



Oklahoma State Department of Health
Creating a State of Health

January 28, 2020

License Number: AL6006

Ms. Kelly Crossfield, Administrator
Red Bud Assisted Living
215 W Freeman
Perkins, OK 74059

RE: Survey Event ID: F5ZE11

Dear Ms. Crossfield:

On **January 15, 2020**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on January 15, 2020.

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;

Board of Health

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- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

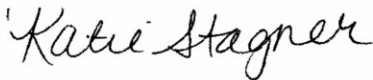
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,



Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING. _____	(X3) DATE SURVEY COMPLETED 01/15/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W FREEMAN PERKINS, OK 74059		
(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 re-licensure survey was conducted 01/14/2020 and 01/15/2020. Resident census was 21. The following deficient practices were cited.	C 000		
C 301 SS=E	310:663-3-1(a) SERVICE IN ASSISTED LIVING (a) An assisted living center shall not care for any resident needing care in excess of the level that the assisted living center is licensed to provide or capable of providing. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to ensure 5 (#2, 3, 4, 5 and #7) of 8 sampled residents did not exceed the care the center was capable of providing according to the new resident contract that the resident's representative signed upon completion of the sale of the center to new owners. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 01/15/2020 the resident contract was reviewed. The contract documented at the top of page 2, "The following criteria are the maximum assistance available at (name-deleted) Assisted Living: ...Resident may need assistance from no more than one caregiver with bathing or showering...Resident may receive help with incontinence management...Resident may require reminders, motivation, and/or assistance such as	C 301		

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: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/15/2020
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RED BUD ASSISTED LIVING

**215 W FREEMAN
PERKINS, OK 74059**

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C 301	Continued From page 1 help with buttoning blouse, tying shoelaces, etc...Resident may require encouragement and/or minimal assistance with no more than one caregiver to transfer or ambulate...The resident must not be a threat to him/her self or others at any time..." Resident #2 Resident #2's contract was signed by the resident's responsible party 12/09/19. The resident's most recent assessment, dated 11/19/19, documented the resident was alert but only oriented to self. She needed the assistance of two people for bathing, dressing, toileting and transferring, was incontinent, wore adult briefs and was unable to assist staff with brief changes. On 01/14/2020 at 11:30 a.m., the LPN (licensed practical nurse) stated the resident was chairfast, on hospice, could not feed herself and required two people for total care. At 1:30 p.m., the resident was observed while the hospice nurse changed the dressing to a wound on the resident's foot. The resident was unable to respond to verbal stimuli, unable to move herself and required both the hospice nurse and hospice aide to move her from side to side in bed. The resident was wearing an adult brief. Resident #3 Resident #3's contract was signed by her responsible party 12/02/19. Her assessment, dated 11/12/19, documented the resident was chairfast and could not bear weight. On 01/14/2020 at 11:30 a.m., the LPN stated resident #3 was chairfast and required two	C 301		

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C 301	Continued From page 2 people for all personal care as the resident could not assist with her care. At 1:30 p.m., the resident was interviewed in her room. She was alert and oriented to self and place, but confused as to time. She was sitting in a wheelchair. A hospital bed, a shower chair and a toilet chair were all observed in her room. She stated it took two people to shower her. On 01/15/2020 at 1:30 p.m., LTCA/employee #2 stated resident #3 could not bear any weight and it required two people to shower, transfer and change the resident's briefs. Resident #4 Resident #4's responsible party signed the new contract on 11/27/19. Her assessment, dated 01/09/2020, documented the resident was chairfast, required staff to push her wheelchair, was incontinent and was unable to assist with brief changes. On 01/14/2020, the LPN stated resident #4 was chairfast, could not feed herself and required two people for all personal care as the resident could not assist with her care. On 01/15/2020 at 1:32 p.m., LTCA/employee #2 and CMA (certified medication aide)/employee #1 were observed putting the resident back to bed. They put a gait belt around the resident's waist and it took both of them to lift the resident using the gait belt and her waistband. The resident could not bear any weight. They changed the resident's brief. LTCA/employee #2 stated the resident has not been able to assist with any personal care or been able to bear weight for at least the last three to four weeks.	C 301			

