

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

January 13, 2025

License Number: AL5598

Ms. Marsha Triplett, Administrator
Jasmine Estates Of Edmond
1001 S Bryant Ave
Edmond, OK 73034

Survey Event ID: XENY11

Dear Ms. Triplett:

On **December 27, 2024**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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. 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 will be completed for each violation; and
- (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 a 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, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: JASMINE ESTATES OF EDMOND
Address: 1001 S BRYANT AVE
City, State, Zip: EDMOND, OK 73034
Provider #: AL5598
Complaint #: OK00074428
Investigation Date(s): 12/20/24, 12/23/24, and 12/26/24 through 12/27/24

ALLEGATION
The center failed to ensure adequate supervision, care and treatment was provided according to the contract, the plan of care and the standard of care and failed to ensure residents' safety.
The center failed to ensure adequate staff to meet the needs of the residents and to keep the residents safe.

An unannounced on-site investigation was initiated 12/20/2024 at 12:22 p.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 facility was conducted upon entrance, and at other various times throughout the survey. Residents were observed for falls, fall interventions in place, and receiving care.

Facility policy and procedures were reviewed. Nurses' notes, physician orders, Care plans, State reportables, marketing materials, grievances, hospital records, resident contracts, and staff schedules were reviewed.

Residents and resident representatives were interviewed regarding falls, staff supervision and care. Staff were interviewed regarding facility policy and procedures related to falls, resident supervision, and staffing.

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: 01/08/2025

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 complaint investigation (#OK00074428) was conducted on 12/20/24, 12/23/24, and 12/26/24 through 12/27/24. Facility Census: 45 The following abbreviations will be used throughout this document: DON- director of nursing ER- emergency room OSDH - Oklahoma State Department of Health OT- occupational therapy PT-physical therapy RN- registered nurse ST- speech therapy	C 000		
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 comprehensive assessments were completed every 12 months for two (#2, 3, and #4) of eight sampled residents whose comprehensive assessments were reviewed.	C 522		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
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C 522	Continued From page 1 The DON identified 45 residents resided in the center. Findings: 1. Resident #3 was admitted to the facility on 10/29/15 with diagnoses which included dementia and depression. It was documented the last comprehensive assessment was completed on 05/11/23. On 12/26/24 at 1:52 p.m., the DON stated there was no annual assessment completed for Resident #3. 2. Resident #4 was admitted to the facility on 01/20/20 with diagnoses which included dementia and bipolar. It was documented the last comprehensive assessment was completed on 05/11/23. On 12/27/24 at 8:06 a.m., the DON stated there was no annual assessment completed for Resident #4 3. Resident #2 was admitted to the center on 05/18/23 with diagnoses which included dementia and cerebral infarct. It was documented the last comprehensive assessment was completed on 06/16/23. On 12/26/24 at 1:54 p.m., the DON stated there was no annual assessment completed for Resident #2.	C 522		

Oklahoma State Department of Health

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C 542	Continued From page 2	C 542		
C 542 SS=D	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 coordinate an assessment with the signature of a RN or the resident's personal physician for two (#1 and #6) of eight sampled residents whose assessments were reviewed. The DON identified 45 residents resided in the center. Findings: 1. Resident #6 had diagnoses which included dementia with Parkinson's disease, seizure disorder, and weakness. Resident #6's comprehensive assessment, dated 5/14/24, was not coordinated and signed by a RN or the resident's personal physician. On 12/23/24 at 3:11 p.m., the DON stated the assessment for Resident #6 did not contain a RN or physician signature and it should. 2. Resident #1 had diagnoses which included vascular dementia. Resident #1's comprehensive assessment, dated 11/14/24, was not coordinated and signed by a RN or the resident's personal physician.	C 542		

Oklahoma State Department of Health

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C 542	Continued From page 3 On 12/26/24 at 1:50 p.m., the DON stated the assessment for Resident #1 did not contain a RN or physician signature and it should.	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 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 facility failed to conduct a personal interview between the resident and/or the resident's representative for three (#1, 2, and #6) of eight sampled residents whose assessments were reviewed. The DON identified 45 residents resided in the center. Findings: 1. Resident #2 had diagnoses which included dementia and cerebral infarct. Resident #2's comprehensive assessment, dated 06/16/23, did not document a personal interview between the resident and/or the resident's representative. On 12/26/24 at 1:54 p.m., the DON stated there	C 543		

