OKLAHOMA
State Department
of Health

Delivery via email to: jpomeroy@homesteadofowasso.com

April 15, 2024

License Number: AL7225

Joseph Pomeroy, Administrator
The Homestead Of Owasso
14701 East 86th Street North
Owasso, OK 74055

RE: Survey Event ID: VMK811

Dear Mr. Pomeroy:

On **April 4, 2024**, 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 **April 4, 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:

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

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

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

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

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

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **The Homestead of Owasso**
Address: **14701 East 86th Street**
City, State, Zip: **Owasso, OK, 74055**
Provider #: **AL7225**
Complaint #: **OK00062864**
Investigation Dates: **04/02/24 through 04/04/24**

ALLEGATIONS

1.The center failed to ensure food was prepared under sanitary conditions.

An unannounced on-site investigation was initiated 04/02/2024 at 11:15 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:

A tour of the kitchen was conducted during the survey. The kitchen was observed for sanitary conditions.

Kitchen inspection reports and cleaning schedules were reviewed. Staff were interviewed and asked about kitchen policy and procedures.

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The attached Statement of Deficiencies, Form 2567, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 04/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7225	A. BUILDING: _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF OWASSO	14701 EAST 86TH STREET NORTH OWASSO, OK 74055

(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 04/02/24 through 04/04/24. A complaint investigation (#OK00062864) was conducted in conjunction with the survey. Facility Census: 49 Listed below are the abbreviations that will be used throughout this document. AL - assisted living CNA - certified nurse aide CPR - cardiopulmonary resuscitation ED - executive director RCC - resident care coordinator Res - resident	C 000		
C 391 SS=E	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 and interview, the center failed to ensure food service areas were kept clean and maintained in good repair. The "Assisted Living Resident Condition and Care Overview" form, dated 04/02/24, documented 49 residents resided in the center. Findings: On 04/02/24 at 1:38 p.m., a tour of the AL dining room and kitchen was conducted . The following observations were made.	C 391		

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C 391	Continued From page 1 a. paint/material was peeling off of the bottom of the cabinet in the drink station area, b. white residue was on the ice shoot located on the ice machine in the drink station area. c. there was an accumulation of food inside of the reach in coolers, reach in freezers, and hot boxes, d. the light shield was hanging loose in the dry storage area, e. one of two door gaskets were split on the True two door reach in cooler, f. there was an accumulation of food and black residue on the floor under reach in coolers, reach in freezers, food preparation tables, food storage racks, the dish machine, and the three compartment sink, g. there was blue tape wrapped around the piping below the dish machine and the three compartment sink, h. the base board was missing below the dish machine and the three compartment sink, i. there was an accumulation of brown and white residue the dish machine, spray nozzle hose, and the three compartment sink, j. the low temperature dish machine did not dispense sanitizer during the sanitization cycle. The sanitizer was 0 parts per million, k. there was lint and/or black residue on the ceiling vents,	C 391		

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C 391	Continued From page 2 l. there was lint and grease on the oven hood filters, and m. there was black residue on the legs of food preparation tables, and the piping below the two compartment sink. On 04/02/24 at 1:56 p.m., dietary aide #1 was asked about the sanitization cycle on the low temperature dish machine. They stated the sanitizer solution should be 100 parts per million. On 04/02/24 at 2:08 p.m., a tour of the kitchenette in the memory care unit was conducted. The following observations were made. a. there was an accumulation of brown and yellow residue in the ice machine, b. the bottom section of the cabinets were missing and/or in bad repair. c. there was black residue in the cabinet below the sink, d. there was brown residue and trash on the floor under the reach in cooler and the ice machine, and e. the base board was missing off of the wall behind the reach in cooler. On 04/02/24 at 2:13 p.m., the dietary supervisor was asked how staff ensured food service areas were kept clean and maintained in good repair. They stated staff cleaned daily and maintenance concerns were reported to the ED. They stated dietary was not responsible for the kitchenette in	C 391		