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RED BUD ASSISTED LIVING

**215 W FREEMAN
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C 301	Continued From page 3 Resident #5 The resident's responsible party signed the new contract on 12/03/19. Resident #5's assessment, dated 12/10/19, documented the resident was chairfast, flaccid on the right side, was unable to self-propel his wheelchair, and required two people for all personal care as he was unable to assist with his care. On 01/14/2020, the LPN stated resident #5 was chairfast, could not self-propel his wheelchair and required two people for all personal care as the resident could not assist with his care. On 01/15/2020 at 2:25 p.m., LTCA/employee #2 stated resident #5 could be combative with care and it took two people for all personal care as the resident could not assist with his care. At 2:30 p.m., LTCA/employee #2 and CMA/employee #1 were observed transferring the resident from his recliner to his wheelchair and from his wheelchair to his bed. They put a gait belt around his waist and lifted him from his recliner using the gait belt and his waistband. Resident #5 was able to bear some weight, but could not pivot to sit in the wheelchair, so both staff pivoted him and sat him in the wheel chair. LTCA/employee #2 pushed the wheelchair to the bed and both employees picked the resident up under his arms and with the gait belt. The resident was unable to bear any weight this time. Both employees had to lay him on the bed. Resident #7 Resident #7's responsible party signed the new contract on 12/05/19. The resident's	C 301		

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C 301	Continued From page 4 assessment, dated 11/19/19, documented the resident was chairfast, could not bear weight, and required the assistance of two people for bathing, transferring and toileting. On 01/14/2020, the LPN stated resident #7 was chairfast, could not self-propel her wheelchair and required total care from staff as she could not assist with her care. On 01/15/2020, LTCA/employee #2 and CMA/employee #1 were observed transferring the resident from her wheelchair to the bedside commode. They put a gait belt around the resident's waist and the staff had to move the resident's feet from the wheelchair pedals to the floor as the resident could not move her feet. Both staff picked the resident up and transferred her to the bedside commode. The resident was unable to bear any weight. On 01/15/2020 at 3:00 p.m., the administrator stated none of the residents in the center had a plan of accommodation in place and stated the above residents were above the level of care as outlined in the new contract.	C 301			
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled	C 911			

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C 911	Continued From page 5 nursing interventions; This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the center failed to ensure registered nurse supervision of self-administration of medications for 1 (#1) of 1 sampled resident that self-administered medications. This had the potential for more than minimal harm, at a pattern. Findings: Resident #1 was admitted to the center 08/06/19 with an order to self-administer her medications. The most recent self-administration assessment was dated 12/06/19. No documentation of medication monitoring was included in the resident's record. On 01/15/2020 at 11:00 a.m., the LPN (licensed practical nurse) stated she had not monitored the resident's medication since she came to work at the center about four months ago and did not have any documentation that the resident's medications were monitored by the center before she came. At 3:15 p.m., the resident stated no one from the center monitored her medications. She also stated she ordered all her own medications from the pharmacy. Her medications were observed in a locked cabinet in her room.	C 911		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document	C1951		

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C1951	Continued From page 6 all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to ensure wound care was documented for 1 (#2) of 1 sampled resident who had physician ordered wound care. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 01/14/2020 at 11:30 a.m., a resident report was received from the LPN (licensed practical nurse). She stated resident #2 was only oriented to self, was chairfast, required the assistance of two people for all activities of daily living, had a wound to her right foot and was on hospice. At 1:30 p.m., the hospice nurse was observed providing wound care. The wound was to the resident's right outside foot near the last toe. It was approximately the size of a nickel. There were two areas of eschar (black scabbing) and scant amount of active bleeding. The hospice nurse stated the wound was dressed three times weekly and the center's nurse did the wound dressing on the days when hospice did not see the resident. The center's records for resident #2 were reviewed and no documentation of wound care was found. At 4:20 p.m., the center's LPN was asked how often she did wound care for resident #2. She	C1951		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RED BUD ASSISTED LIVING