Oklahoma State Department of Health

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C 543	Continued From page 4 was no signature for the resident or resident representative interview on Resident #2's assessment. They stated the assessments were supposed to be signed. 2. Resident #6 had diagnoses which included dementia with Parkinson's disease, seizure disorder, and weakness. Resident #6's comprehensive assessment, dated 5/14/24, did not document a personal interview between the resident and/or the resident's representative. On 12/23/24 at 3:11 p.m., the DON stated there was no signature for the resident or resident representative interview on Resident #6's assessment. They stated the signatures should be completed in no more than a week. 3. Resident #1 had diagnoses which included vascular dementia. Resident #1's comprehensive assessment, dated 11/14/24, did not document a personal interview between the resident and/or the resident's representative. On 12/26/24 at 1:50 p.m., the DON stated there was no signature for the resident or resident representative interview on Resident #1's assessment	C 543			
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident.	C 552			

Oklahoma State Department of Health

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C 552	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the center failed to update/revise a plan of care related to falls for one (#7) of eight sampled residents reviewed for falls. The DON identified 45 residents resided in the center. Findings: Resident #7 had a diagnosis of dementia. An "Combined Initial and Final State Reportable Incident" form, dated 02/14/24, documented certain injuries. It documented Resident #7 fell on 02/12/24 with no injuries noted. It documented on 02/13/24, the resident went out with family. It documented family requested an x-ray due to the resident having difficulties walking and transferring. It documented the x-ray results showed a slight impacted nondisplaced transcervical fracture of the left hip. It documented the MD and family made the decision not to surgically repair. It documented hospice was to bring a lift for non-weight bearing transfers. It documented after eating the resident would be removed out of the dining room and placed in the common area for increased observation to redirect as needed for unassisted transfers. It documented the resident's care plan was updated to reflect those changes.	C 552		

Oklahoma State Department of Health

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C 552	Continued From page 6 The above interventions were not on the resident's care plan, dated 09/19/23, by hospice. On 12/26/24 at 11:09 a.m., the DON stated Resident #7 moved out on 03/24/24. They stated the resident's care plan was last updated on 09/19/23. They stated the care plan was not updated as documented on the State reportable.	C 552		
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 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.	C1505		

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
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C1911	Continued From page 8 Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the center failed to submit a final report to OSDH within 10 business days for one (#6) of eight sampled residents reviewed for falls. The DON identified 45 residents resided in the center. Findings: Resident #6 had diagnoses which included	C1911		

Oklahoma State Department of Health

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C1911	Continued From page 9 dementia with Parkinson's disease, seizure disorder, and weakness. A "Hospital After Visit Summary", dated 04/13/24, documented the reason for the visit was a fall from a wheelchair with diagnosis of facial laceration. An "Initial State Reportable Incident" form, dated 4/15/24, documented certain injuries with an incident date of 04/13/24. It documented the resident had a fall and hit their head on the corner of the chair causing a laceration to their upper right brow. It documented the resident was sent to the ER. A "Combined Initial and Final State Reportable Incident" form, dated 06/10/24, documented certain injuries with an incident date of 04/13/24. It documented the resident had a fall and hit their head on the corner of a chair causing a laceration to their upper right brow. It documented the resident was sent to the ER. It documented the resident returned to the community on hospice with sutures in place to their right upper brow. On 12/23/24 at 3:16 p.m., the administrator stated they were not employed with the facility at the time of the incident. On 12/23/24 at 3:21 p.m., the administrator reviewed Resident #6's incident form. They stated the timeline for submitting a final report with the State was 10 business days. The administrator stated Resident #6's final incident report was not submitted in a timely manner.	C1911		

Delivery via email to: marsha.triplett@jasmineestatesedmond.com

January 24, 2025

License Number: AL5598

Ms. Marsha Triplett, Administrator
Jasmine Estates Of Edmond
1001 S Bryant Ave
Edmond, OK 73034

Survey Event ID: XENY11

Dear Ms. Triplett:

On **December 27, 2024**, agents from our office completed a complaint investigation 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:

- **C522:** The plan of correction did not address annual assessments.
- **C1505:** The plan of correction did not address staff education for the deficiency.