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C 391	Continued From page 3 the memory care unit. They shown and made aware of the above observations.	C 391		
C 954 SS=E	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 center failed to ensure direct care staff were trained in CPR and first aid for two (CNA #1 and CNA #3) of five sampled staff reviewed for CPR and first aid training. The "Assisted Living Resident Condition and Care Overview" form, dated 04/02/24, documented 49 residents resided in the center. Findings: 1. CNA #1 was hired on 02/14/24. There was no documentation they were trained in CPR and first aid. 2. CNA#3 was hired on 01/19/24. There was no documentation they were trained in CPR and first aid. On 04/03/24 at 7:20 a.m., the assistant ED was	C 954		

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	AL7225	A. BUILDING: _____ B. WING _____	C 04/04/2024

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C 954	Continued From page 4 asked to provide documentation CNA # and CNA #3 were trained in CPR and first aid. On 04/04/24 at 1:49 p.m., the assistant ED stated CNA #1 and CNA #3 were not trained in CPR and first aid.	C 954		
C5015 SS=E	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident;	C5015		

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C5015	Continued From page 5	C5015		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the center failed to ensure all plans of accommodation were signed by the physician for two (#1 and #4) of four sampled residents reviewed for plans of accommodation.

The "Assisted Living Resident Condition and Care Overview" form, dated 04/02/24, documented 49 residents resided in the center.

Findings:

1. A plan of accommodation, dated 01/03/24, documented Res #1 had a specific need for accommodation regarding hospice and end of life care. There was no documentation the resident's physician signed the written plan of accommodation.

2. A plan of accommodation, dated 01/03/24, documented Res #4 had a specific need for accommodation regarding hospice and end of life care. There was no documentation the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7225	A. BUILDING: _____ B. WING _____	C 04/04/2024

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C5015	Continued From page 6 physician signed the written plan of accommodation. On 04/04/24 at 9:17 a.m., the RCC and regional clinical consultant were asked what was the protocol for obtaining a signature from residents physicians for a specific need for an accommodation. The RCC stated the plan of accommodation should be signed by the physician as soon as the accommodation was implemented. They were shown the plans of accomodation for Res #1 and Res #4. The RCC stated they should have been signed.	C5015		

OKLAHOMA
State Department
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Delivery via email to: jpomeroy@homesteadofowasso.com

April 19, 2024

License Number: AL7225

Mr. Joseph Pomeroy, Administrator
The Homestead Of Owasso
14701 East 86th Street North
Owasso, OK 74055

RE: Survey Event VMK811

Dear Mr. Pomeroy:

On **April 4, 2024**, a Licensure inspection with complaints 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 **May 7, 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,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/18/2024** **Facility Name:** Homestead of Owasso **License Number:** AL7225 **Survey Event ID:** VMK811 **Date Survey Completed: 4/4/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: observation and interview, the center failed to ensure food service areas were kept clean and maintained in good repair.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Assisted Living Kitchen: a. New baseboard will be installed by maintenance to correct the deficiency by 4/19/24 b. the ice machine in the drink station area will be delimed to correct this deficiency by 4/19/24. Weekly scheduled, deliming will be implemented by 4/19/24. c. The coolers, freezers and hot boxes will be cleaned by 4/19/24 and put on a weekly schedule for full cleaning and will be cleaned as needed daily to be implemented by 4/19/24 and ongoing. d. The light shield was fixed the day of survey. Routine inspection of light shields will occur daily. Maintenance will provide repair as needed by 4/19/24 and ongoing. e. Maintenance will order gaskets to repair on the two door cooler. Gaskets will be installed by maintenance as soon as they are received. Anticipate arrival of gaskets by 5/3/24. f. The floors will be on a routine schedule to be cleaned after every shift by 4/19/24 and ongoing. Deep clean of floors will be completed by 4/19/24 and put on a quarterly schedule going forward. g. Maintenance will remove blue tape and repairs will be made to plumbing by 4/23/24. h. New baseboard will be installed by maintenance to correct the deficiency by 4/24/24. i. The dish area and equipment will be cleaned with degreaser to eliminate residue. The dish machine, spray nozzle hose and three compartment sink will be on a schedule to be cleaned daily after every shift by 4/19/24 and ongoing. j. The equipment failure was repaired and now works as intended. Testing of sanitizer with test strips and checking the sanitizer liquid to ensure there is liquid in the reservoir, will be scheduled three times a day beginning 4/19/24 and ongoing. k. Ceiling vents will be cleaned by 4/23/24. The vents will

