
Delivery via email to: nathan.raith@claremoreokla.com; Linda.Pearce@BridgesOK.com

June 14, 2023

License Number: AL6602

Mr. Nathan Raith, Administrator
The Courtyards At Claremore Assisted Living Memory
915 East 16th Street
Claremore, OK 74017

RE: Survey Event ID: QR5F11

Dear Mr. Raith:

On **June 1, 2023**, agents from our office concluded a State Licensure survey with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on June 1, 2023.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT

Facility: The Courtyards at Claremore Assisted Living
Address: 915 East 16th St
City, State, Zip: Claremore, OK, 74017
Provider #: AL6602
Complaint #: OK00060626
Investigation Date(s): 05/31/23 and 06/01/23

ALLEGATION(S)

1. The center failed to ensure residents were not abused or subjected to intimidation by staff members.

An unannounced on-site investigation was initiated 05/31/2023 at 7:05 a.m.

A sample of eight 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 Summary of Complaint Investigation:

Tours of the facility was conducted upon entrance and at other various times throughout the survey. Resident hallways were observed for staff assistance with resident care needs. Staff and resident interactions were observed.

Incident reports, including state reportable incidents were reviewed. Staff training records related to abuse and abuse prohibition were reviewed. Resident records including assessments, care plans, physician orders, nursing notes, and resident agreements sheets were reviewed. Policy and procedures were reviewed.

Residents and family members were interviewed regarding if they felt safe at the facility, had experienced any abuse or neglect, and/or had experienced any intimidation from staff members. Staff members were interviewed regarding the facility's policy regarding abuse and intimidation.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Gladys Rosann
Dosch

Digitally signed by Gladys
Rosann Dosch
Date: 2023.06.02 11:48:38 -05'00'

G. Rose Dosch RN

Date report completed: 06/02/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/01/2023
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C 000	INITIAL COMMENTS A relicensure survey was conducted on 05/31/23 through 06/01/23. A complaint investigation (#OK00060626) was conducted in conjunction with the survey. Listed below are the abbreviations that will be used throughout this survey. CMA - certified medication aide CNA - certified nurse aide DA - dietary aide DM - dietary manager DON - director of nursing LED - life enrichment director OSDH - Oklahoma State Department of Health Res - resident RN- registered nurse	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure food was stored, prepared, and served in a sanitary manner. The "Resident list Report" documented 44 residents resided in the facility. Findings: 1. On 05/31/23 at 7:36 a.m., during the initial tour	C 391		

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

TITLE

(X6) DATE

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C 391	Continued From page 1 of the kitchen, Cook #1 was making French toast and observed wearing rings and a bracelet while cooking. They did have gloves on. The freezer was observed and had debris observed on the floor of the freezer. The door handles to the freezer and refrigerator was observed to have hand prints, and a sticky substance on the handles. The refrigerator was observed to have a large metal bowl covered with foil. The bowl was not labeled as to the contents or the date prepared. Sliced tomatoes in a large resealable bag was observed with the date of 05/26. On 05/31/23 at 7:42 a.m., an unlabeled package of what appeared to be uncooked bacon, was observed on the bottom of the refrigerator. A large container of tomato paste was observed in the refrigerator with a label date documenting "prepared on 05/15/15." An unlabeled large plastic tub with foil on the top contained what appeared to be applesauce. At that time, the LED came up to the surveyor and provided some paperwork. The LED did not have on a hair net and had passed through the food prep area. An opened package of ham slices were observed in an unlabeled resealable plastic bag which was laying on top of a bag of shredded cheese. A large gray garbage can was observed out of the food prep area in the refrigerator area near the back door. The lid to the garbage can was tied to the can and was sitting off the can. On 05/31/23 at 7:49 a.m., the DM entered the kitchen wearing a ball cap and washed her hands. The DM stated the facility kept left overs for three days. They were shown the items in the refrigerator and stated the small bag of bacon should not have been in there and tossed it. The DM stated the applesauce and salad should have had a date on it but it would have been tossed in	C 391		

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C 391	Continued From page 2 three days. The DM stated the sliced tomatoes were from a cook-out last weekend and should have been thrown out. The DM stated the tomato paste could be kept longer due to the acidity but did not know how long. The DM stated everything should have a label and should be disposed of in three days. The DM stated the ham should not have been placed on top of the shredded cheese. 2. On 05/31/23 at 11:28 a.m., lunch preparation and service was observed. Cook #1 had long painted nails. Cook #1 had on a hair net but it was not covering all of their hair in the front and had a strand on long hair on the left side touching her shoulder. The vents on the ceiling in the kitchen were observed to contain a large amount of dust on and around the vents. On 05/31/23 at 11:32 a.m., Cook #1 was observed to touch their face, touch the trash can lid, and then place gloves on their hands and dipped up pears into bowls for dessert. Cook #1 opened a honey bun and placed it in a bowel while wearing the same gloves. Cook #1 then removed the gloves, touched the trash can lid place on an oven mitt and checked the corn bread which was baking in the oven. Cook #1 placed the other mitt on the other hand and moved the potatoes in the oven, then washed her hands. On 05/31/23 at 11:41 a.m., Cook #1 removed their gloves and touched the trash can lid and ear, got a container from a shelf, drained the juice from the can of pears, then touched the trash can lid, and put new gloves on. Hand washing was not observed before Cook #1 placed on new gloves and dipped the remaining pears into the container.	C 391		