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

Respectfully,



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

Enclosure

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A complaint investigation (#OK00074428) was conducted on 12/20/24, 12/23/24, and 12/26/24 through 12/27/24. Facility Census: 45 The following abbreviations will be used throughout this document: DON- director of nursing ER- emergency room OSDH - Oklahoma State Department of Health OT- occupational therapy PT-physical therapy RN- registered nurse ST- speech therapy	C 000	Refer to POC Template, Survey Event ID # XENY11, ID Prefix Tag C 522		
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 comprehensive assessments were completed every 12 months for two (#2, 3, and #4) of eight sampled residents whose comprehensive assessments were reviewed.	C 522			

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Oklahoma State Department of Health

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C 522	Continued From page 1 The DON identified 45 residents resided in the center. Findings: 1. Resident #3 was admitted to the facility on 10/29/15 with diagnoses which included dementia and depression. It was documented the last comprehensive assessment was completed on 05/11/23. On 12/26/24 at 1:52 p.m., the DON stated there was no annual assessment completed for Resident #3. 2. Resident #4 was admitted to the facility on 01/20/20 with diagnoses which included dementia and bipolar. It was documented the last comprehensive assessment was completed on 05/11/23. On 12/27/24 at 8:06 a.m., the DON stated there was no annual assessment completed for Resident #4 3. Resident #2 was admitted to the center on 05/18/23 with diagnoses which included dementia and cerebral infarct. It was documented the last comprehensive assessment was completed on 06/16/23. On 12/26/24 at 1:54 p.m., the DON stated there was no annual assessment completed for Resident #2.	C 522			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 542	Continued From page 2	C 542	Refer to POC Template, Survey Event ID # XENY11, ID Prefix Tag C 542	
C 542 SS=D	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 coordinate an assessment with the signature of a RN or the resident's personal physician for two (#1 and #6) of eight sampled residents whose assessments were reviewed. The DON identified 45 residents resided in the center. Findings: 1. Resident #6 had diagnoses which included dementia with Parkinson's disease, seizure disorder, and weakness. Resident #6's comprehensive assessment, dated 5/14/24, was not coordinated and signed by a RN or the resident's personal physician. On 12/23/24 at 3:11 p.m., the DON stated the assessment for Resident #6 did not contain a RN or physician signature and it should. 2. Resident #1 had diagnoses which included vascular dementia. Resident #1's comprehensive assessment, dated 11/14/24, was not coordinated and signed by a RN or the resident's personal physician.	C 542		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 542	Continued From page 3 On 12/26/24 at 1:50 p.m., the DON stated the assessment for Resident #1 did not contain a RN or physician signature and it should.	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 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 facility failed to conduct a personal interview between the resident and/or the resident's representative for three (#1, 2, and #6) of eight sampled residents whose assessments were reviewed. The DON identified 45 residents resided in the center. Findings: 1. Resident #2 had diagnoses which included dementia and cerebral infarct. Resident #2's comprehensive assessment, dated 06/16/23, did not document a personal interview between the resident and/or the resident's representative. On 12/26/24 at 1:54 p.m., the DON stated there	C 543	Refer to POC Template, Survey Event ID # XENY11, ID Prefix Tag C 543	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 was no signature for the resident or resident representative interview on Resident #2's assessment. They stated the assessments were supposed to be signed. 2. Resident #6 had diagnoses which included dementia with Parkinson's disease, seizure disorder, and weakness. Resident #6's comprehensive assessment, dated 5/14/24, did not document a personal interview between the resident and/or the resident's representative. On 12/23/24 at 3:11 p.m., the DON stated there was no signature for the resident or resident representative interview on Resident #6's assessment. They stated the signatures should be completed in no more than a week. 3. Resident #1 had diagnoses which included vascular dementia. Resident #1's comprehensive assessment, dated 11/14/24, did not document a personal interview between the resident and/or the resident's representative. On 12/26/24 at 1:50 p.m., the DON stated there was no signature for the resident or resident representative interview on Resident #1's assessment	C 543		
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident.	C 552		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 552	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the center failed to update/revise a plan of care related to falls for one (#7) of eight sampled residents reviewed for falls. The DON identified 45 residents resided in the center. Findings: Resident #7 had a diagnosis of dementia. An "Combined Initial and Final State Reportable Incident" form, dated 02/14/24, documented certain injuries. It documented Resident #7 fell on 02/12/24 with no injuries noted. It documented on 02/13/24, the resident went out with family. It documented family requested an x-ray due to the resident having difficulties walking and transferring. It documented the x-ray results showed a slight impacted nondisplaced transcervical fracture of the left hip. It documented the MD and family made the decision not to surgically repair. It documented hospice was to bring a lift for non-weight bearing transfers. It documented after eating the resident would be removed out of the dining room and placed in the common area for increased observation to redirect as needed for unassisted transfers. It documented the resident's care plan was updated to reflect those changes.	C 552	Refer to POC Template, Survey Event ID # XENY11, ID Prefix Tag C 552	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 552	Continued From page 6 The above interventions were not on the resident's care plan, dated 09/19/23, by hospice. On 12/26/24 at 11:09 a.m., the DON stated Resident #7 moved out on 03/24/24. They stated the resident's care plan was last updated on 09/19/23. They stated the care plan was not updated as documented on the State reportable.	C 552		
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 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.	C1505	Refer to POC Template, Survey Event ID # XENY11, ID Prefix Tag C 1505	

