Oklahoma State Department of Health
Creating a State of Health

December 30, 2019

License Number: AL7228

Ms. Arvella McCollom, Administrator
Green Tree At Sand Springs
4402 South 129th West Avenue
Sand Springs, OK 74063

RE: Survey Event ID: IUSJ11

Dear Ms. McCollom:

On **December 18, 2019,** agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on December 18, 2019.

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) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

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

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

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

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

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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

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
	AL7228	A. BUILDING: _____ B. WING _____	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN TREE AT SAND SPRINGS	4402 SOUTH 129TH WEST AVENUE SAND SPRINGS, OK 74063

(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 completed on 12/16/19 to 12/18/19. Census was 64. Deficient practice was cited as follows.	C 000		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to provide registered nurse supervision to ensure a resident (#12) did not fill a medication reminder box for one (#7) of one sampled resident who had been assessed by the center to self-administer medications. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 12/17/19 at 1:00 p.m., resident #7 was asked if she took her own medications, or if the center administered her medication. Resident #12 resident #7's spouse stated he took care of their medications since they had moved into the center, because the center had a monthly charge for medication administration. Resident #12, stated he filled resident #7's medication reminder box. Resident #7 and resident #12's weekly	C 911		

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C 911	Continued From page 1 medication reminder boxes were observed sitting on the table. On 12/18/19 at 12:05 p.m., a self-administration of medication review document, dated 12/10/19 was reviewed with the registered nurse (RN). The RN stated this was when she had verified resident #7 was able to self administer her medications. The RN stated she was not aware that resident #12 was filling a medication reminder box for resident #7. Resident #7's December 2019 physicians order did not document resident could self-administer her medication.	C 911		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure qualified staff administered inhaled medications for 2 (#5 and #11) of 2 sampled residents who had physician ordered medications administered via dry powder inhaler and nebulizer (changes medication from a liquid to a mist). This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #5 Resident #5 was admitted to the center 03/28/19	C 921		

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C 921	Continued From page 2 with diagnoses to include COPD (chronic obstructive pulmonary disease). The resident had a physician's order, dated 04/22/19 for Advair Diskus dry powder inhaler one puff twice daily. The resident's MAR (medication administration record) for September, October and November, 2019 documented LTCA/MAT (long term care aide/medication administration technician)/employee #2 administered the Advair Diskus inhaler once in October, three times in November and twice in December, 2019. Resident #11 Resident #11 was admitted to the center with diagnoses to include COPD. The resident had an order for albuterol sulfate, dated 09/30/19, 2.5 grams per 3 milliliters, one vial three times daily per nebulizer. The resident's MAR documented LTCA/MAT/employee #2 administered the albuterol nebulizer three times in October and twice in November, 2019. On 12/18/19 at 10:25 a.m., the registered nurse was shown resident #5's and resident #11's MARs for October, November and December, 2019. She stated all staff who had administered the nebulizer treatments and inhalers were certified medications aides with Department approved training in respiratory medications. She was told LTCA/MAT/employee #2 was a MAT. She stated she did not know LTCA/MAT/employee #2 was a MAT.	C 921		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care	C5010		

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C5010	Continued From page 3 A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by:	C5010		

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C5010	Continued From page 4 Based on observation, interview and record review, it was determined the center failed to monitor services provided by third party providers, and failed to ensure physician orders were consistent with the center's orders and completed by third party providers for 2 (#5 and #6) of 2 sampled residents who received services for FSBS (finger stick blood sugar testing), insulin administration, oxygen and medications via nebulizer (changes medication from a liquid to a mist). This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #5 Resident #5 was admitted to the center 03/28/19 with diagnoses to include diabetes mellitus and COPD chronic obstructive pulmonary disease). On 12/16/19 at 3:20 p.m., a verbal report about the residents was received from licensed practical nurse (LPN) #1. She stated resident #5 was diabetic, was on oxygen and had FSBS testing by home health, but did not receive insulin. The center's December, 2019 physician orders for resident #5 were reviewed. The resident had a physician's order, dated 04/16/19, for Lantus (insulin) injection 12 units at 8 a.m. and 8 units at 4:00 p.m. The orders included continuous oxygen at 2 liters per minute per nasal cannula and albuterol sulfate 2.5 mg/3 ml (milligram) one vial per nebulizer (breathing) treatment every four hours as needed for shortness of breath. The center's orders also documented the resident was to receive Novolog (insulin) per sliding scale (dose dependent upon the results of FSBS).	C5010		

