OKLAHOMA
State Department
of Health

Delivery via email to: admin@redbudassistedliving.com

April 13, 2023

License Number: AL6006

Mr. Jaden Chappell, Administrator
Red Bud Assisted Living
215 W Freeman
Perkins, OK 74059

RE: Survey Event ID: IFJB11

Dear Mr. Chappell:

On **March 31, 2023**, agents from our office concluded a State Licensure survey in conjunction with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **March 31, 2023**.

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

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

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

(1) Address how corrective action will be accomplished for affected residents;

(2) Address how other residents with the potential to be affected will be identified;

(3) Address measures or systemic changes to ensure the deficiency will not recur;

(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;

(5) Include dates when corrective action and monitoring will be completed for each violation;

(6) Be signed by the administrator.

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

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

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

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

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

be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Red Bud Assisted Living**
Address: **215 West Freeman**
City, State, Zip: **Perkins OK 74059**
Provider #: **AL6006**
Complaint #: **OK00060219**
Investigation Dates: **03/29/23 and 03/31/23**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to protect residents from misappropriation of property.	**US**
2. The center failed to ensure medications were administered as per physician's orders.	**US**
3. The center failed to follow infection prevention/control policies and procedures.	**S**

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 03/29/2023 at 2:00 p.m.

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

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

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to misappropriation of property was conducted.

Resident council, incident reports, employee handbook and clinical records were reviewed at the time of the survey.

Resident's apartments were observed and contained personal belongings. A daybed was observed in an apartment that had recently belonged to a discharged resident.

Residents stated the staff had not taken any of their personal property. Staff stated they had not received any personal belongings of value from the residents or resident family members. Staff stated they had purchased the daybed from a former resident's family who stated they were not able to transport the bed from the center. The staff stated they were leaving the daybed at the center.

A resident's family member stated they were throwing away two chairs which were in their family member's apartment and had offered them to a staff member. They stated they were not worth any value.

At the time of the survey no deficiency was found related to misappropriation.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

Medication administration records, physician's orders, and incident reports were reviewed at the time of the survey.

Medications were observed being administered as ordered.

Residents stated they received their medications as ordered by the physician. Staff stated they administered medications according to the physician's orders.

At the time of the survey no deficiency was found related to medication administration.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Deficient practice was substantiated for allegation #3. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Billie Seeman, RN

Date report completed: 04/10/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6006	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED BUD ASSISTED LIVING	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 relicensure survey was conducted on 03/29/23 and 03/31/23. A complaint investigation (#OK00060219) was conducted in conjunction with the survey.	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the center failed to maintain the kitchen in accordance with Chapter 257 Food Service Establishment Regulations to ensure: a. the kitchen was clean and sanitary; b. frozen food was sealed to protect from contaminates including freezer burn; and c. the commercial grade can opener was clean and in good repair. The administrator identified 10 residents who resided in the assisted living center. Findings: The undated "Food Storage, Preparation and Services" policy, read in parts, "...Food Preparation...All food contact surfaces and utensils will be clean to prevent cross-contamination and food borne illness..." The "Dietary Consultant Review", dated 03/18/22,	C 391		

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C 391	Continued From page 1 read in parts, " ...Kitchen is sanitary; floor, stove, oven ...Stove/griddle needs cleaning ..." The "Dietary Consultant Review", dated 12/02/22, read in parts, " ...Freezer - Opened items not in sealed container ...Place in sealed container ..." "...310:257-5-37 Food storage...food shall be protected from contamination by storing the food...Where it is not exposed to splash, dust, or other contamination ...310:257-7-19 Can openers...Cutting or piercing parts of can openers shall be readily removable for cleaning and for replacement ...310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (a)...Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris..." On 03/29/23 at 2:15 p.m. a tour of kitchen was conducted. The following was observed: a. Both ovens were dirty with black dried on food and debris; b. The stove was dirty with black dried on food; c. The grill was dirty and had food debris; d. Food crumbs and stains were observed in drawers; e. The can opener was dirty and discolored; f. The window blinds had were dirty and sticky; and g. A bag of frozen chicken strips was not sealed	C 391		

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C 391	Continued From page 2 in the freezer. On 03/29/23 at 2:54 p.m., the dietary supervisor stated the stove, ovens, and grill were dirty and needed to be cleaned. The dietary supervisor stated the discolored areas in the drawers with the pans was from the cooking spray and the debris in the drawers needed to be cleaned. The dietary supervisor stated the can opener should be cleaned after each use and the blade may need to be replaced. The dietary supervisor stated the blinds in the kitchen were cleaned every six months. The dietary supervisor stated the frozen chicken strips should have been sealed before they were placed back in the freezer after they had been opened.	C 391		
C 393 SS=D	310:663-3-8(c) FOOD PREPARTION, STORAGE AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours. This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure potentially hazardous foods were disposed of in 24 hours.	C 393		

