaza Assisted Living And Memory Care
3704 North Asbury
Bethany, OK 73008

RE: Survey Event SB1O11

Dear Ms. Zemke:

On **June 14, 2023,** agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1505:** The plan of correction does not address how corrective measures were achieved for Residents #10, 8 and #14.

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/27/2023** **Facility Name:** Southern Plaza Assisted Living and Memory Care **License Number:** AL5549 **Survey Event ID:** SB1011 **Date Survey Completed: 6/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1304	Based on: Based on record review and interview, the centerfailed to ensure medications were ordered andavailable for administration according to theResident Agreement for one (#6) of nine sampledresidents reviewed for provision of servicesaccording to the Resident Service Agreement.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The POC is submitted as a regulation requirement and not an admission of guilt.

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 affected resident received the medication on day 5 after the order was received and has continued to receive the medication per physician order.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	When a medication is not given to a resident, the Director of Nursing shall receive an alert email from the medication program, Accuflow. DON shall investigate whey the medication was not given and follow up with the pharmacy if needed.
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?	When a medication is not given to a resident, the Director of Nursing shall receive an alert email from the medication program, Accuflow. The DON shall investigate why the medication was not given and follow up with the pharmacy if needed.
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.	During the weekly leadership meetings, the Executive Director shall review any missed medications with the DON. If residents are receiving all of their physician ordered medications this method is working. During the monthly Quality Control meetings, the Executive Director shall review any medications that have not been given or received for all residents. During the weekly leadership meetings and the monthly quality control meetings, the Executive Director shall review any missed medications and investigate all situations with the DON.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/15/2023

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Danielle Tuttle		**Date** Enter a date of signature. 8/9/23	
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: 7/27/2023** **Facility Name:** Southern Plaza Assisted Living and Memory Care **License Number:** AL5549 **Survey Event ID:** SB1011 **Date Survey Completed: 6/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505	Based on: Based on observation, record review, andinterview, the center failed to:a. ensure staff maintained infection control measures during the medication pass for two(#11, and #12) of four sampled residents; reviewed during medication observation, and b. ensure medications were available to administer according to the physician order for three (#10, 8, and #14) of ten sampled residents reviewed for physician orders, and c. provide a renal diet as ordered by the physician for one (#1) of ten sampled residents reviewed for diet orders.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The POC is submitted as a regulation requirement and not an admission of guilt.

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?	A. Blood pressure cuffs shall be sanitized before each use. An in-service on proper sanititization shall occur with nursing staff regarding sanitation of equipment. B. When a medication is not given to a resident, the Director of Nursing shall receive an alert email from the medication program, Accuflow. DON shall investigate whey the medication was not given and follow up with the pharmacy if needed. C. The renal diet was removed for the resident #1 by their physician the day of the survey.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A. Blood pressure cuffs shall be sanitized before each use. An in-service on proper sanititization shall occur with nursing staff regarding sanitation of equipment. B. When a medication is not given to a resident, the Director of Nursing shall receive an alert email from the medication program, Accuflow. DON shall investigate whey the medication was not given and follow up with the pharmacy if needed. C. All diets shall be followed per physician orders.
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. An in-service shall occur with current staff regarding sanitation of all equipment. New employees shall receive the sanitation of equipment policy during their Skills Check Class with the Nurse. B. When a medication is not given to a resident, the Director of Nursing shall receive an alert email from the medication program, Accuflow. The DON shall investigate why the medication was not given and follow up with the pharmacy if needed.

	C. When physician orders are received for any diet restrictions, the DON shall ensure the kitchen staff are aware and the resident receives the diet order. If the kitchen staff cannot accommodate a special diet, the nurse shall notify the resident/family and physician. If the resident does not wish to follow the special diet, they will sign a Diet Waiver. The physician will submit a change of diet order if they choose.
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.	During the weekly leadership meetings, the Executive Director shall review the sanitation policy, any missed medications with the DON, and all special diets. If the medical equipment is sanitized before use on a resident, residents are receiving all of their physician ordered medications and the special diets are being acoomodated these methods is working. During the monthly Quality Control meetings, the Executive Director shall review the skills trainings to ensure that the sanitation policy has been taught, any medications that have not been given or received for all residents and all new special diets for residents for the month. During the weekly leadership meetings and the monthly quality control meetings, the Executive Director shall review the skills trainings to ensure the sanitation policy has been trained with all employees, review any missed medications and investigate all situations, and review any new special diets ordered for any resident.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Danielle Tenbrunsel	**Date** Enter a date of signature.	8/9/23

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

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

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

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

OKLAHOMA
State Department
of Health

Delivery via email to: danellezemke@southernplaza.net

August 16, 2023

License Number: AL5549

Ms. Danelle Zemke, Executive Director
Southern Plaza Assisted Living and Memory Care
3704 North Asbury
Bethany, OK 73008

Survey Event ID: SB1O11

Dear Ms. Zemke:

On **June 14, 2023,** a Relicensure survey and a Complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 31, 2023**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/27/2023** **Facility Name:** Southern Plaza Assisted Living and Memory Care **License Number:** AL5549 **Survey Event ID:** SB1011 **Date Survey Completed: 6/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1304	Based on: Based on record review and interview, the centerfailed to ensure medications were ordered andavailable for administration according to theResident Agreement for one (#6) of nine sampledresidents reviewed for provision of servicesaccording to the Resident Service Agreement.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The POC is submitted as a regulation requirement and not an admission of guilt.