**215 W FREEMAN
PERKINS, OK 74059**

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C1951	Continued From page 7 stated she had done the wound care once a week since the wound care order was changed on 11/20/19. She was asked for the wound care documentation. She stated she did not document the wound care because the software the center used did not allow her to.	C1951		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010		

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C5010	Continued From page 8 This Rule is not met as evidenced by: Based on interview, and record review, it was determined the center failed to ensure third party staff providing sitter services were from a licensed agency, had current credentials, or had a current background check while providing services for 1 (#4) of 1 sampled resident that utilized the services of a private sitter. This failed practice had the potential for more than minimal harm at a pattern. Findings: A verbal report on the residents was received from the center's LPN (licensed practical nurse) on 01/14/2020. She stated none of the residents had a private sitter but resident #4 had sitters the family hired through a licensed agency. On 01/15/2020 at 12:20 p.m., a woman in street clothes was observed feeding resident #4. CMA (certified medication aide)/employee #1 was asked who was feeding resident #4. She stated her private sitter was feeding her. CMA/employee #1 said the sitter came four days per week to assist the resident and had come four days per week since the resident was admitted 08/30/19. At 12:30 p.m., the sitter stated the family hired her to come four days a week. She was asked what she did for the resident. She stated she could not do much for her as she was not a	C5010			

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C5010	Continued From page 9 certified long term care aide because she let that certification go a long time ago. She said she just does private care now for different clients. At 12:32 p.m., the administrator was asked about the private sitter for resident #4. She stated the sitter was employed by an agency. She was asked for a background check for the sitter. She provided a small stack of background checks, but the sitter's name was not on any of the background checks. The administrator was informed the sitter said she was not hired through an agency. The administrator stated she was not aware this sitter was not hired through an agency because the family assured her all the sitters that they hired were through an agency. The administrator said she would need to go ask the sitter to leave.	C5010			

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name RED BUD ASSISTED LIVING																				
Type of Survey (select all that apply) <table border="1"><tr><td>L</td><td>L</td><td></td><td></td><td></td></tr></table>	L	L				<table><tr><td>A Complaint Investigation</td><td>E Initial Certification</td><td>I Recertification</td></tr><tr><td>B Dumping Investigation</td><td>F Inspection of Care</td><td>J Sanctions/Hearing</td></tr><tr><td>C Federal Monitoring</td><td>G Validation</td><td>K State License</td></tr><tr><td>D Follow-up Visit</td><td>H Life Safety Code</td><td>L CHOW</td></tr><tr><td>M Other</td><td></td><td></td></tr></table>	A Complaint Investigation	E Initial Certification	I Recertification	B Dumping Investigation	F Inspection of Care	J Sanctions/Hearing	C Federal Monitoring	G Validation	K State License	D Follow-up Visit	H Life Safety Code	L CHOW	M Other		
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M Other																					
Extent of Survey (select all that apply) <table border="1"><tr><td>A</td><td></td><td></td><td></td><td></td></tr></table>	A					<table><tr><td>A Routine/Standard Survey (all providers/suppliers)</td></tr><tr><td>B Extended Survey (HHA or Long Term Care Facility)</td></tr><tr><td>C Partial Extended Survey (HHA)</td></tr><tr><td>D Other Survey</td></tr></table>	A Routine/Standard Survey (all providers/suppliers)	B Extended Survey (HHA or Long Term Care Facility)	C Partial Extended Survey (HHA)	D Other Survey											
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C Partial Extended Survey (HHA)																					
D Other Survey																					

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 36967	01/14/2020	01/15/2020	0.25	0.00	13.50	0.00	4.50	6.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours....

0.00

Total SA Clerical/Data Entry Hours....