	be inspected weekly by the dietary staff and Dietary manager, and cleaned as needed by 4/23/24 and ongoing. l. The oven hood will be cleaned by 4/23/24. A weekly schedule of cleaning and soaking the filters in degreaser will be implemented by 4/23/24 and ongoing. m. The legs of kitchen appliances will be cleaned by 4/19/24. A schedule for weekly cleaning will be implemented on 4/23/24 and ongoing. Memory Care Kitchen: A The ice machine will be delimed to correct this deficiency by 4/19/24. A weekly cleaning schedule will be implemented to include weekly deliming of the ice machine. Implement by 4/24/24. b. Bids have been obtained to provide cabinet repair to kitchen sink cabinet. Temporary repair of closing the bottom of the cabinet will be completed by 4/24/24 to meet requirement of good repair and safety until new/remodeled cabinet can be put in place. c. Bids have been obtained to provide cabinet repair and removal of black residue to kitchen sink cabinet. Temporary repair of closing the bottom of the cabinet will be completed by 4/24/24 to meet requirement of good repair and safety until new/remodeled cabinet can be put in place. d. The floors will be on a routine schedule to be cleaned after every shift by 4/19/24 and ongoing. Deep clean of floors will be completed by 4/19/24 and put on a quarterly schedule going forward. e. New baseboard will be installed by maintenance behind the refrigerator. Will be completed by 4/25/24
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents are included in this correction. The ED and Dietary Manager will monitor compliance routinely and ongoing. The ED and/or the Dietary Manager will provide additional training as need is identified and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	A weekly, monthly and quarterly schedule will be developed and will be posted in the kitchens for documenting each task as completed and initialed by staff by 4/23/24. Dietary manager and /or ED will review the documentation daily for compliance and address non-compliance immediately. The ED and/or the Dietary Manager will provide additional training as need is identified and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained?	a. Routine daily, weekly and quarterly audits will be performed by the ED and Dietary Manager to ensure

Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	compliance. The ED and/or Dietary Manager will sign off on each completed cleaning task sheet and/ or at the end of each day. Implement 4/23/24 and ongoing. b. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and Dietary Manager. Written and implemented 4/23/24. Routine weekly, monthly and quarterly audits of both kitchens will be performed by the ED and Dietary Manager to ensure compliance. Implement 4/23 and ongoing. The ED and/or the Dietary Manager will document any occurrence of non-compliance ongoing and will provide disciplinary counseling and re-training to the staff member beginning 4/27 and ongoing. The ED and/or the Dietary manager will update the Plan of Correction as needed to follow up and ensure goals are met ongoing. c. The Plan of Correction will be written to address this deficiency and include monitoring by the ED and Dietary Manager. Written and implemented . Routine weekly, monthly and quarterly audits of the documentation and random checks on tasks for both kitchens will be performed by the ED and Dietary Manager to ensure compliance beginning 4/23/24 and ongoing. The ED and/or the Dietary Manager will document any occurrence of non-compliance ongoing and will provide disciplinary counseling and re-training as needed to the staff member beginning 4/27/24 and ongoing. The completed logs will be kept with the Plan of Correction in the QA Binder. Implement 4/27/24 and ongoing. The completed logs for both kitchens will be kept with the Plan of Correction in the QA Binder. Implement 4/27/24 and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/7/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.	**Date** Enter a date of signature. 9-18-24