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C 391	Continued From page 3 On 05/31/23 at 11:47 a.m., Cook #1 wiped their eye after making a labeled for the pears and placing the container in the refrigerator. Cook #1 moved the pears in the bowls over by the steam table, scratched their back, placed the oven mitts on their hands and emptied the pot of greens into a container on the steam table. Cook #1 set the pot of brown beans on the counter by the steam table, touched the door handle to the janitor closet went in and the brought a cleaning pad and a pitcher to the two compartment sink and hand washed it with dish soap. Cook #1 dried their hands with paper towels and placed gloves on. Cook #1 then used the pitcher to dip into the beans and transfer the beans into a container on the steam table. Cook #1 did not sanitized the pitcher before use. On 05/31/23 at 11:50 a.m., Cook #1 was observed to obtain food temperatures by wiping the thermometer with a paper towel between foods. Cook #1 then touched the trash can lid with gloved hand and then with un-gloved hand. She then put on oven mitts retrieved the potatoes from the oven and took the temperature of the potatoes. Hand washing was not observed. Cook #1 placed gloves on hands touched multiple seasonings on the shelf, then placed the oven fried potatoes into a container on the steam table with her gloved hands. On 05/31/23 at 11:54 a.m., DA #1 was observed to come into the kitchen and get a gallon of milk they took to the milk to the dining room, then returned to the kitchen and placed the milk back in the refrigerator. The DA did not wash their hands when they entered the kitchen. On 05/31/23 at 11:55 a.m., after Cook #1 washed	C 391		

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C 391	Continued From page 4 her hands they scratched the side of their face, opened the seasoning salt, place gloves on their hands, put the seasoning salt on the potatoes, and tossed the potatoes with their gloved hands at the steam table. On 05/31/23 at 12:02 p.m., Cook #1 started plating food for the memory care unit. Cook #1 was observed to touch their face with gloved hand and held small bowls against clothing to take over to the steam table. Cook #1 was observed to touch the plate surfaces, the inside of the bowls, and the corn bread with her gloved hands as she served the meal multiple times. Cook #1 did not remove gloves and wash her hands after touching her face. On 05/31/23 at 12:13 p.m., DA #1 returned to the kitchen, hand washing was not observed, DA #1 retrieved a bin off the shelf and left the kitchen. On 05/31/23 at 12:18 p.m., Cook #1 returned from taking the meals to the memory unit. Cook #1 was observed to wash her hands and then touched the trash can lid, the cook then placed gloves on hands then touched the paper cards for the resident meal request which were in the window pass of the kitchen then started serving the lunch meals for the resident who were in the dining room. Cook #1 was observed to touch the eating surfaces of the plates and bowls while serving the food. On 05/31/23 at 12:24 p.m., Cook #1 was observed moving plates and bowls with the items touching the cook's clothing. On 06/01/23 at approximately 10:00 a.m., the DM stated the staff could not wear dangling jewelry but rings were not a problem. The DM stated	C 391		

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C 391	Continued From page 5 hand washing should be performer anytime you remove your gloves or anytime you touch something dirty. The DM stated the first thing you do was wash your hands when you enter the kitchen and a hair net or ball cap should be worn to cover the hair. The DM stated the dishes should not be held against clothing. The DM stated all things in the refrigerator should have a date and label. The DM stated should not touch food with bare hands or gloved hand unless it was clean glove. The DM stated the maintenance person cleaned the vents and it had been a while since the vents were cleaned. The DM stated all the dishes should be washed and sanitized before use.	C 391		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure admission assessments were completed within 30 days for one (#1) of eight sampled residents whose assessments were reviewed. The "Resident List Report" documented 44 residents resided in the facility.	C 521		

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C 521	Continued From page 6 Findings: A review of Res #1 records documented the resident was admitted on 12/05/23. The clinical records did not contain an admission assessment. On 06/01/23 at 11:23 a.m., the DON stated she could not locate the admission assessment.	C 521		
C 522 SS=E	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 facility failed to: a. complete an annual comprehensive assessment within 14 days after admission for three (#6, 7, and #8) of eight sampled residents reviewed for assessments and, b. complete an annual comprehensive assessment every 24 months for one (#8) of eight sampled resident whose assessments were reviewed.	C 522		