0.00

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

0.00

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



Oklahoma State Department of Health
Creating a State of Health

February 11, 2020

License Number: AL6006

Ms. Kelly Crossfield, Administrator
Red Bud Assisted Living
215 W Freeman
Perkins, OK 74059

RE: Survey Event F5ZE11

Dear Ms. Crossfield:

On January 15, 2020, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **February 8, 2020**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

for Sue Davis
Long Term Care Enforcement Coordinator
Oklahoma State Department of Health

SD/jt

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
Becky Payton (*Secretary*)

Jenny Alexopoulos, DO
Terry R Gerard II, DO
Charles W Grim, DDS, MHSA

R Murall Krishna, MD
Ronald D Osterhout
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/15/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W FREEMAN PERKINS, OK 74059		
(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 re-licensure survey was conducted 01/14/2020 and 01/15/2020. Resident census was 21. The following deficient practices were cited.	C 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law and does not waive any appeal or other rights. C301 Service in Assisted Living 1. Resident #3, #4, #5, and #7 have been assessed by Registered Nurse with no adverse effect noted from practice cited. Resident # 2 no longer resides in facility. A plan of accommodation on Resident #3, #4, #5, and #7 have been implemented and care plans updated to reflect plan of accommodations. 2. All Residents have the potential to be affected by this practice. 3. Staff re-educated on the resident contract and the levels of care the center is licensed to	
C 301 SS=E	310:663-3-1(a) SERVICE IN ASSISTED LIVING (a) An assisted living center shall not care for any resident needing care in excess of the level that the assisted living center is licensed to provide or capable of providing. RECEIVED FEB 06 2020 LONG TERM CARE This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to ensure 5 (#2, 3, 4, 5 and #7) of 8 sampled residents did not exceed the care the center was capable of providing according to the new resident contract that the resident's representative signed upon completion of the sale of the center to new owners. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 01/15/2020 the resident contract was reviewed. The contract documented at the top of page 2, "The following criteria are the maximum assistance available at (name-deleted) Assisted Living: ...Resident may need assistance from no more than one caregiver with bathing or showering...Resident may receive help with incontinence management...Resident may require reminders, motivation, and/or assistance such as	C 301		

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

[Signature]