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C 393	Continued From page 3 The administrator identified 10 residents who resided in the center. Findings: The undated "Food Storage, Preparation and Services" policy, read in part, "...Leftovers that are potentially hazardous foods will be used, or disposed of, within twenty-four (24) hours..." The menu, dated 03/26/23, documented roast, carrots and potatoes were served for lunch. On 03/29/23 at 2:15 p.m., a container labeled as "Stew" dated 03/26/23 was observed in the refrigerator. On 03/29/23 at 2:54 p.m., the dietary supervisor stated they used the left-over roast, and added carrots, potatoes, stewed tomatoes, corn, green beans, peas, and tomato sauce to make the stew. The dietary supervisor stated the stew was served for supper on 03/26/23. The dietary supervisor stated the stew was considered a potentially hazardous food and should have been discarded.	C 393		
C1505 SS=E	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	C1505		

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C1505	Continued From page 4 medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure the blood pressure cuff was disinfected between residents for two (#5 and #8) of three sampled residents who were observed to have their blood pressure obtained during a medication administration pass. The administrator identified 10 clients who resided in the center. Findings:	C1505		

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C1505	Continued From page 5 The "Cleaning/Disinfecting Multi-Resident Use Equipment" policy, dated 12/2022, read in parts, "...Resident-care equipment can be source of indirect transmission of pathogens/infections. Reusable resident-care equipment must be cleaned and disinfected between each resident use...Examples include...blood pressure cuffs..." On 03/31/23 at 7:14 a.m., LPN (Licensed Practical Nurse) #1 obtained Resident #7's blood pressure. The LPN placed the blood pressure cuff on the top of the medication cart without cleaning or disinfecting the blood pressure cuff after use. On 03/31/23 at 7:45 a.m., LPN #1 obtained Resident #8's blood pressure without cleaning or disinfecting the blood pressure cuff prior to or after obtaining the resident's blood pressure. On 03/31/23 at 7:49 a.m., LPN #1 obtained Resident #5's blood pressure without cleaning or disinfecting the blood pressure cuff prior to or after obtaining the resident's blood pressure. On 03/31/23 at 10:45 a.m., LPN #1 stated the blood pressure cuff should have been cleaned between each resident. LPN #1 stated they forgot to clean the blood pressure cuff between the residents.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: admin@redbudassistedliving.com

April 24, 2023

License Number: AL6006

Mr. Jaden Chappell, Administrator
Red Bud Assisted Living
215 W Freeman
Perkins, OK 74059

Survey Event ID: IFJB11

Dear Mr. Chappell:

On **March 31, 2023,** a Licensure survey and a complaint investigation were conducted at your Assisted Living Center. 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 have been corrected and you were in substantial compliance by **April 22, 2023**.

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

Respectfully,

Tempal Killman

Digitally signed by
Tempal Killman
Date: 2023.04.24 15:21:11
-05'00'

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

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure survey was conducted on 03/29/23 and 03/31/23. A complaint investigation (#OK00060219) was conducted in conjunction with the survey.	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.	
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the center failed to maintain the kitchen in accordance with Chapter 257 Food Service Establishment Regulations to ensure: a. the kitchen was clean and sanitary; b. frozen food was sealed to protect from contaminates including freezer burn; and c. the commercial grade can opener was clean and in good repair. The administrator identified 10 residents who resided in the assisted living center. Findings: The undated "Food Storage, Preparation and Services" policy, read in parts, "...Food Preparation...All food contact surfaces and utensils will be clean to prevent cross-contamination and food borne illness..." The "Dietary Consultant Review", dated 03/18/22,	C 391	**C391 FOOD STORAGE, PREPARATION AND SERVICE** Both ovens and stove have been cleaned from food and debris. The grill has been cleaned. All drawers were cleaned and removed all crumbs. The can opener has been cleaned and new blade ordered. New window blinds have been ordered and all food has been sealed in refrigerator and freezer. All residents have the potential to be affected by this practice. Dietary staff educated on the policies and procedures regarding keeping all food-contact surfaces and non-food contact surfaces in dietary department clean to sight and touch. Education included the cooking equipment, pans and nonfood contact surfaces shall be kept free of accumulation of dust, dirt, food and debris. Dietary staff educated on the labeling and sealing of frozen food to protect from	

