OKLAHOMA
State Department
of Health

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

August 2, 2021

License Number: AL7228

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

Survey Event ID: CJEN11

Dear Ms. McCollom:

On **July 20, 2021,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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. 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 will be completed for each violation; and
(6) Be signed by the administrator.

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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.

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

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

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

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

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

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

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

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

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

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

Sincerely,

Lisa Calvin

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

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Green Tree at Sand Springs**
Address: **4402 South 129th West Avenue**
City, State, Zip: **Sand Springs, Okla. 74063**
Provider #: **AL7228**
Complaint #: **#OK00057349**
Investigation Date(s): **07/19/2021 and 07/20/2021**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have adequate staff and provide the care residents need and meet staffing requirements.	S
2. The center failed to ensure staff followed proper infection control procedures.	US

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Click to enter a date at 07/19/2021 at 09:36 a.m.

A sample of 3 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C0910 and C0961 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.
Signage was posted on entrance doors. One point of entry is used to screen in residents, family and staff members. Covid positive residents were in private rooms with signage on doors, and plastic pods were set up

for staff to don/doff proper PPE. Staff and residents are tested weekly due to outbreak status. Housekeeping was observed cleaning resident rooms. Infection policy and procedure was reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

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

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

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

Thank you for bringing these concerns to our attention.

Kayfield for Mary Cooper

Mary Cooper RN

Date report completed: 07/21/2021

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	AL7228	A. BUILDING: _____ B. WING _____	C 07/20/2021

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

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C 000	INITIAL COMMENTS An abbreviated survey was conducted on 07/19/2021 and 07/20/2021 to investigate complaint #OK00057349. Census was 46. The following abbreviations may have been utilized in the writing of this report. ADL (activities of daily living) CNA (certified nursing assistant) CMA (certified medication aide) LPN (licensed practical nurse)	C 000		
C 910 SS=E	310:663-9-1 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:	C 910		

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C 910	Continued From page 1	C 910		

This Rule is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to provide services(adequate staffing) according to the "Assisted Living Resident Agreement" for three (#1, 2 and #3) of three sampled residents for services.

The facility identified 46 who resided in the facility.

Findings:

1. Resident #1 was admitted to the facility on 07/27/18 with diagnoses which included dementia, dysphagia (swallowing problems) and gait disorder.

"Assisted Living Residency Agreement", dated 08/04/18, documented, "...II.Agreements A. Company agrees to the following...3 to provide additional services to the Resident, as agreed upon in the Negotiated Service agreement..."

"[Named facility]...Negotiated Services Agreement", dated, 03/25/2021, documented, "...Mobility... Requires more than one person assist for any transfer or mobility needs." "...Toileting...Requires physical assistance of more than one staff in the bathroom for toileting..." "...Bladder management...requires assistance of more than one staff to don/doff incontinence care products after each episode..." "Bowel management...requires assistance of more than one staff to don/doff incontinence care

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C 910	Continued From page 2	C 910		

products after each episode..."

2. Resident #2 was admitted to the facility on 11/23/2016 with diagnoses which included hypertension (high blood pressure), high cholesterol, cerebrovascular accident (stroke) and hyponatremia (low sodium).

"Assisted Living Residency Agreement", dated 10/24/18, documented, "...II.Agreements A. Company agrees to the following...3 to provide additional services to the Resident, as agreed upon in the Negotiated Service agreement..."

"[Named facility]...Negotiated Services Agreement", dated 06/19/21, documented, "...Mobility...Requires more than one person assist for any transfer or mobility needs...Requires two or more staff to safely transfer..." "...Toileting...Requires physical assistance of more than one staff in the bathroom for toileting..." "...Bladder management... Requires assistance of more than one staff to don/doff incontinence care products after each episode..." "Bowel management...Requires assistance of more than one staff to don/doff incontinence care products after each episode..."

3. Resident #3 was admitted to the facility on 09/22/17 with diagnoses which included acute renal failure, anemia and history of benign prostatic hypertrophy.

"Assisted Living Residency Agreement", dated 03/03/18, documented, "...II.Agreements A. Company agrees to the following...3. to provide additional services to the Resident, as agreed upon in the Negotiated Service agreement..."

A "Plan of accommodation", dated 05/01/19,

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C 910	Continued From page 3	C 910		

documented, "...his condition is consistent with discharge criteria..." Goal: After discussing other options with the family and/or responsible party, it has been agreed upon that keeping resident in his current environment will provide the highest quality of life..."

"[Named facility]...Negotiated Services Agreement", dated 05/31/21, documented, "...Mobility...Requires more than one person assist for any transfer or mobility needs." "...Toileting...Requires frequent escort to bathroom to toilet, frequent request for escort at night...Requires physical assistance of one-two staff in the bathroom for toileting..." "...Bladder management...resident has frequent incontinent accidents and requires assist x 1-2 with incontinent care, occasional two person..." "Bowel management...resident had occasional incontinent accidents. Resident requires assist x 1-2 person with incontinent care..."