TITLE

Administrator

(X6) DATE

2-6-2020

STATE FORM

8899

F5ZE11

If continuation sheet 1 of 10

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/15/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 216 W FREEMAN PERKINS, OK 74059		
(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 301	Continued From page 1 help with buttoning blouse, tying shoelaces, etc...Resident may require encouragement and/or minimal assistance with no more than one caregiver to transfer or ambulate...The resident must not be a threat to him/her self or others at any time..." Resident #2 Resident #2's contract was signed by the resident's responsible party 12/09/19. The resident's most recent assessment, dated 11/19/19, documented the resident was alert but only oriented to self. She needed the assistance of two people for bathing, dressing, toileting and transferring, was incontinent, wore adult briefs and was unable to assist staff with brief changes. On 01/14/2020 at 11:30 a.m., the LPN (licensed practical nurse) stated the resident was chairfast, on hospice, could not feed herself and required two people for total care. At 1:30 p.m., the resident was observed while the hospice nurse changed the dressing to a wound on the resident's foot. The resident was unable to respond to verbal stimuli, unable to move herself and required both the hospice nurse and hospice aide to move her from side to side in bed. The resident was wearing an adult brief. Resident #3 Resident #3's contract was signed by her responsible party 12/02/19. Her assessment, dated 11/12/19, documented the resident was chairfast and could not bear weight. On 01/14/2020 at 11:30 a.m., the LPN stated resident #3 was chairfast and required two	C 301	provide or capable of providing. Registered Nurse assessed residents care needs and implemented Plan of Accommodation on residents needing higher level of care.. Resident #2 no longer resides in facility. Resident #3 to is receiving additional Nursing care and visits from Home Health Agency in coordination with facility care services. Resident #5 receiving Hospice services in to receive additional nursing visits and care until placement in Veteran Center to receive VA benefits later this month. Care Plan meeting with Resident #7 and Resident Family set up to discuss alternative placement options; increased staff assistance provided until alternative placement is made. Process for Director of Nursing to review activities of daily living documentation for increased level of care implemented for compliance in providing care in accordance with resident contract, excess services will be reviewed and addressed and	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/15/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W FREEMAN PERKINS, OK 74059		
(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 301	Continued From page 2 people for all personal care as the resident could not assist with her care. At 1:30 p.m., the resident was interviewed in her room. She was alert and oriented to self and place, but confused as to time. She was sitting in a wheelchair. A hospital bed, a shower chair and a toilet chair were all observed in her room. She stated it took two people to shower her. On 01/15/2020 at 1:30 p.m., LTCA/employee #2 stated resident #3 could not bear any weight and it required two people to shower, transfer and change the resident's briefs. Resident #4 Resident #4's responsible party signed the new contract on 11/27/19. Her assessment, dated 01/09/2020, documented the resident was chairfast, required staff to push her wheelchair, was incontinent and was unable to assist with brief changes. On 01/14/2020, the LPN stated resident #4 was chairfast, could not feed herself and required two people for all personal care as the resident could not assist with her care. On 01/15/2020 at 1:32 p.m., LTCA/employee #2 and CMA (certified medication aide)/employee #1 were observed putting the resident back to bed. They put a gait belt around the resident's waist and it took both of them to lift the resident using the gait belt and her waistband. The resident could not bear any weight. They changed the resident's brief. LTCA/employee #2 stated the resident has not been able to assist with any personal care or been able to bear weight for at least the last three to four weeks.	C 301	reviewed with Registered Nurse Consultant. 4. Director of Nursing will monitor care services in accordance with each Plan of Accommodation for compliance. Registered Nurse to review and monitor services provided according to Plan of Accommodation for compliance. Monthly monitoring of the reviews will be performed. Quality Assurance committee to review quarterly for compliance. All reviews will be documented to evidence the correction. 5. Completion Date: 2/8/2020	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/15/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W FREEMAN PERKINS, OK 74059		
(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 301	Continued From page 3 Resident #5 The resident's responsible party signed the new contract on 12/03/19. Resident #5's assessment, dated 12/10/19, documented the resident was chairfast, flaccid on the right side, was unable to self-propel his wheelchair, and required two people for all personal care as he was unable to assist with his care. On 01/14/2020, the LPN stated resident #5 was chairfast, could not self-propel his wheelchair and required two people for all personal care as the resident could not assist with his care. On 01/15/2020 at 2:25 p.m., LTCA/employee #2 stated resident #5 could be combative with care and it took two people for all personal care as the resident could not assist with his care. At 2:30 p.m., LTCA/employee #2 and CMA/employee #1 were observed transferring the resident from his recliner to his wheelchair and from his wheelchair to his bed. They put a gait belt around his waist and lifted him from his recliner using the gait belt and his waistband. Resident #5 was able to bear some weight, but could not pivot to sit in the wheelchair, so both staff pivoted him and sat him in the wheel chair. LTCA/employee #2 pushed the wheelchair to the bed and both employees picked the resident up under his arms and with the gait belt. The resident was unable to bear any weight this time. Both employees had to lay him on the bed. Resident #7 Resident #7's responsible party signed the new contract on 12/05/19. The resident's	C 301		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/15/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W FREEMAN PERKINS, OK 74059		
(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 301	Continued From page 4 assessment, dated 11/19/19, documented the resident was chairfast, could not bear weight, and required the assistance of two people for bathing, transferring and toileting. On 01/14/2020, the LPN stated resident #7 was chairfast, could not self-propel her wheelchair and required total care from staff as she could not assist with her care. On 01/15/2020, LTCA/employee #2 and CMA/employee #1 were observed transferring the resident from her wheelchair to the bedside commode. They put a gait belt around the resident's waist and the staff had to move the resident's feet from the wheelchair pedals to the floor as the resident could not move her feet. Both staff picked the resident up and transferred her to the bedside commode. The resident was unable to bear any weight. On 01/15/2020 at 3:00 p.m., the administrator stated none of the residents in the center had a plan of accommodation in place and stated the above residents were above the level of care as outlined in the new contract.	C 301		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled	C 911	C911 Nurse 1. Resident #1 assessed by Registered Nurse with no adverse effect noted from practice cited. Medication monitoring completed on Resident #1 by Registered Nurse. 2. All Residents have the potential to be affected by this practice. 3. Director of Nursing re-educated on nurse supervision of self-administration of medications. Action plan	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/15/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W FREEMAN PERKINS, OK 74059		