If continuation sheet 8 of 10

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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
C1911	Continued From page 8 Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the center failed to submit a final report to OSDH within 10 business days for one (#6) of eight sampled residents reviewed for falls. The DON identified 45 residents resided in the center. Findings: Resident #6 had diagnoses which included	C1911	Refer to POC Template, Survey Event ID # XENY11, ID Prefix Tag C 543	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/27/2024
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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	
C1911	Continued From page 9 dementia with Parkinson's disease, seizure disorder, and weakness. A "Hospital After Visit Summary", dated 04/13/24, documented the reason for the visit was a fall from a wheelchair with diagnosis of facial laceration. An "Initial State Reportable Incident" form, dated 4/15/24, documented certain injuries with an incident date of 04/13/24. It documented the resident had a fall and hit their head on the corner of the chair causing a laceration to their upper right brow. It documented the resident was sent to the ER. A "Combined Initial and Final State Reportable Incident" form, dated 06/10/24, documented certain injuries with an incident date of 04/13/24. It documented the resident had a fall and hit their head on the corner of a chair causing a laceration to their upper right brow. It documented the resident was sent to the ER. It documented the resident returned to the community on hospice with sutures in place to their right upper brow. On 12/23/24 at 3:16 p.m., the administrator stated they were not employed with the facility at the time of the incident. On 12/23/24 at 3:21 p.m., the administrator reviewed Resident #6's incident form. They stated the timeline for submitting a final report with the State was 10 business days. The administrator stated Resident #6's final incident report was not submitted in a timely manner.	C1911			



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/21/2025

Facility Name: Jasmine Estates Edmond

License Number: AL5598-5598

Survey Event ID: XENY11

Date Survey Completed: 12/27/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522

Based on: Based on record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for two (#2, 3, and #4) of eight sampled residents whose comprehensive assessments were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

These Residents will have charts audited for admission, 14 day, and significant changes assessments. Residents found to be missing current assessments will have assessments completed by March 12, 2025

All Residents will have charts audited for admission, 14 day, and significant changes assessments. Residents found to be missing current assessments will have assessments completed by March 12, 2025

Executive Director will educate Wellness Director on assessment timeframes, state assessment, eval and service plan completion. Monthly ED/WD meetings will be held to review and assess timely completions.

Admission, 14 day and significant change assessments will be reviewed monthly for completion by the Wellness Director and Executive Director.

All assessments will be evaluated to make sure they contain signatures.

Assessments will be added to QA and reviewed quarterly for completion and accuracy.

Records will be kept in a QA Binder in Nurse's office.

3/12/2025

Administrator's Signature Administrator signature required.

OAC 310:663-25-4(F)

Date Enter a date of signature.

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: 1/21/2025

Facility Name: Jasmine Estates Edmond

License Number: AL5598-5598

Survey Event ID: XENY11

Date Survey Completed: 12/27/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 542

Based on: This Rule is not met as evidenced by: C 542 Based on record review and interview, the center failed to coordinate an assessment with the signature of an RN or the resident's personal physician for two (#1 and #6) of eight sampled This Rule is not met as evidenced by: C 542 Based on record review and interview, the center failed to coordinate an assessment with the signature of a RN or the resident's personal physician for two (#1 and #6) of eight sampled

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The charts of these residents will be audited for signature on assessments by Physician/RN. All assessments found to be without signature will be coordinated with RN/Physician to obtain signature.

All residents will have charts audited for signature on assessments by Physician/RN. Any assessments found to be without signature will be corrected by obtaining RN/Physician signature.