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/18/2024** **Facility Name:** Homestead of Owasso **License Number:** AL7225 **Survey Event ID:** VMK811 **Date Survey Completed: 4/4/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 954	Based on: record review and interview, the center failed to ensure direct care staff were trained in CPR and first aid for two (CNA #1 and CNA #3) of five sampled staff reviewed for CPR and first aid training

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All staff will receive CPR and First Aid training during their new hire onboarding training process beginning 4/23/24. Those employees who currently do not have this training will receive training by 5/1/24. All staff to receive training in CPR and First Aid by 5/1/24 to ensure that all staff are in compliance. The ED/AED and RCC will ensure compliance of completion of training by 5/1/24.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents are included in this correction. The ED/AED and RCC will monitor compliance routinely and ongoing. The ED/ AED and or RCC will ensure CPR and First aid training is completed during the onboarding process and provide additional training as need is identified and ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The ED/AED and RCC will keep a log of all staff and completion of required training. The log will be reviewed monthly/ quarterly during the QA meeting. Any identified missing training or non-compliance will be addressed immediately and training or disciplinary action will be implemented by 5/1/24
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	a. Routine monthly and quarterly audits will be performed and discussed by the ED/ AED and RCC to ensure compliance. The ED/ AED and RCC will perform a review of completion of required training in QA meetings. Any identified missing training or non-compliance will be addressed immediately and training or disciplinary action will be implemented. Implement 5/1/24 and ongoing. b. Routine monthly and quarterly audits will be performed and discussed by the ED/ AED and RCC to ensure compliance. The ED/ AED and RCC will perform a review of

	completion of required training in QA meetings. A Plan of Correction will be written to address onboarding training process. The Plan of Correction, audits and QA meeting minutes will be kept in the QA binder. Any identified missing training or non-compliance will be addressed immediately and training or disciplinary action will be implemented. Implement 5/1/24 and ongoing. c. All audits and QA meeting minutes will be kept in the QA binder by 5/1/24 and ongoing Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/7/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.	**Date** Enter a date of signature. 4/10/24

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/18/2024** **Facility Name:** Homestead of Owasso **License Number:** AL7225 **Survey Event ID:** VMK811 **Date Survey Completed: 4/4/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 5015	Based on: record review and interview, the center failed to ensure all plans of accommodation were signed by the physician for two (#1 and #4) of four sampled residents reviewed for plans of accommodation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	A Plan of Correction will be written and implemented by 4/18/24. The RCC and AED will ensure that Plans of Accommodation are signed by all parties, including the primary care physician within 7 days of initiation. The RCC and/or the AED will fax the Plan of Accommodation to the primary care physician immediately upon initiation. The primary care physician will be informed that the form must be signed and returned, within 5 days. A copy of the fax confirmation will be attached to the Plan of Accommodation. If the faxed signed document is not received within 5 days, the request will be sent again, noting a second request and request for immediate response. The fax confirmation will be attached to the Plan of Accommodation. This fax will be followed up with a phone call to the primary care physician office alerting and requesting immediate response. If the signed Plan of Accommodation is not received within two days, the AED/RCC will go to the primary care physician office, if it is local to obtain signature. If that is not possible, attempts to get a verbal approval from the primary care physician will be made by the RCC and AED. If attempts to get primary care physician signature in a timely manner fail, RCC and AED will continue to try to get completed until a signature is obtained, but will request within 7 days, the hospice medical director to provide signature to ensure compliance with physician signature. All attempts to obtain signature in a timely manner will be documented. This process will be implemented 4/17/24.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents are included in this correction. The RCC and AED will monitor compliance routinely and ongoing. The