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C 522	Continued From page 7 1. Res #6 was admitted to the facility on 03/26/23 with diagnoses which included hypertensive heart disease, arterial fibromuscular depolarization, bradycardia, and osteoarthritis of knee. An assessment dated 04/11/23, was not marked what kind of assessment it was. The assessment was not completed within the 14 day required time frame. On 06/01/23 at 9:45 p.m., the DON stated the assessment would have been the 14 day comprehensive assessment and it was not completed within the time window. 2. Res #7 admitted to the facility on 04/28/23 and had diagnoses which included type two diabetes mellitus, gout, and hypertension. Review of the resident's clinical record did not contain a comprehensive assessment. On 06/01/23 at 12:22 p.m. the DON was asked if the resident had a comprehensive assessment. The DON stated if the resident had a 14 -day comprehensive assessment it would be in the chart. After the DON looked in the chart the DON stated the chart did not contain the assessment. 3. Res #8 admitted to the facility 03/04/22 and had diagnoses which included heart failure, hypertension, and pain. Review of the resident record did not contain an admission assessment or an annual assessment for 2023. On 06/01/23 at 1:47 p.m., the DON stated the comprehensive admission assessment and	C 522		

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C 522	Continued From page 8 annual assessment should be in the chart if they had been completed. She stated the resident had been in the facility long enough for an annual assessment.	C 522		
C 531 SS=E	310:663-5-3(a) ASSESSMENT FORM (a) The admission assessment form shall include but not be limited to the following: (1) resident's identification; (2) disease diagnosis/infections; (3) mental health history, and mental retardation or developmental disability; (4) physical functioning which includes the numbers of persons needed to assist with activities of daily living; (5) incontinence; (6) medications; (7) special treatment and procedures; (8) cognitive function; and (9) signatures and dates. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the resident assessments documented the required components for three (#1, 7, and #8) of eight residents whose records were reviewed. The "Resident list Report" documented 44 residents resided in the facility.	C 531		

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C 531	Continued From page 9 Findings: 1. Res #1 was admitted on 12/05/23. The admission assessment, dated 01/04/23, did not document a signature from the coordinating RN or physician. On 06/01/23 at 11:23 a.m., the DON confirmed the assessment should have been signed by the RN. 2. Res #7 was admitted on 04/28/23. The admission assessment, dated 04/28/23, did not contain the required eight components. On 06/01/23 at 12:42 p.m., the DON stated the admission assessment was not complete. The cognitive function should have been completely filled out. 3. Res #8 was admitted on 03/05/22. The admission assessment, dated 03/05/22, did not contain the resident or resident representatives signature or date. On 06/01/23 at 1:47 p.m., the DON stated the assessment should have a signature and date for the resident.	C 531		
C 532 SS=D	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine;	C 532		

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C 532	Continued From page 10 (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive assessments contained the required components for one (#6) of eight sampled residents. The "Resident list Report" documented 44 residents resided in the facility. Findings: A preadmission assessment, dated 02/24/23, documented the residents was alert oriented times three, forgetful, with good judgment. The resident used a walker and cane for ambulation. The assessment documented Res #6 required assistance with bathing, dressing, transferring, toileting, and ambulation. Res #6 was admitted to the facility on 03/26/23	C 532		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER THE COURTYARDS AT CLAREMORE ASSISTED LIVIN			STREET ADDRESS, CITY, STATE, ZIP CODE 915 EAST 16TH STREET CLAREMORE, OK 74017		
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C 532	Continued From page 11 with diagnoses which included hypertensive heart disease, arterial fibromuscular depolarization, bradycardia, and osteoarthritis of knee. An assessment, dated 04/11/23, was not marked what kind of assessment it was. The assessment was also not complete with the required components. The mental/cognitive functional status was not completed. The mental health section was blank. The physical functional status section was blank. The oral/nutritional status was not complete and physical impairments was blank. On 06/01/23 at 9:45 p.m., the DON stated the assessment would have been the comprehensive admission assessment and it was not completed in the time window nor was the assessment completed with all the areas filled out. She stated the resident went on palliative care and she probably combined the 14 day and a significant change on 04/11/23.	C 532			
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the facility	C 954			

Oklahoma State Department of Health

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C 954	Continued From page 12 failed to ensure recently hired direct care staff were trained in first aide for two (CMA #1 and CNA #1) of two direct care staff whose training records were reviewed. The "Resident list Report" documented 44 residents resided in the facility. Findings: CMA #1's employee file, who was hired on 01/25/23, did not have documentation of first aide training. CNA #1's employee file, who was hired on 04/20/23, also did not have documentation of first aide training. On 05/31/23 at 5:00, the administrator stated they did not know if first aide was offered to the staff and would have to check. On 05/31/23 at 5:19 p.m., the DON stated first aide should be up to date on everyone but did not know where this documentation was kept. On 06/01/23 at 2:35 p.m., the administrator stated the staff members who were reviewed for first aide training had not had the training.	C 954		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) 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	C1911		

