OKLAHOMA
State Department
of Health

Delivery via email to: rachel.sanders@claremoreokla.com; Ellen.kremeier@bridgesok.com; Susan.easterling@bridgesok.com

July 3, 2024

License Number: AL6602

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

RE: Survey Event ID: KSU311

Dear Ms. Sanders:

On **June 28, 2024**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for no 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 28, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action 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 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to: IDRCoordinator@health.ok.gov
Or mail to:

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

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

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

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

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6602	A. BUILDING: _____ B. WING _____	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COURTYARDS AT CLAREMORE ASSISTED LIVIN	915 EAST 16TH STREET CLAREMORE, OK 74017

(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 from 06/26/24 through 06/28/24. Facility Census: 44 Listed below are abbreviations that will be used throughout this used in the document. document. DON - director of nursing LPN - licensed practical nurse RN - registered nurse	C 000		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a significant change assessment was coordinated and signed by a registered nurse or a resident's personal physician for one (#7) of eight sampled residents reviewed for assessments. An Assisted Living Resident Condition and Care Overview form, dated 06/26/24, documented 44 residents resided at the facility. Findings: Resident #7 was admitted to the facility on 10/24/23. A significant change assessment, dated 06/06/24,	C 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 542	Continued From page 1 for Resident #7 did not include the signature of a registered nurse or physician. On 06/28/24 at 9:20 a.m., RN #1 stated they sometime complete the assessments fully and other times the DON [an LPN] would do the assessment and they would interview the resident later. They stated they had erred by not conducting the interview and signing the assessment and they would go and interview the resident at that time.	C 542		
C1329 SS=C	310:663-13-2(9) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (9) conformity with state law; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident service contracts included a statement of conformity with state laws, for eight (#1, 2, 3, 4, 5, 6, 7, and #8) of eight sampled residents reviewed for resident service contracts. An Assisted Living Resident Condition and Care Overview form, dated 06/26/24, documented 44 residents resided at the facility. Findings: Resident medical records of residents #1, 2, 3, 4, 5, 6, 7, and #8 were reviewed for completed service contracts. Each was found to be missing a statement of conformity to state law.	C1329		

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C1329	Continued From page 2 On 6/27/24 at 12:00 p.m., the Administrator stated they did not see a statement of conformity to state law in the residents' service contracts and would check with their leadership. On 6/27/24 at 12:33 p.m., the Administrator stated their lawyer was reading through the contract to see if they could identify the statement in the contract. On 6/27/24 at 12:58 p.m., the Administrator stated they had not been using the most current form of their service contract that did have the statement of conformity to state law. They stated the current 44 residents at the facility had signed the old form that did not have the statement. They stated they will meet with the residents and families to go over the current contract.	C1329		

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Delivery via email to: rachel.sanders@claremoreokla.com; Ellen.kremeier@bridgesok.com; Susan.easterling@bridgesok.com

July 17, 2024

License Number: AL6602

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

RE: Survey Event KSU311

Dear Ms. Sanders:

On **June 28, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **July 23, 2024**.

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

Enclosure

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Delivery via email to: rachel.sanders@claremoreokla.com; Ellen.kremeier@bridgesok.com; Susan.easterling@bridgesok.com

July 3, 2024

License Number: AL6602

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

RE: Survey Event ID: KSU311

Dear Ms. Sanders:

On **June 28, 2024**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for no 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 28, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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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.

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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.

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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

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Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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Oklahoma State Department of Health

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C1329 SS=C	310:663-13-2(9) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (9) conformity with state law; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident service contracts included a statement of conformity with state laws, for eight (#1, 2, 3, 4, 5, 6, 7, and #8) of eight sampled residents reviewed for resident service contracts. An Assisted Living Resident Condition and Care Overview form, dated 06/26/24, documented 44 residents resided at the facility. Findings: Resident medical records of residents #1, 2, 3, 4, 5, 6, 7, and #8 were reviewed for completed service contracts. Each was found to be missing a statement of conformity to state law.	C1329	How will the corrective action be accomplished for the residents cited? The facility will ensure the residents identified on the 2567 will sign new service contracts which include a statement of conformity with state law. 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. In-service was scheduled for 7/10/24, regarding statements of conformity of state law being included in service contracts and will continue through 7/23/24 as needed.	

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OKLAHOMA
State Department of Health

Delivery via email to: rachel.sanders@claremoreokla.com; Ellen.kremeier@bridgesok.com; Susan.easterling@bridgesok.com

August 7, 2024

License Number: AL6602

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

RE: Survey Event KSU312

Dear Ms. Sanders:

On **August 5, 2024,** an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your Licensure survey on **June 28, 2024,** have now been corrected effective **July 23, 2024.**

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 08/05/24 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