(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 911	Continued From page 5 nursing interventions; This Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the center failed to ensure registered nurse supervision of self-administration of medications for 1 (#1) of 1 sampled resident that self-administered medications. This had the potential for more than minimal harm, at a pattern. Findings: Resident #1 was admitted to the center 08/06/19 with an order to self-administer her medications. The most recent self-administration assessment was dated 12/06/19. No documentation of medication monitoring was included in the resident's record. On 01/15/2020 at 11:00 a.m., the LPN (licensed practical nurse) stated she had not monitored the resident's medication since she came to work at the center about four months ago and did not have any documentation that the resident's medications were monitored by the center before she came. At 3:15 p.m., the resident stated no one from the center monitored her medications. She also stated she ordered all her own medications from the pharmacy. Her medications were observed in a locked cabinet in her room.	C 911	implemented on Director of Nursing to include providing supervision of medications on residents whom self-administer medications. New Electronic Health Record implemented and monthly monitoring of medications on residents whom self-administer medications has been added as monthly nursing task. 4. Monthly medication review by registered nurse consultant implemented for compliance. Administrator will review the completion of medication oversight by registered nurse on a monthly basis for compliance. Quarterly monitoring of the reviews will be performed. Quality Assurance committee will review for compliance. All reviews will be documented to evidence the correction.	
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document	C1951	5. Completion Date: 2/5/2020	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/16/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 216 W FREEMAN PERKINS, OK 74059		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1951	Continued From page 6 all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to ensure wound care was documented for 1 (#2) of 1 sampled resident who had physician ordered wound care. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 01/14/2020 at 11:30 a.m., a resident report was received from the LPN (licensed practical nurse). She stated resident #2 was only oriented to self, was chairfast, required the assistance of two people for all activities of daily living, had a wound to her right foot and was on hospice. At 1:30 p.m., the hospice nurse was observed providing wound care. The wound was to the resident's right outside foot near the last toe. It was approximately the size of a nickel. There were two areas of eschar (black scabbing) and scant amount of active bleeding. The hospice nurse stated the wound was dressed three times weekly and the center's nurse did the wound dressing on the days when hospice did not see the resident. The center's records for resident #2 were reviewed and no documentation of wound care was found. At 4:20 p.m., the center's LPN was asked how often she did wound care for resident #2. She	C1951	C1951 Maintenance of Records 1. Resident #2 no longer resides in facility. Reeducation provided to Director of Nursing/Licensed Nurse on proper documentation of nursing services provided to residents consistent with professional standards of practice. 2. All Residents have the potential to be affected by this practice. 3. Director of Nursing re-educated on resident records containing documentation on all services provided under the direction of a licensed health care professional consistent with professional standards of practice. New electronic health record implemented to assist with scheduled treatments and documentation for services provided to residents by licensed health care professional. Wound care documentation will be reviewed by registered nurse for completion.	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/15/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W FREEMAN PERKINS, OK 74059		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1951	Continued From page 7 stated she had done the wound care once a week since the wound care order was changed on 11/20/19. She was asked for the wound care documentation. She stated she did not document the wound care because the software the center used did not allow her to.	C1951	4. Consulting registered nurse to audit completion of wound documentation for compliance. Administrator to review documentation of wound care for compliance. Monthly monitoring of the reviews will be performed by Registered Nurse consultant and Quality Assurance committee will review for compliance. All reviews will be documented to evidence the correction. 5. Completion Date: 2/5/2020	
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/15/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W FREEMAN PERKINS, OK 74069		
(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
C5010	Continued From page 8 This Rule is not met as evidenced by: Based on interview, and record review, it was determined the center failed to ensure third party staff providing sitter services were from a licensed agency, had current credentials, or had a current background check while providing services for 1 (#4) of 1 sampled resident that utilized the services of a private sitter. This failed practice had the potential for more than minimal harm at a pattern. Findings: A verbal report on the residents was received from the center's LPN (licensed practical nurse) on 01/14/2020. She stated none of the residents had a private sitter but resident #4 had sitters the family hired through a licensed agency. On 01/15/2020 at 12:20 p.m., a woman in street clothes was observed feeding resident #4. CMA (certified medication aide)/employee #1 was asked who was feeding resident #4. She stated her private sitter was feeding her. CMA/employee #1 said the sitter came four days per week to assist the resident and had come four days per week since the resident was admitted 08/30/19. At 12:30 p.m., the sitter stated the family hired her to come four days a week. She was asked what she did for the resident. She stated she could not do much for her as she was not a	C5010	C5010 Care and Services – Coordination of Care 1. Resident #4 assessed by Registered Nurse with no adverse effect noted from practice cited. Family friend instructed not to provide care to resident. Family notified and re-educated on policy for licensed agencies and center staff only allowed to provide care for residents. 2. All Residents have the potential to be affected by this practice. 3. All Staff re-educated on home care services and intermittent periodic, or recurrent nursing care through a licensed home care agency. Staff re-educated on monitoring the delivery of those services from licensed agencies. Family re-educated on third party care givers being from a licensed agency. Residents and Families educated upon admission of third-party care providers being only from a licensed agency. Coordination of Care	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/15/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W FREEMAN PERKINS, OK 74059		
(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
C5010	Continued From page 9 certified long term care aide because she let that certification go a long time ago. She said she just does private care now for different clients. At 12:32 p.m., the administrator was asked about the private sitter for resident #4. She stated the sitter was employed by an agency. She was asked for a background check for the sitter. She provided a small stack of background checks, but the sitter's name was not on any of the background checks. The administrator was informed the sitter said she was not hired through an agency. The administrator stated she was not aware this sitter was not hired through an agency because the family assured her all the sitters that they hired were through an agency. The administrator said she would need to go ask the sitter to leave.	C5010	Record implemented for private care sitters. All private care givers required to wear a name tag from licensed agency and sign in upon arrival. All staff to monitor visitors and outside care providers. 4. Director of Nursing will monitor private care givers on a daily basis for compliance. Administrator to monitor visitors and third-party providers for compliance. Monthly monitoring of the reviews will be performed and Quality Assurance Committee to review for compliance. All reviews will be documented to evidence the correction. 5. Completion Date: 2/5/2020	