On 07/19/21 at 3:00p.m., June and July 2021 staffing schedules were reviewed with the administrator and LPN #1. On the following dates there was only one staff member assigned to the assisted living building and one staff member assigned to the memory care building for 10 p.m. to 6 p.m.

The Administrator acknowledged the findings.
June 6, 2021, one CMA one CNA,
June 10, 2021 two CMA,
June 17, 2021 one CMA, one CNA,
June 28, 2021 two CMA,
July 5, 2021 one CMA, one CNA.

At 3:00 p.m., the administrator was asked what if a resident needed a medication in the middle of the night. She said, "They (staff) flip, one comes

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C 910	Continued From page 4	C 910		

over here the other goes over there, they flip flop then come back."

On 07/19/21 at 3:42 p.m., resident #1's care plan was reviewed with LPN #1. She was asked if the care plan documents that more than one staff is needed and there is only one staff member working is the care plan being implemented, she replied, no.

On 07/20/21, at 5:50 a.m., CMA #5 was asked was there a situation where she left assisted living to come to the memory care. She stated, "I have had to leave that alone over there in the AL, if someone needs a pill over here" she reported the last time was about three weeks ago.

At 6:05 a.m., CNA #4 who primarily works in the memory care building, was asked what the staff did if a resident needed a pill in one building and there was no CMA working and only two staff members. She replied, we traded places. She was asked if she had ever been denied assistance from staff working in the assisted living side, she stated, "they have told me to wait...they are making rounds when I do." She was asked to identify residents in the memory care that were two person assistance for bed mobility, transfers and dressing. She identified resident #1 and resident #2.

At 8:30 a.m., resident #1, #2 and #3's "negotiated services agreement" was reviewed with the administrator. She acknowledged the residents' needs could not be met with one staff member working at night due to residents requiring one to two person assistance for transfers, mobility and toileting.

At 9:35 a.m., the administrator was asked if

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C 910	Continued From page 5 families were notified when there was one staff member working at night and the facility plan to deal with emergent situations. She stated, "No". At 9:40 a.m., CMA #7 who primarily works in the assisted living building was asked to identify any residents that needed two person assistance for transfers. She identified resident #3.	C 910		
C 961 SS=E	310:663-9-6(a) MINIMUM STAFF FOR SERVICES (a) The right number of trained staff shall be on duty, awake, and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents and to carry out all the processes listed in the continuum of care facility's, or assisted living center's, written emergency and disaster preparedness plan for fires and other natural disasters. This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide	C 961		

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C 961	Continued From page 6 services(adequate staffing) according to the "Assisted Living Resident Agreement" for three (#1, 2 and #3) of three sampled residents for services. The facility identified 46 who resided in the facility. Findings: 1. Resident #1 was admitted to the facility on 07/27/18 with diagnoses which included dementia, dysphagia (swallowing problems) and gait disorder. "Assisted Living Residency Agreement", dated 08/04/18, documented, "...II.Agreements A. Company agrees to the following...3 to provide additional services to the Resident, as agreed upon in the Negotiated Service agreement..." "[Named facility]...Negotiated Services Agreement", dated, 03/25/2021, documented, "...Mobility... Requires more than one person assist for any transfer or mobility needs." "...Toileting...Requires physical assistance of more than one staff in the bathroom for toileting..." "...Bladder management...requires assistance of more than one staff to don/doff incontinence care products after each episode..." "Bowel management...requires assistance of more than one staff to don/doff incontinence care products after each episode..." 2. Resident #2 was admitted to the facility on 11/23/2016 with diagnoses which included hypertension (high blood pressure), high cholesterol, cerebrovascular accident (stroke) and hyponatremia (low sodium).	C 961		

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The Administrator acknowledged the findings.
June 6, 2021, one CMA one CNA,
June 10, 2021 two CMA,
June 17, 2021 one CMA, one CNA,
June 28, 2021 two CMA,
July 5, 2021 one CMA, one CNA.

At 3:00 p.m., the administrator was asked what if a resident needed a medication in the middle of the night. She said, "They (staff) flip, one comes over here the other goes over there, they flip flop then come back."

On 07/19/21 at 3:42 p.m., resident #1's care plan was reviewed with LPN #1. She was asked if the care plan documents that more than one staff is needed and there is only one staff member working is the care plan being implemented, she

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C 961	Continued From page 9	C 961		

replied, no.

On 07/20/21, at 5:50 a.m., CMA #5 was asked was there a situation where she left assisted living to come to the memory care. She stated, "I have had to leave that alone over there in the AL, if someone needs a pill over here" she reported the last time was about three weeks ago.

At 6:05 a.m., CNA #4 who primarily works in the memory care building, was asked what the staff did if a resident needed a pill in one building and there was no CMA working and only two staff members. She replied, we traded places. She was asked if she had ever been denied assistance from staff working in the assisted living side, she stated, "they have told me to wait...they are making rounds when I do." She was asked to identify residents in the memory care that were two person assistance for bed mobility, transfers and dressing. She identified resident #1 and resident #2.