Executive Director will educate Wellness Director on coordinating assessment signatures with RN/Physician. Monthly ED/WD meetings will be held to review and assess accuracy of assessments.

Assessments will be reviewed monthly between Wellness Director and Executive Director for signatures.

All assessments will be reviewed to make sure they contain signatures.

Assessments will be added to QA and reviewed Quarterly for completion.

Records will be kept in a QA binder in Nurse's office.

3/12/2025

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.

Marshall R. Tupper, LHA, ED

Date Enter a date of signature.

1-23-25

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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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.](#)

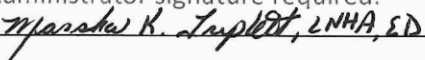
Facility in Compliance by: [Click here to enter a date.](#)

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/21/2025	
	Facility Name: Jasmine Estates Edmond	
	License Number: AL5598-5598	
	Survey Event ID: XENY11	
Date Survey Completed: 12/27/2024		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 543 SS=D	Based on: This Rule is not met as evidenced by: C 543 Based on record review and interview, the facility failed to conduct a personal interview between the resident and/or the resident's representative for three (#1, 2, and #6) of eight sampled residents whose assessments were reviewed.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: It is the intent of this facility to be in compliance with all state rules and regulations. This facility will implement actions to correct the deficiency.		
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		The Executive Director will educate the Wellness Director about conducting a personal interview with resident to include family representative as evidenced by their signature on assessment form.
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 assessments will be audited for signature of the resident/family representative involved with the interview for the assessment.
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?		Executive Director will educate Wellness Director on ensuring a personal interview is done between resident and wellness director to include family representative and to be evidenced by signature of resident /family representative involved with the interview for the assessment. Assessments will be reviewed with family in person or by telephone and signed. If done by phone, assessments will be sent by DocuSign for signature and made available in paper form to the Wellness Director who will have it signed on next visit.
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.		Assessments will be reviewed monthly by the Wellness Director and Executive Director for personal interview as evidence by resident/family representative signature. All assessments will be reviewed to make sure a personal interview has been conducted with the resident/family representative. Assessment will be added to QA and reviewed Quarterly for accuracy and completion to include the interview and signature.

		Records will be kept in a binder in the Nurse's office.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/12/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature.	
<i>M. J. Smith, R. N., LHA, ED</i>		<i>1-23-25</i>	
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: 1/21/2025		
	Facility Name: Jasmine Estates Edmond		
	License Number: AL5598-5598		
	Survey Event ID: XENY11		
			Date Survey Completed: 12/27/2024
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 552 SS=D		Based on: This Rule is not met as evidenced by: Based on record review and interview, the center failed to update/revise a plan of care related to falls for one (#7) of eight sampled residents reviewed for falls.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: It is the intent of this facility to be in compliance with all state rules and regulations. This facility will implement actions to correct the deficiency.			
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS	
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		This Resident's Care Plan will be reviewed by the Wellness Director and updated with interventions r/t falls.	
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 plans will be audited and fall interventions reviewed for completion/appropriateness per resident and care plans updated where 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?		Executive Director will educate Wellness Director on completing Change of Condition assessments after falls that result in change of condition/care and updating care plan within a timely manner. Wellness Director will review and update care plan with interventions r/t falls in a timely manner after each fall.	
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.		Incident reports and fall interventions will be reviewed monthly with care plans to monitor proper updating of care plans. Care plans will be updated in a timely manner after each fall to show interventions to attempt to prevent future falls. Incident reports will be added to QA for updating of care plans and monitoring of interventions. Records will be kept in a QA binder in the Nurse's office.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/12/2025	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature. 1-23-25	
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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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: 1/21/2025	
	Facility Name: Jasmine Estates Edmond	
	License Number: AL5598-5598	
Survey Event ID: XENY11		Date Survey Completed: 12/27/2024
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 1505 SS=D	Based on: This REQUIREMENT is not met as evidencedby: Based on record review and interview, the center failed to implement a physician's order for one (#6) of eight sampled residents reviewed for falls.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: It is the intent of this facility to be in compliance with all state rules and regulations. This facility will implement actions to correct the deficiency.		
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	This resident is no longer in the facility so corrective action cannot be taken.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Charts will be audited for documentation of completion for all orders or documentation to show why completion did not occur.	
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?	Orders pertaining to 3 rd party companies will be sent in a timely manner to 3 rd party and followed up on for completion and documentation of such and result of evaluations.	
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.	Evaluations will be reviewed monthly for documentation in resident chart for completion and for 3rd party involvement in resident's care. Monthly audits will be conducted on MARS/TARS to ensure Physcian orders have been implemented. Orders will be reviewed weekly for completion and added to QA for quarterly review. Community will require 3rd parties to fill out communication form with each visit in community with each resident seen. These documents will be retained in our files. Copies of POC/485's will be kept up to date in kWellness Director's office.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	3/12/2025	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. 	Date Enter a date of signature. 1-23-25