Oklahoma State Department of Health
Creating a State of Health

March 11, 2020

License Number: AL6006

Mr. David Bilby, Administrator
Red Bud Assisted Living
215 W Freeman
Perkins, OK 74059

RE: Survey Event F5ZE12

Dear Mr. Bilby:

On **March 2, 2020**, a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 15, 2020**, have now been corrected effective **February 5, 2020**.

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

Sincerely,

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
Becky Payton (*Secretary*)

Jenny Alexopoulos, DO
Terry R Gerard II, DO
Charles W Grim, DDS, MHSA

R Murali Krishna, MD
Ronald D Osterhout
Charles Skillings

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/02/2020
NAME OF PROVIDER OR SUPPLIER RED BUD ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 215 W FREEMAN PERKINS, OK 74059			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{C 000}	INITIAL COMMENTS A follow up survey was completed on 03/02/2020. Census was 14. Deficient practice was cleared.	{C 000}			

Oklahoma State Department of Health

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

TITLE

(X6) DATE

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name RED BUD ASSISTED LIVING		
Type of Survey (select all that apply)	A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit M Other	E Initial Certification F Inspection of Care G Validation H Life Safety Code	I Recertification J Sanctions/Hearing K State License L CHOW
D D L			
Extent of Survey (select all that apply)	A Routine/Standard Survey (all providers/suppliers) B Extended Survey (HHA or Long Term Care Facility) C Partial Extended Survey (HHA) D Other Survey		
A			

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID <i>ML</i> 41872	03/02/2020	03/02/2020	2.00	0.00	2.50	0.00	4.00	0.50
2.								
3.								
4.								
5.								
6.								
7.								
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11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....	0.00	Total RO Supervisory Review Hours.....	0.00
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Total SA Clerical/Data Entry Hours.....	0.00	Total RO Clerical/Data Entry Hours.....	0.00
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Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No