	RCC and AED will ensure that every effort is made to be compliant with this regulation.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The RCC and AED will implement a procedure to obtain primary care physician signatures in a timely and ensure that Plans of Accommodation are signed by all parties, including the primary care physician within 7 days of initiation. The RCC and/or the AED will fax the Plan of Accommodation to the primary care physician immediately upon initiation. The primary care physician will be informed that the form must be signed and returned, within 5 days. A copy of the fax confirmation will be attached to the Plan of Accommodation. If the faxed signed document is not received within 5 days, the request will be sent again, noting a second request and request for immediate response. This fax confirmation will be attached to the Plan of Accommodation. This fax will be followed up with a phone call to the primary care physician office alerting and requesting immediate response. If the signed Plan of Accommodation is not received within two days, the AED/RCC will go to the physician office if it is local to obtain signature. If that is not possible, attempts by to get a verbal approval from the physician will be made by the RCC and AED. If attempts to get physician signature in a timely manner fail, RCC and AED will continue to try to get completed until a signature is obtained, but will request within 7 days, the hospice medical director to provide signature to ensure compliance with physician signature. All attempts to obtain signature in a timely manner will be documented. This process will be implemented 4/17/24.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	a. The RCC and AED will keep a log of Plans of Accommodation in process and will ensure timely follow up on signatures is done as described in the Plans of Accommodation process. As the Plans are returned signed, the log will be updated to reflect the completion of signatures by physician, resident/POA, RCC and ED. Implement 4/17/24. b. Plans of Accommodation will be discussed during routine QA meetings and log will be reviewed. The list of the Plans of Accommodations will be kept in the QA binder for updating as needed. Any non-compliance regarding signatures on the Plans of Accommodation will result in

	updating the Plan of Correction and additional direction and guidance will be provided to the RCC and AED by the ED and Regional Clinical Consultant. Implement 4/17/24 and ongoing c. QA meeting notes, including Plans of Accommodation review and report will be kept in the QA binder. ED and Regional Clinical Consultant will review these documents monthly and quarterly. Implement on 4/17/24. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/7/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 4-18-24

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7225	A. BUILDING: _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF OWASSO	14701 EAST 86TH STREET NORTH OWASSO, OK 74055

(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 04/02/24 through 04/04/24. A complaint investigation (#OK00062864) was conducted in conjunction with the survey. Facility Census: 49 Listed below are the abbreviations that will be used throughout this document. AL - assisted living CNA - certified nurse aide CPR - cardiopulmonary resuscitation ED - executive director RCC - resident care coordinator Res - resident	C 000		
C 391 SS=E	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 and interview, the center failed to ensure food service areas were kept clean and maintained in good repair. The "Assisted Living Resident Condition and Care Overview" form, dated 04/02/24, documented 49 residents resided in the center. Findings: On 04/02/24 at 1:38 p.m., a tour of the AL dining room and kitchen was conducted . The following observations were made.	C 391		

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C 391	Continued From page 1 a. paint/material was peeling off of the bottom of the cabinet in the drink station area, b. white residue was on the ice shoot located on the ice machine in the drink station area. c. there was an accumulation of food inside of the reach in coolers, reach in freezers, and hot boxes, d. the light shield was hanging loose in the dry storage area, e. one of two door gaskets were split on the True two door reach in cooler, f. there was an accumulation of food and black residue on the floor under reach in coolers, reach in freezers, food preparation tables, food storage racks, the dish machine, and the three compartment sink, g. there was blue tape wrapped around the piping below the dish machine and the three compartment sink, h. the base board was missing below the dish machine and the three compartment sink, i. there was an accumulation of brown and white residue the dish machine, spray nozzle hose, and the three compartment sink, j. the low temperature dish machine did not dispense sanitizer during the sanitization cycle. The sanitizer was 0 parts per million, k. there was lint and/or black residue on the ceiling vents,	C 391		

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	AL7225	A. BUILDING: _____ B. WING _____	C 04/04/2024