Oklahoma State Department of Health

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C1911	Continued From page 13 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 facility failed to ensure allegations of abuse were reported to OSDH made via facsimile or by telephone within one Department business day of the reportable incident's discovery. The DON stated one allegation of abuse had occurred in the previous six months. Findings: A facility policy, titled "Allegations of Abuse to be Reported within 2 hours" dated 07/31/18 read in part, "...C. Director of Nursing/Administrator do initial state report, send in any staff to Nursing/CNA Board if applicable within 2 hours..."	C1911		

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C1911	Continued From page 14 The investigation timeline, provided by the DON, for the incident dated 04/28/23, documented the allegation of abuse had been reported to the DON on 04/25/23. The facsimile transmission report, dated 04/28/23 at 2:54 p.m., documented the report had been successfully received by OSDH. On 05/31/23 at 10:15 a.m., the DON stated Res #1 no longer resided at the facility. The DON stated they were unaware at the time that any abuse allegations had to be reported immediately per the facility policy and subsequently did not report it for three days.	C1911		

Delivery via email to: Linda.Pearce@BridgesOK.com; Nathan.Raith@ClaremoreOkla.com

June 30, 2023

License Number: AL6602

Mr. Nathan Raith, Administrator
The Courtyards At Claremore Assisted Living Memory
915 East 16th Street
Claremore, OK 74017

Survey Event ID: QR5F11

Dear Mr. Raith:

On **June 1, 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 will be corrected and you will be in substantial compliance by **June 29, 2023**.

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

Respectfully,

Tempal Killman

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

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Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure survey was conducted on 05/31/23 through 06/01/23. A complaint investigation (#OK00060626) was conducted in conjunction with the survey. Listed below are the abbreviations that will be used throughout this survey. CMA - certified medication aide CNA - certified nurse aide DA - dietary aide DM - dietary manager DON - director of nursing LED - life enrichment director OSDH - Oklahoma State Department of Health Res - resident RN - registered nurse	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure food was stored, prepared, and served in a sanitary manner. The "Resident list Report" documented 44 residents resided in the facility. Findings: 1. On 05/31/23 at 7:36 a.m., during the initial tour	C 391	How will the corrective action be accomplished for the residents cited? The facility will ensure food is stored, prepared and served in a sanitary manner. The areas identified will be cleaned and maintained in a sanitary manner. The Dietary Manager will monitor daily to ensure appropriate storage of food, use of hair nets, hand washing technique and use of gloves. How will the facility identify other residents having the potential to be affected by this problem? There were 44 residents identified residing in the facility. Inservice was scheduled for 6-21-23 regarding kitchen sanitation, the cleaning schedule, proper wearing of hair nets, hand washing technique and appropriate use of gloves and will continue through 6-30-23 as needed.	

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

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QR5F11

TITLE
Administrator

(X6) DATE

6-23-23

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C 391	Continued From page 1 of the kitchen, Cook #1 was making French toast and observed wearing rings and a bracelet while cooking. They did have gloves on. The freezer was observed and had debris observed on the floor of the freezer. The door handles to the freezer and refrigerator was observed to have hand prints, and a sticky substance on the handles. The refrigerator was observed to have a large metal bowl covered with foil. The bowl was not labeled as to the contents or the date prepared. Sliced tomatoes in a large resealable bag was observed with the date of 05/26. On 05/31/23 at 7:42 a.m., an unlabeled package of what appeared to be uncooked bacon, was observed on the bottom of the refrigerator. A large container of tomato paste was observed in the refrigerator with a label date documenting "prepared on 05/15/15." An unlabeled large plastic tub with foil on the top contained what appeared to be applesauce. At that time, the LED came up to the surveyor and provided some paperwork. The LED did not have on a hair net and had passed through the food prep area. An opened package of ham slices were observed in an unlabeled resealable plastic bag which was laying on top of a bag of shredded cheese. A large gray garbage can was observed out of the food prep area in the refrigerator area near the back door. The lid to the garbage can was tied to the can and was sitting off the can. On 05/31/23 at 7:49 a.m., the DM entered the kitchen wearing a ball cap and washed her hands. The DM stated the facility kept left overs for three days. They were shown the items in the refrigerator and stated the small bag of bacon should not have been in there and tossed it. The DM stated the applesauce and salad should have had a date on it but it would have been tossed in	C 391	What measures will be put into place or what systematic changes will be made to ensure this will not happen again? Effective immediately the Dietary Manager and/or designee will conduct rounds and make observations 5 times a week for 1 week to establish compliance then weekly for 2 months to maintain compliance. Once compliance is achieved the Dietary Manager and/or designee will conduct rounds and make observations monthly through 2 QA meetings to ensure continued compliance. How will the facility Quality Assurance Committee monitor the corrective action? The Quality Assurance Committee will monitor the effectiveness of the plan until compliance is achieved and continue to monitor for two quarters after compliance.	6-29-23