At 8:30 a.m., resident #1, #2 and #3's "negotiated services agreement" was reviewed with the administrator. She acknowledged the residents' needs could not be met with one staff member working at night due to residents requiring one to two person assistance for transfers, mobility and toileting.

At 9:35 a.m., the administrator was asked if families were notified when there was one staff member working at night and the facility plan to deal with emergent situations. She stated, "No".

At 9:40 a.m., CMA #7 who primarily works in the assisted living building was asked to identify any residents that needed two person assistance for transfers. She identified resident #3.

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 _____	C 07/20/2021

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

OKLAHOMA
State Department
of Health

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

August 16, 2021

License Number: AL7228

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

Survey Event ID: CJEN11

Dear Ms. McCollom:

On **July 20, 2021,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **September 10, 2021**.

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.

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2021.08.16 13:19:01 -05'00'

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

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/12/2021** **Facility Name:** Green Tree at Sand Springs **License Number:** AL7228 **Survey Event ID:** CJEN11 **Date Survey Completed: 7/20/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 910	Based on: interview and record review, it was determined the facility failed to provide services (adequate staffing) according to the "Assisted Living Resident Agreement" for three (#1, 2 and #3) of three sampled residents for services.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and the conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. The plan of correction is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements.

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 Residence Director or designee will ensure that (adequate staffing) will be provided in compliance with 310:663-9-1 for three (#1, 2 and #3) residents identified as requiring more than one person assist in accordance with the "Assisted Living Agreement" and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. If resources have been exhausted the assisted living will act in accordance with 310:663-9-6 (b). The Residence Director or designee will be in-serviced accordingly.
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 requiring more than one person assist 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?	Should a staffing crisis ensue, the Resident Director or designee of the assisted living will act in accordance with 310:663-9-6 (b). (1) Disclose the one-person staffing and the plan for dealing with urgent and emergent situations to residents and their representatives before admission or prior to one-person staffing if such staffing was not previously practiced by the assisted living center; and, (2) Have in place a plan, approved by the Department, for dealing with urgent or emergent situations, including resident falls, during periods when the assisted living center has only one direct-care staff member on duty.
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;	The Resident Director or designee will audit the "Assisted Living Agreement" for residents requiring more than one person assist along with the corresponding staffing schedule and follow the plan approved by the Department when dealing with urgent or emergent situations.

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 Resident Director or designee will regularly conduct an evaluation of the number of residents requiring more than one person assist and the associated staffing schedule. 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?	9/10/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Arvella McCollom** OAC 310:663-25-4(F)	**Date 8/12/2021**

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: 8/12/2021** **Facility Name:** Green Tree at Sand Springs **License Number:** AL7228 **Survey Event ID:** CJEN11 **Date Survey Completed: 7/20/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 961	Based on: interview and record review, it was determined the facility failed to provide services (adequate staffing) according to the "Assisted Living Resident Agreement" for three (#1, 2 and #3) of three sampled residents for services.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and the conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. The plan of correction is submitted as a confirmation of our ongoing efforts to comply with all statutory and regulatory requirements.

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 Residence Director or designee will ensure that (adequate staffing) will be provided in compliance with 310:663-9-6(a) for three (#1, 2 and #3) residents identified as requiring more than one person assist in accordance with the "Assisted Living Agreement". If resources have been exhausted the assisted living will act in accordance with 310:663-9-6 (b). The Residence Director or designee will be in-serviced accordingly.
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 requiring more than one person assist 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?	Should a staffing crisis ensue, the Resident Director or designee of the assisted living will act in accordance with 310:663-9-6 (b). (1) Disclose the one-person staffing and the plan for dealing with urgent and emergent situations to residents and their representatives before admission or prior to one-person staffing if such staffing was not previously practiced by the assisted living center; and, (2) Have in place a plan, approved by the Department, for dealing with urgent or emergent situations, including resident falls, during periods when the assisted living center has only one direct-care staff member on duty.
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	The Resident Director or designee will audit the "Assisted Living Agreement" for residents requiring more than one person assist along with the corresponding staffing schedule and follow the plan approved by the Department when dealing with urgent or emergent situations. a)The Resident Director or designee will regularly conduct an evaluation of the number of residents requiring more

c. How monitoring records will be kept to evidence the correction.	than one person assist and the associated staffing schedule. 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?	9/10/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Arvella McCollom** OAC 310:663-25-4(F)	**Date 8/12/2021**

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

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

December 16, 2022

License Number: AL7228

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

Survey Event ID: CJEN12

Dear Ms. McCollom:

On **December 15, 2022,** an offsite/paper complaint revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **July 20, 2021,** have now been corrected effective **November 19, 2021.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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 _____	R-C 12/15/2022

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 An offsite/paper revisit was completed on 12/15/22. Credible 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