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 affected resident received the medication on day 5 after the order was received and has continued to receive the medication per physician order.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	When a medication is not given to a resident, the Director of Nursing shall receive an alert email from the medication program, Accuflow. DON shall investigate whey the medication was not given and follow up with the pharmacy if needed.
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?	When a medication is not given to a resident, the Director of Nursing shall receive an alert email from the medication program, Accuflow. The DON shall investigate why the medication was not given and follow up with the pharmacy if needed.
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.	During the weekly leadership meetings, the Executive Director shall review any missed medications with the DON. If residents are receiving all of their physician ordered medications this method is working. During the monthly Quality Control meetings, the Executive Director shall review any medications that have not been given or received for all residents. During the weekly leadership meetings and the monthly quality control meetings, the Executive Director shall review any missed medications and investigate all situations with the DON.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/31/2023

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Daulle Cole		**Date** Enter a date of signature. 8/14/23	
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: 7/27/2023** **Facility Name:** Southern Plaza Assisted Living and Memory Care **License Number:** AL5549 **Survey Event ID:** SB1011 **Date Survey Completed: 6/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505	Based on: Based on observation, record review, andinterview, the center failed to:a. ensure staff maintained infection control measures during the medication pass for two(#11, and #12) of four sampled residents; reviewed during medication observation, and b. ensure medications were available to administer according to the physician order for three (#10, 8, and #14) of ten sampled residents reviewed for physician orders, and c. provide a renal diet as ordered by the physician for one (#1) of ten sampled residents reviewed for diet orders.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The POC is submitted as a regulation requirement and not an admission of guilt.

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?	A. Blood pressure cuffs shall be sanitized before each use. An in-service on proper sanitititization shall occur with nursing staff regarding sanitation of equipment. B. When a medication is not given to a resident, the Director of Nursing shall receive an alert email from the medication program, Accuflow. DON shall investigate whey the medication was not given and follow up with the pharmacy if needed. Resident #10 received their nose spray per physician orders. Resident #8 received thickner powder for all liquids per physician orders. Resident #14 received the Ferrous Gluconate, B-Complex, Memantine, and ADK supplement per physician orders. C. The renal diet was removed for the resident #1 by their physician the day of the survey.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A. Blood pressure cuffs shall be sanitized before each use. An in-service on proper sanitititization shall occur with nursing staff regarding sanitation of equipment. B. When a medication is not given to a resident, the Director of Nursing shall receive an alert email from the medication program, Accuflow. DON shall investigate whey the medication was not given and follow up with the pharmacy if needed. C. All diets shall be followed per physician orders.
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. An in-service shall occur with current staff regarding sanitation of all equipment. New employees shall receive the sanitation of equipment policy during their Skills Check Class with the Nurse.

	B. When a medication is not given to a resident, the Director of Nursing shall receive an alert email from the medication program, Accuflow. The DON shall investigate why the medication was not given and follow up with the pharmacy if needed. C. When physician orders are received for any diet restrictions, the DON shall ensure the kitchen staff are aware and the resident receives the diet order. If the kitchen staff cannot accommodate a special diet, the nurse shall notify the resident/family and physician. If the resident does not wish to follow the special diet, they will sign a Diet Waiver. The physician will submit a change of diet order if they choose.
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.	During the weekly leadership meetings, the Executive Director shall review the sanitation policy, any missed medications with the DON, and all special diets. If the medical equipment is sanitized before use on a resident, residents are receiving all of their physician ordered medications and the special diets are being acoomodated these methods is working. During the monthly Quality Control meetings, the Executive Director shall review the skills trainings to ensure that the sanitation policy has been taught, any medications that have not been given or received for all residents and all new special diets for residents for the month. During the weekly leadership meetings and the monthly quality control meetings, the Executive Director shall review the skills trainings to ensure the sanitation policy has been trained with all employees, review any missed medications and investigate all situations, and review any new special diets ordered for any resident.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Danielle Cutler	**Date** Enter date of signature. 8/14/23

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

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

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. **Surveyor:** Surveyor

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

OKLAHOMA
State Department
of Health

Delivery via email to: danellezemke@southernplaza.net

September 13, 2023

License Number: AL5549

Ms. Danelle Zemke, Administrator
Southern Plaza Assisted Living And Memory Care
3704 North Asbury
Bethany, OK 73008

RE: Survey Event SB1O12

Dear Ms. Zemke:

On **September 11, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 14, 2023,** have now been corrected effective **August 31, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5549	A. BUILDING: _____ B. WING _____	R-C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN PLAZA ASSISTED LIVING AND MEMORY	3704 NORTH ASBURY BETHANY, OK 73008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 09/11/23. The facility was in substantial compliance.	{C 000}		

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