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C 391	Continued From page 2 three days. The DM stated the sliced tomatoes were from a cook-out last weekend and should have been thrown out. The DM stated the tomato paste could be kept longer due to the acidity but did not know how long. The DM stated everything should have a label and should be disposed of in three days. The DM stated the ham should not have been placed on top of the shredded cheese. 2. On 05/31/23 at 11:28 a.m., lunch preparation and service was observed. Cook #1 had long painted nails. Cook #1 had on a hair net but it was not covering all of their hair in the front and had a strand on long hair on the left side touching her shoulder. The vents on the ceiling in the kitchen were observed to contain a large amount of dust on and around the vents. On 05/31/23 at 11:32 a.m., Cook #1 was observed to touch their face, touch the trash can lid, and then place gloves on their hands and dipped up pears into bowls for dessert. Cook #1 opened a honey bun and placed it in a bowl while wearing the same gloves. Cook #1 then removed the gloves, touched the trash can lid place on an oven mitt and checked the corn bread which was baking in the oven. Cook #1 placed the other mitt on the other hand and moved the potatoes in the oven, then washed her hands. On 05/31/23 at 11:41 a.m., Cook #1 removed their gloves and touched the trash can lid and ear, got a container from a shelf, drained the juice from the can of pears, then touched the trash can lid, and put new gloves on. Hand washing was not observed before Cook #1 placed on new gloves and dipped the remaining pears into the container.	C 391		

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This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that the Facility violated any federal or state regulation or failed to follow any applicable standard of care. Further, nothing contained herein shall be construed as an admission that any of the allegations or accusations against the Facility are true or accurate.

Oklahoma State Department of Health

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C 391	Continued From page 3 On 05/31/23 at 11:47 a.m., Cook #1 wiped their eye after making a labeled for the pears and placing the container in the refrigerator. Cook #1 moved the pears in the bowls over by the steam table, scratched their back, placed the oven mitts on their hands and emptied the pot of greens into a container on the steam table. Cook #1 set the pot of brown beans on the counter by the steam table, touched the door handle to the janitor closet went in and the brought a cleaning pad and a pitcher to the two compartment sink and hand washed it with dish soap. Cook #1 dried their hands with paper towels and placed gloves on. Cook #1 then used the pitcher to dip into the beans and transfer the beans into a container on the steam table. Cook #1 did not sanitized the pitcher before use. On 05/31/23 at 11:50 a.m., Cook #1 was observed to obtain food temperatures by wiping the thermometer with a paper towel between foods. Cook #1 then touched the trash can lid with gloved hand and then with un-gloved hand. She then put on oven mitts retrieved the potatoes from the oven and took the temperature of the potatoes. Hand washing was not observed. Cook #1 placed gloves on hands touched multiple seasonings on the shelf, then placed the oven fried potatoes into a container on the steam table with her gloved hands. On 05/31/23 at 11:54 a.m., DA #1 was observed to come into the kitchen and get a gallon of milk they took to the milk to the dining room, then returned to the kitchen and placed the milk back in the refrigerator. The DA did not wash their hands when they entered the kitchen. On 05/31/23 at 11:55 a.m., after Cook #1 washed	C 391		

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C 391	Continued From page 4 her hands they scratched the side of their face, opened the seasoning salt, place gloves on their hands, put the seasoning salt on the potatoes, and tossed the potatoes with their gloved hands at the steam table. On 05/31/23 at 12:02 p.m., Cook #1 started plating food for the memory care unit. Cook #1 was observed to touch their face with gloved hand and held small bowls against clothing to take over to the steam table. Cook #1 was observed to touch the plate surfaces, the inside of the bowls, and the corn bread with her gloved hands as she served the meal multiple times. Cook #1 did not remove gloves and wash her hands after touching her face. On 05/31/23 at 12:13 p.m., DA #1 returned to the kitchen, hand washing was not observed, DA #1 retrieved a bin off the shelf and left the kitchen. On 05/31/23 at 12:18 p.m., Cook #1 returned from taking the meals to the memory unit. Cook #1 was observed to wash her hands and then touched the trash can lid, the cook then placed gloves on hands then touched the paper cards for the resident meal request which were in the window pass of the kitchen then started serving the lunch meals for the resident who were in the dining room. Cook #1 was observed to touch the eating surfaces of the plates and bowls while serving the food. On 05/31/23 at 12:24 p.m., Cook #1 was observed moving plates and bowls with the items touching the cook's clothing. On 06/01/23 at approximately 10:00 a.m., the DM stated the staff could not wear dangling jewelry but rings were not a problem. The DM stated	C 391		