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C 391	Continued From page 2 l. there was lint and grease on the oven hood filters, and m. there was black residue on the legs of food preparation tables, and the piping below the two compartment sink. On 04/02/24 at 1:56 p.m., dietary aide #1 was asked about the sanitization cycle on the low temperature dish machine. They stated the sanitizer solution should be 100 parts per million. On 04/02/24 at 2:08 p.m., a tour of the kitchenette in the memory care unit was conducted. The following observations were made. a. there was an accumulation of brown and yellow residue in the ice machine, b. the bottom section of the cabinets were missing and/or in bad repair. c. there was black residue in the cabinet below the sink, d. there was brown residue and trash on the floor under the reach in cooler and the ice machine, and e. the base board was missing off of the wall behind the reach in cooler. On 04/02/24 at 2:13 p.m., the dietary supervisor was asked how staff ensured food service areas were kept clean and maintained in good repair. They stated staff cleaned daily and maintenance concerns were reported to the ED. They stated dietary was not responsible for the kitchenette in	C 391		

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C 391	Continued From page 3 the memory care unit. They shown and made aware of the above observations.	C 391		
C 954 SS=E	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 center failed to ensure direct care staff were trained in CPR and first aid for two (CNA #1 and CNA #3) of five sampled staff reviewed for CPR and first aid training. The "Assisted Living Resident Condition and Care Overview" form, dated 04/02/24, documented 49 residents resided in the center. Findings: 1. CNA #1 was hired on 02/14/24. There was no documentation they were trained in CPR and first aid. 2. CNA#3 was hired on 01/19/24. There was no documentation they were trained in CPR and first aid. On 04/03/24 at 7:20 a.m., the assistant ED was	C 954		

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	AL7225	A. BUILDING: _____ B. WING _____	C 04/04/2024

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C 954	Continued From page 4 asked to provide documentation CNA # and CNA #3 were trained in CPR and first aid. On 04/04/24 at 1:49 p.m., the assistant ED stated CNA #1 and CNA #3 were not trained in CPR and first aid.	C 954		
C5015 SS=E	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident;	C5015		

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	AL7225	A. BUILDING: _____ B. WING _____	C 04/04/2024

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C5015	Continued From page 5	C5015		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the center failed to ensure all plans of accommodation were signed by the physician for two (#1 and #4) of four sampled residents reviewed for plans of accommodation.

The "Assisted Living Resident Condition and Care Overview" form, dated 04/02/24, documented 49 residents resided in the center.

Findings:

1. A plan of accommodation, dated 01/03/24, documented Res #1 had a specific need for accommodation regarding hospice and end of life care. There was no documentation the resident's physician signed the written plan of accommodation.

2. A plan of accommodation, dated 01/03/24, documented Res #4 had a specific need for accommodation regarding hospice and end of life care. There was no documentation the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7225	A. BUILDING: _____ B. WING _____	C 04/04/2024

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C5015	Continued From page 6 physician signed the written plan of accommodation. On 04/04/24 at 9:17 a.m., the RCC and regional clinical consultant were asked what was the protocol for obtaining a signature from residents physicians for a specific need for an accommodation. The RCC stated the plan of accommodation should be signed by the physician as soon as the accommodation was implemented. They were shown the plans of accomodation for Res #1 and Res #4. The RCC stated they should have been signed.	C5015		

OKLAHOMA
State Department of Health

Delivery via email to: Jpomeroy@homesteadofowasso.com

May 15, 2024

License Number: AL7225

Mr. Joseph Pomeroy, Administrator
The Homestead Of Owasso
14701 East 86th Street North
Owasso, OK 74055

RE: Survey Event VMK812

Dear Mr. Pomeroy:

On **May 14, 2024,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 4, 2024,** have now been corrected effective **May 7, 2024.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

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	AL7225	A. BUILDING: _____ B. WING _____	R-C 05/14/2024

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THE HOMESTEAD OF OWASSO	14701 EAST 86TH STREET NORTH OWASSO, OK 74055

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 05/14/24. 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