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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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: 1/21/2025

Facility Name: Jasmine Estates Edmond

License Number: Click here to enter assisted living center's license number.

Survey Event ID: Click here to enter Survey Event ID from cover letter and STATE FORM.

Date Survey Completed: Click here to enter a date from Box X3 on STATE FORM.

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1911 SS=D

Based on: his Rule is not met as evidenced by: Based on record review and interview, the center failed to submit a final report to OSDH within 10 business days for one (#6) of eight sampled residents reviewed for falls.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Research will be conducted to determine the final outcome of this incident. A late Final will be sent to State.

State Reportables will be audited weekly for final submissions. Any reports w/o finals will be researched for final outcome, corrected and submitted to State.

Incidents will be reviewed by WD and ED in a timely manner after occurrence for a timeline to report. Initial will be sent w/n 24 business hours by WD or ED.

Initial incident reports will be turned into State within 24 hours, unless abuse/neglect is suspected, with finals turned in upon investigation completion, not to exceed 10 business days. Incidents will be monitored daily in stand-up.

Incidents will be investigated within a timely manner in a meeting b/w ED and WD setting 5 business days as the objective to file Final and not to exceed 10 days.

Incident reports will be added to QA and reviewed for completion monthly.

Reportables will be kept in a State Reportable binder kept in the ED's office.

3/12/2025

Administrator's Signature Administrator signature required.

OAC 310:663-25-4(F)

Monisha K. Lupton, CNHA, ED

Date Enter a date of signature.

1-23-25

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.			

Delivery via email to: marsha.triplett@jasmineestatesedmond.com

January 29, 2025

License Number: AL5598

Ms. Marsha Triplett, Administrator
Jasmine Estates Of Edmond
1001 S Bryant Ave
Edmond, OK 73034

Survey Event ID: XENY11

Dear Ms. Triplett:

On **December 27, 2024**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The Amended plan of correction you submitted is not acceptable for the following reasons:

- **C522:** The POC did not include annual assessments on the list of assessments that will be audited. The deficiency is about annual assessments not being completed.
- **C1505:** The plan of correction did not address staff education to ensure physician orders are implemented.

Please provide a 2nd Amended plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,



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: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 complaint investigation (#OK00074428) was conducted on 12/20/24, 12/23/24, and 12/26/24 through 12/27/24. Facility Census: 45 The following abbreviations will be used throughout this document: DON- director of nursing ER- emergency room OSDH - Oklahoma State Department of Health OT- occupational therapy PT-physical therapy RN- registered nurse ST- speech therapy	C 000	Refer to POC Template, Survey Event ID # XENY11, ID Prefix Tag C 522	
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 comprehensive assessments were completed every 12 months for two (#2, 3, and #4) of eight sampled residents whose comprehensive assessments were reviewed.	C 522		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/27/2024
NAME OF PROVIDER OR SUPPLIER JASMINE ESTATES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 522	Continued From page 1 The DON identified 45 residents resided in the center. Findings: 1. Resident #3 was admitted to the facility on 10/29/15 with diagnoses which included dementia and depression. It was documented the last comprehensive assessment was completed on 05/11/23. On 12/26/24 at 1:52 p.m., the DON stated there was no annual assessment completed for Resident #3. 2. Resident #4 was admitted to the facility on 01/20/20 with diagnoses which included dementia and bipolar. It was documented the last comprehensive assessment was completed on 05/11/23. On 12/27/24 at 8:06 a.m., the DON stated there was no annual assessment completed for Resident #4 3. Resident #2 was admitted to the center on 05/18/23 with diagnoses which included dementia and cerebral infarct. It was documented the last comprehensive assessment was completed on 06/16/23. On 12/26/24 at 1:54 p.m., the DON stated there was no annual assessment completed for Resident #2.	C 522		