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If continuation sheet 5 of 15

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C 391	Continued From page 5 hand washing should be performer anytime you remove your gloves or anytime you touch something dirty. The DM stated the first thing you do was wash your hands when you enter the kitchen and a hair net or ball cap should be worn to cover the hair. The DM stated the dishes should not be held against clothing. The DM stated all things in the refrigerator should have a date and label. The DM stated should not touch food with bare hands or gloved hand unless it was clean glove. The DM stated the maintenance person cleaned the vents and it had been a while since the vents were cleaned. The DM stated all the dishes should be washed and sanitized before use.	C 391		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure admission assessments were completed within 30 days for one (#1) of eight sampled residents whose assessments were reviewed. The "Resident List Report" documented 44 residents resided in the facility.	C 521	How will the corrective action be accomplished for the residents cited? The facility will ensure admission assessments are completed for residents within 30 days before or at the time of admission. The resident identified has discharged from the facility. Residents will be monitored by the Director of Nursing upon admission to ensure admission assessments are completed. How will the facility identify other residents having the potential to be affected by this problem? There were 44 residents identified residing in the facility. Inservice was scheduled for 6-21-23 regarding completion of admission assessments within 30 days before admission or at the time of admission and will continue through 6-30-23 as needed. What measures will be put into place or what systematic changes will be made to ensure this will not happen again? Effective immediately the Director of Nursing and/or designee will conduct random audits 5 times a week for 1 week to establish compliance then weekly for 2 months to maintain compliance. Once compliance is achieved the Director of Nursing and/or designee will conduct random audits monthly through 2 QA meetings to ensure continued compliance.	

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C 521	Continued From page 6 Findings: A review of Res #1 records documented the resident was admitted on 12/05/23. The clinical records did not contain an admission assessment. On 06/01/23 at 11:23 a.m., the DON stated she could not locate the admission assessment.	C 521	How will the facility Quality Assurance Committee monitor the corrective action? The Quality Assurance Committee will monitor the effectiveness of the plan until compliance is achieved and continue to monitor for two quarters after compliance.	6-29-23
C 522 SS=E	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 facility failed to: a. complete an annual comprehensive assessment within 14 days after admission for three (#6, 7, and #8) of eight sampled residents reviewed for assessments and, b. complete an annual comprehensive assessment every 24 months for one (#8) of eight sampled resident whose assessments were reviewed.	C 522	How will the corrective action be accomplished for the residents cited? The facility will ensure a comprehensive assessment is completed within 14 days of admission and once every 12 months thereafter. Comprehensive assessments will be completed for the residents identified. The Director of Nursing will develop a schedule and monitor the completion of assessments when they are due. How will the facility identify other residents having the potential to be affected by this problem? There were 44 residents identified residing in the facility. Inservice was scheduled for 6-21-23 regarding completion of the comprehensive assessment within 14 days and once every 12 months and will continue through 6-30-23 as needed. What measures will be put into place or what systematic changes will be made to ensure this will not happen again? Effective immediately the Director of Nursing and/or designee will conduct random audits 5 times a week for 1 week to establish compliance then weekly for 2 months to maintain compliance. Once compliance is achieved the Director of Nursing and/or designee will conduct random audits monthly through 2 QA meetings to ensure continued compliance.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/01/2023
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(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 7 1. Res #6 was admitted to the facility on 03/26/23 with diagnoses which included hypertensive heart disease, arterial fibromuscular depolarization, bradycardia, and osteoarthritis of knee. An assessment dated 04/11/23, was not marked what kind of assessment it was. The assessment was not completed within the 14 day required time frame. On 06/01/23 at 9:45 p.m., the DON stated the assessment would have been the 14 day comprehensive assessment and it was not completed within the time window. 2. Res #7 admitted to the facility on 04/28/23 and had diagnoses which included type two diabetes mellitus, gout, and hypertension. Review of the resident's clinical record did not contain a comprehensive assessment. On 06/01/23 at 12:22 p.m. the DON was asked if the resident had a comprehensive assessment. The DON stated if the resident had a 14 -day comprehensive assessment it would be in the chart. After the DON looked in the chart the DON stated the chart did not contain the assessment. 3. Res #8 admitted to the facility 03/04/22 and had diagnoses which included heart failure, hypertension, and pain. Review of the resident record did not contain an admission assessment or an annual assessment for 2023. On 06/01/23 at 1:47 p.m., the DON stated the comprehensive admission assessment and	C 522	How will the facility Quality Assurance Committee monitor the corrective action? The Quality Assurance Committee will monitor the effectiveness of the plan until compliance is achieved and continue to monitor for two quarters after compliance.	6-29-23