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C5010	Continued From page 5 This order was documented twice on the physician's orders, dated 04/16/19 and 06/06/19. No sliding scale was documented with either order and there was no order for FSBS testing. The home health orders for the resident's most recent certification period from 11/24/19 to 01/22/20, documented the oxygen was to be 3 liters per minute and Xopenex 0.63mg/3ml per nebulizer treatment three times daily. The home health nurse was to come twice daily to perform FSBS PRN (as needed) and administer insulin as needed. The home health orders also included an order for Lantus injection 12 units every a.m. and 8 units every p.m., Novolog (insulin) sliding scale and included a sliding scale for insulin dosage. The order also instructed to contact the physician for FSBS results above 300 mg/dl (milligrams per deciliter). The same physician was documented on both the center's orders and home health orders. The center's RN (registered nurse) was asked for home health visit notes and FSBS/insulin logs. She provided 19 visit notes for December, 2019 and no visit notes for October and November, 2019. FSBS/insulin logs from 11/22/19 were provided. Insulin administration times were documented on 12 of the visit notes and not at all on the FSBS/insulin logs. On 11/22/19, the FSBS log documented the resident's FSBS result was 391, on 11/26/19 304, 11/27/19 371, on 12/11/19 381 and 12/16/19 314. There was no documentation proving the physician was notified as per order. On 12/17/19 at 4:45 p.m., the RN was asked about resident #5's insulin. She stated resident # 5 was only on sliding scale insulin and not routine	C5010		

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C5010	Continued From page 6 insulin. On 12/18/19 at 11:45 a.m., resident #5 was interviewed in her room. The resident had oxygen via nasal cannula on and her oxygen concentrator was set at 3 liters per minute. She stated her oxygen should be set at 3 liters per minute. She also stated a nurse came to do her FSBS testing and give her insulin, but she was not sure who came or how often. At 12:00 p.m., the RN (registered nurse) stated she did not know if the physician had been notified when the resident's FSBS results were over 300 as ordered. She stated she would have to call the home health to find out. She also stated she was not aware the home health orders and the center's orders were different. She also said she had had only one home health conference and only one home health company showed up for the conference. She stated she did not have documentation of the conference. Resident #6 was admitted to the center on 10/22/19 with a diagnosis of Diabetes Mellitus. A physician's order dated 12/10/19 documented resident #6 was to start Lantus insulin 10 units at hour of sleep (bedtime). A nursing note entry on 12/10/19 documented Lantus 10 units at hour of sleep. Home health nurse to administer insulin. The medication administration record documented the center did not administer the insulin on 12/11/19 and 12/12/19. On 12/17/19 at 3:40 p.m., resident #6 stated she got her insulin at night, and that home health would be coming soon to give her shot.	C5010		

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C5010	Continued From page 7 At 3:45 p.m., the RN stated resident #6 did not get insulin. Just FSBS testing per home health. At 3:50 p.m., the RN came back with the home health's most recent orders and stated she was wrong, the resident did get insulin at hour of sleep (bedtime) from home health nurses but she was unaware of the insulin dose. She was asked what time the center's policy said hour of sleep was. She stated 8:00 p.m. At 4:20 p.m., the home health nurse was observed in the resident's room administering her insulin. The home health nurse stated the resident got her insulin every day anywhere from 3:00 p.m. to 5:00 p.m. At 4:54 p.m., the RN was asked if resident #6 was on home health services because her care plan, dated 11/21/19, did not document she received third party provider services. The RN stated yes, but the care plan did not document the third party provider services. The home health certification and plan of care, dated 10/13/19 to 12/21/19, documented to notify the physician if glucose was less than 60 milligrams per deciliter (mg/dl) or greater than 250 mg/dl and that the resident was to get her insulin at hour of sleep. The RN was asked why the resident was not getting her insulin at the time ordered by the physician. She stated she did not know why home health was giving the insulin early every day. The home communication log (used by home health for documentation of vital signs and blood glucose levels kept in the residents room), dated 10/23/19 to 12/13/19, was reviewed with the RN.	C5010		

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C5010	Continued From page 8 There were 8/10 results that were noted to be greater than 250 mg/dl. When asked if home health or the center notified the physician of these elevated results. The RN stated the home health staff would notify her of elevated glucose levels, or write the results in the nurse notes. However, she did not notify the physician regarding the elevated glucose results, she thought home health did.	C5010		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL7228	GREEN TREE AT SAND SPRINGS

Type of Survey (select all that apply)

2				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 36967	12/16/2019	12/18/2019	0.50	0.00	15.50	0.00	5.50	4.50
2. 41872	12/16/2019	12/18/2019	0.25	0.00	15.50	0.00	7.75	5.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

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

DEC 3 1 2019

Oklahoma State Department of Health
Creating a State of Health

January 30, 2020

License Number: AL7228

Ms. Arvella McCollom, Administrator
Green Tree At Sand Springs
4402 South 129th West Avenue
Sand Springs, OK 74063

RE: Survey Event IUSJ11

Dear Ms. McCollom:

On December 18, 2019, 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 **March 12, 2020**.