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C 391	Continued From page 2 in the freezer. On 03/29/23 at 2:54 p.m., the dietary supervisor stated the stove, ovens, and grill were dirty and needed to be cleaned. The dietary supervisor stated the discolored areas in the drawers with the pans was from the cooking spray and the debris in the drawers needed to be cleaned. The dietary supervisor stated the can opener should be cleaned after each use and the blade may need to be replaced. The dietary supervisor stated the blinds in the kitchen were cleaned every six months. The dietary supervisor stated the frozen chicken strips should have been sealed before they were placed back in the freezer after they had been opened.	C 391	**C393 FOOD PREPARATION, STORAGE, AND SERVICE** All leftovers that are potentially hazardous have been disposed from refrigerator. All non-hazardous leftovers have been disposed from dietary department. Refrigerator has been cleaned and all potentially hazardous foods over 24 hours of use, and all non-potentially hazardous foods over 48 hours of use, have been removed. All residents have the potential to be affected by this practice. Dietary staff has been educated on the importance of following policies and protocols regarding leftovers. Dietary staff educated on process of all leftovers that are potentially hazardous shall be used, or disposed of withing twenty-four (24) hours. All non-potentially hazardous shall be used or disposed within 48 hours. Dietary supervisor will monitor daily for compliance.	
C 393 SS=D	310:663-3-8(c) FOOD PREPARTION, STORAGE AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours. This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure potentially hazardous foods were disposed of in 24 hours.	C 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6006	A. BUILDING: _____ B. WING _____	03/31/2023

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 393	Continued From page 3 The administrator identified 10 residents who resided in the center. Findings: The undated "Food Storage, Preparation and Services" policy, read in part, "...Leftovers that are potentially hazardous foods will be used, or disposed of, within twenty-four (24) hours..." The menu, dated 03/26/23, documented roast, carrots and potatoes were served for lunch. On 03/29/23 at 2:15 p.m., a container labeled as "Stew" dated 03/26/23 was observed in the refrigerator. On 03/29/23 at 2:54 p.m., the dietary supervisor stated they used the left-over roast, and added carrots, potatoes, stewed tomatoes, corn, green beans, peas, and tomato sauce to make the stew. The dietary supervisor stated the stew was served for supper on 03/26/23. The dietary supervisor stated the stew was considered a potentially hazardous food and should have been discarded.	C 393	Administrator/Designee will monitor three times weekly and audit the use or disposing of leftovers within appropriate timeframes. Results of this monitoring will be documented and reviewed in the quarterly QAA meeting. Completion Date: 4/22/2023	
C1505 SS=E	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	C1505	**C 1505 RESIDENT RIGHTS – MEDICAL CARE** Resident #7, #8 and #5 have been assessed by Registered Nurse with no adverse effect noted from practice cited. Blood pressure cuff immediately sanitized. LPN #1 re-educated and skills checked on Infection control practices for sanitizing blood pressure cuff between each resident during medication pass.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 4 medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure the blood pressure cuff was disinfected between residents for two (#5 and #8) of three sampled residents who were observed to have their blood pressure obtained during a medication administration pass. The administrator identified 10 clients who resided in the center. Findings:	C1505	All Residents have the potential to be affected by this practice. Licensed nurses, certified medication aides and medication administration technicians re-educated on maintaining infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections to include cleaning and sanitizing blood pressure cuffs between each resident during medication pass. RN Consultant or designee to randomly audit four times weekly blood pressure cuffs cleaned and sanitized between each resident during medication pass. Results of this monitoring will be documented and reviewed in quarterly QA meeting. **Completion Date: 4/22/23**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1505	Continued From page 5 The "Cleaning/Disinfecting Multi-Resident Use Equipment" policy, dated 12/2022, read in parts, "...Resident-care equipment can be source of indirect transmission of pathogens/infections. Reusable resident-care equipment must be cleaned and disinfected between each resident use...Examples include...blood pressure cuffs..." On 03/31/23 at 7:14 a.m., LPN (Licensed Practical Nurse) #1 obtained Resident #7's blood pressure. The LPN placed the blood pressure cuff on the top of the medication cart without cleaning or disinfecting the blood pressure cuff after use. On 03/31/23 at 7:45 a.m., LPN #1 obtained Resident #8's blood pressure without cleaning or disinfecting the blood pressure cuff prior to or after obtaining the resident's blood pressure. On 03/31/23 at 7:49 a.m., LPN #1 obtained Resident #5's blood pressure without cleaning or disinfecting the blood pressure cuff prior to or after obtaining the resident's blood pressure. On 03/31/23 at 10:45 a.m., LPN #1 stated the blood pressure cuff should have been cleaned between each resident. LPN #1 stated they forgot to clean the blood pressure cuff between the residents.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: admin@redbudassistedliving.com

June 1, 2023

License Number: AL6006

Mr. Jaden Chappell, Administrator
Red Bud Assisted Living
215 W Freeman
Perkins, OK 74059

RE: Survey Event IFJB12

Dear Mr. Chappell:

On **May 31, 2023,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 31, 2023,** have now been corrected effective **April 22, 2023.**

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

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	AL6006	A. BUILDING: _____ B. WING _____	R-C 05/31/2023

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{C 000}	INITIAL COMMENTS A revisit was conducted on 05/31/23. All deficiencies from the 03/31/23 survey were cleared.	{C 000}		

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