Oklahoma State Department of Health

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C 522	Continued From page 8 annual assessment should be in the chart if they had been completed. She stated the resident had been in the facility long enough for an annual assessment.	C 522		
C 531 SS=E	310:663-5-3(a) ASSESSMENT FORM (a) The admission assessment form shall include but not be limited to the following: (1) resident's identification; (2) disease diagnosis/infections; (3) mental health history, and mental retardation or developmental disability; (4) physical functioning which includes the numbers of persons needed to assist with activities of daily living; (5) incontinence; (6) medications; (7) special treatment and procedures; (8) cognitive function; and (9) signatures and dates. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the resident assessments documented the required components for three (#1, 7, and #8) of eight residents whose records were reviewed. The "Resident list Report" documented 44 residents resided in the facility.	C 531	How will the corrective action be accomplished for the residents cited? The facility will ensure assessments are completed to include the 8 components set out in the regulations including appropriate signatures. The Director of Nursing will ensure assessments are completed for all residents. How will the facility identify other residents having the potential to be affected by this problem? There were 44 residents identified residing in the facility. Inservice was scheduled for 6-21-23 regarding completion of assessments to include the components required in the regulation including appropriate signatures and will continue through 6-30-23 as needed. What measures will be put into place or what systematic changes will be made to ensure this will not happen again? Effective immediately the Director of Nursing and/or designee will conduct random audits to ensure thorough completion of assessments 5 times a week for 1 week to establish compliance then weekly for 2 months to maintain compliance. Once compliance is achieved the Director of Nursing and/or designee will conduct random audits monthly through 2 QA meetings to ensure continued compliance. How will the facility Quality Assurance Committee monitor the corrective action? The Quality Assurance Committee will monitor the effectiveness of the plan until compliance is achieved and continue to monitor for two quarters after compliance.	6-29-23

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C 531	Continued From page 9 Findings: 1. Res #1 was admitted on 12/05/23. The admission assessment, dated 01/04/23, did not document a signature from the coordinating RN or physician. On 06/01/23 at 11:23 a.m., the DON confirmed the assessment should have been signed by the RN. 2. Res #7 was admitted on 04/28/23. The admission assessment, dated 04/28/23, did not contain the required eight components. On 06/01/23 at 12:42 p.m., the DON stated the admission assessment was not complete. The cognitive function should have been completely filled out. 3. Res #8 was admitted on 03/05/22. The admission assessment, dated 03/05/22, did not contain the resident or resident representatives signature or date. On 06/01/23 at 1:47 p.m., the DON stated the assessment should have a signature and date for the resident.	C 531		
C 532 SS=D	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine;	C 532		

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STATE FORM

6899

QR5F11

If continuation sheet 10 of 15

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C 532	Continued From page 10 (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive assessments contained the required components for one (#6) of eight sampled residents. The "Resident list Report" documented 44 residents resided in the facility. Findings: A preadmission assessment, dated 02/24/23, documented the residents was alert oriented times three, forgetful, with good judgment. The resident used a walker and cane for ambulation. The assessment documented Res #6 required assistance with bathing, dressing, transferring, toileting, and ambulation. Res #6 was admitted to the facility on 03/26/23	C 532	How will the corrective action be accomplished for the residents cited? The facility will ensure the comprehensive assessment are thoroughly completed and contain the required components. The assessment for the resident identified will be reviewed and revised to include all of the components for his care. The Director of Nursing will review the assessments as they come due to ensure all of the residents needs are identified. How will the facility identify other residents having the potential to be affected by this problem? There were 44 residents identified residing in the facility. Inservice was scheduled for 6-21-23 regarding thorough completion of the comprehensive assessments all of the required components are completed and will continue through 6-30-23 as needed. What measures will be put into place or what systematic changes will be made to ensure this will not happen again? Effective immediately the Director of Nursing and/or designee will conduct random audits 5 times a week for 1 week to establish compliance then weekly for 2 months to maintain compliance. Once compliance is achieved the Director of Nursing and/or designee will conduct random audits monthly through 2 QA meetings to ensure continued compliance. How will the facility Quality Assurance Committee monitor the corrective action? The Quality Assurance Committee will monitor the effectiveness of the plan until compliance is achieved and continue to monitor for two quarters after compliance.	6-29-23

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C 532	Continued From page 11 with diagnoses which included hypertensive heart disease, arterial fibromuscular depolarization, bradycardia, and osteoarthritis of knee. An assessment, dated 04/11/23, was not marked what kind of assessment it was. The assessment was also not complete with the required components. The mental/cognitive functional status was not completed. The mental health section was blank. The physical functional status section was blank. The oral/nutritional status was not complete and physical impairments was blank. On 06/01/23 at 9:45 p.m., the DON stated the assessment would have been the comprehensive admission assessment and it was not completed in the time window nor was the assessment completed with all the areas filled out. She stated the resident went on palliative care and she probably combined the 14 day and a significant change on 04/11/23.	C 532			
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the facility	C 954	How will the corrective action be accomplished for the residents cited? The facility will ensure newly hired direct care staff is trained in first aid. The Administrator or Director of Nursing will monitor new hires to ensure training is completed. How will the facility identify other residents having the potential to be affected by this problem? There were 44 residents identified residing in the facility. Inservice was scheduled for 6-21-23 regarding first aide training for direct care staff and documentation in the employee's file that training was provided and will continue through 6-30-23 as needed.		