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

Sincerely,

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

SD/jt

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/14/2020** **Facility Name:** Green Tree at Sand Springs **License Number:** AL7228 **Survey Event ID:** IUSJ11 **Date Survey Completed: 12/18/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 911	Based on: observation, interview and record review, it was determined the center failed to provide registered nurse supervision to ensure a resident (#12) did not fill a medication reminder box for one (#7) of one sampled resident who had been assessed by the center to self-administer medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional)

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?	The order to allow self-administration of medication will be added to the MAR of Resident (#7) based on the physician plan of care. Self-med evaluation was completed on December 20, 2019 and the medication reminder box has been removed.
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 who self-administer have the potential to be affected.
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 Resident Director or Designee will 1) provide in-service, training and education to the RN and nursing team on the staffing requirement of a Registered Nurse as outlined in 310:663-9-1(1). 2) RN and nursing team will be in-serviced for compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions and compliance for self-administration of medications.
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.	Enter methods to ensure corrections are sustained: a) The Resident Director or Designee will randomly audit and review the self-medication record of those residents with physician orders to self-medicate. b) The audits and related documentation will be discussed and measured at each QA meeting. c) The audit will be maintained as part of the QA file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/12/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required.	Date Enter a date of signature.
Priscilla McCellon	01/14/2020

OAC 310:663-25-4(F)

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: 1/14/2020** **Facility Name:** *Green Tree at Sand Springs* **License Number:** AL7228 **Survey Event ID:** IUSJ11 **Date Survey Completed: 12/18/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 921	Based on: interview and record review, it was determined the center failed to ensure qualified staff administered inhaled medications for 2 (#5and #11) of 2 sampled residents who had physician ordered medications administered via dry powder inhaler and nebulizer (changes medication from a liquid to a mist).

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	LTCA/MAT (long term care aide/medication administration technician/employee #2 was removed from the medication cart.
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 receiving via dry powder inhalers and nebulizers have the potential to be affected.
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 Resident Director of Designee will provide in-service, training and education to the Nursing Team and staff to include Certified Nurses Aides, Certified Medication Aides and Medication Administration Techs outlining compliance with 310:663-9-2(a) Medication Staffing.
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.	Enter methods to ensure corrections are sustained: a) The Resident Director or Designee will randomly audit the medication administration record for compliance. b) The audits and related documentation will be discussed and measured at each QA meeting. c) The audit will be maintained as part of the QA file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/12/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 01/14/2020

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: 1/14/2020** **Facility Name:** Green Tree at Sand Springs **License Number:** AL7228 **Survey Event ID:** IUSJ11 **Date Survey Completed: 12/18/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 5010	Based on: observation, interview and record review, it was determined the center failed to monitor services provided by third party providers,and failed to ensure physician orders were consistent with the center's orders and completed by third party providers for 2 (#5 and #6) of 2 sampled residents who received services for FSBS (fingerstick blood sugar testing), insulin administration,oxygen and medications via nebulizer (changes medication from a liquid to a mist).

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	The Resident Director or Designee will review physician orders of Residents' (#5 and #6) to ensure all orders of the 3rd party provider are consistent with the facility documentation, making changes if necessary.
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 receiving third party services have the potential to be affected. Monthly meetings with 3rd party providers has been established.
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 Resident Director or Designee will provide in-service, training and education to the Nursing Team on the Care and Services – Coordination of Care as outlined in 63 O.S. 1-890.8(A-D). The Resident Director or Designee will also provide in-service, training and education to the Nursing Team on monitoring of services provided by third party providers and ensuring physician orders are consistent.
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.	Enter methods to ensure corrections are sustained: a) The Resident Director of Designee will audit third party provider documentation to ensure compliance with documentation and to ensure that physician orders are consistent. b) The audits and related documentation will be discussed and measured at each QA meeting. c) The audit will be maintained as part of the QA file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/12/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Bulla M Ellis OAC 310:663-25-4(F)	**Date** Enter a date of signature. 01/19/2020

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			

FEB 10 2020

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OKLAHOMA
State Department
of Health

Delivery via email to: arvella.mccollom@legendseniorliving.com

November 16, 2020

License Number: AL7228

Ms. Arvella McCollom, Administrator
Green Tree At Sand Springs
4402 South 129th West Avenue
Sand Springs, OK 74063

RE: Survey Event IUSJ12

Dear Ms. McCollom:

On **November 12, 2020,** a desk audit/paper revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 18, 2019,** have now been corrected effective **March 12, 2020.**

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

Sincerely,

Users, Lisa D Calvin

Digitally signed by Users, Lisa D Calvin
Date: 2020.11.16 15:07:17 -06'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

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
	AL7228	A. BUILDING: _____ B. WING _____	R 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN TREE AT SAND SPRINGS	4402 SOUTH 129TH WEST AVENUE SAND SPRINGS, OK 74063

(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 desk audit was completed on 11/12/2020. Evidence of correction was submitted for all deficiencies.	{C 000}		

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