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C 954	Continued From page 12 failed to ensure recently hired direct care staff were trained in first aide for two (CMA #1 and CNA #1) of two direct care staff whose training records were reviewed. The "Resident list Report" documented 44 residents resided in the facility. Findings: CMA #1's employee file, who was hired on 01/25/23, did not have documentation of first aide training. CNA #1's employee file, who was hired on 04/20/23, also did not have documentation of first aide training. On 05/31/23 at 5:00, the administrator stated they did not know if first aide was offered to the staff and would have to check. On 05/31/23 at 5:19 p.m., the DON stated first aide should be up to date on everyone but did not know where this documentation was kept. On 06/01/23 at 2:35 p.m., the administrator stated the staff members who were reviewed for first aide training had not had the training.	C 954	What measures will be put into place or what systematic changes will be made to ensure this will not happen again? Effective immediately the Administrator and/or Director of Nursing will monitor newly hired direct care staff 5 times a week for 1 week to establish compliance then weekly for 2 months to maintain compliance. Once compliance is achieved the Administrator and/or Director of Nursing will monitor newly hired direct care staff monthly through 2 QA meetings to ensure continued compliance. How will the facility Quality Assurance Committee monitor the corrective action? The Quality Assurance Committee will monitor the effectiveness of the plan until compliance is achieved and continue to monitor for two quarters after compliance.	6-29-23
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) 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	C1911	How will the corrective action be accomplished for the residents cited? The facility will ensure allegations of abuse are reported to OSDH within 1 business day of the reportable incident's discovery. The resident identified has discharged from the facility. The Administrator and/or designee will monitor all allegations of abuse to ensure they are reported as required.	

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C1911	Continued From page 13 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 facility failed to ensure allegations of abuse were reported to OSDH made via facsimile or by telephone within one Department business day of the reportable incident's discovery. The DON stated one allegation of abuse had occurred in the previous six months. Findings: A facility policy, titled "Allegations of Abuse to be Reported within 2 hours" dated 07/31/18 read in part, "...C. Director of Nursing/Administrator do initial state report, send in any staff to Nursing/CNA Board if applicable within 2 hours..."	C1911	How will the facility identify other residents having the potential to be affected by this problem? There were 44 residents identified residing in the facility. Inservice was scheduled for 6-21-23 regarding reporting allegations of abuse according to policy and procedure and will continue through 6-30-23 as needed. What measures will be put into place or what systematic changes will be made to ensure this will not happen again? Effective immediately the Director of Nursing and/or designee will conduct random audits, interviews, rounds and make observations 5 times a week for 1 week to establish compliance then weekly for 2 months to maintain compliance. Once compliance is achieved the Director of Nursing and/or designee will conduct random audits, interviews, rounds and make observations monthly through 2 QA meetings to ensure continued compliance. How will the facility Quality Assurance Committee monitor the corrective action? The Quality Assurance Committee will monitor the effectiveness of the plan until compliance is achieved and continue to monitor for two month after compliance.	6-29-23

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C1911	Continued From page 14 The investigation timeline, provided by the DON, for the incident dated 04/28/23, documented the allegation of abuse had been reported to the DON on 04/25/23. The facsimile transmission report, dated 04/28/23 at 2:54 p.m., documented the report had been successfully received by OSDH. On 05/31/23 at 10:15 a.m., the DON stated Res #1 no longer resided at the facility. The DON stated they were unaware at the time that any abuse allegations had to be reported immediately per the facility policy and subsequently did not report it for three days.	C1911			



OKLAHOMA
State Department
of Health

Delivery via email to: Linda.Pearce@BridgesOK.com; rachel.sanders@claremoreokla.com

September 11, 2023

License Number: AL6602

Ms. Rachel Sanders, Administrator
The Courtyards At Claremore Assisted Living Memory
915 East 16th Street
Claremore, OK 74017

RE: Survey Event QR5F12

Dear Ms. Sanders:

On **September 11, 2023**, an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 1, 2023**, have now been corrected effective **June 29, 2023**.

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

Sincerely,

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 09/07/23 and 09/11/23. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE