OKLAHOMA
State Department
of Health

Delivery via email to: dwoodland@sandplumok.com

October 13, 2021

License Number: AL7229

Ms. Dani Woodland, Administrator
Sand Plum Assisted Living Community
9999 East 121st Street South
Bixby, OK 74008-2551

Survey Event ID: 3J9K11

Dear Ms. Woodland:

On **September 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.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance

under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

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

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

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

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

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- 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 Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Sand Plum Assisted Living Community**
Address: **9999 East 121st Street South**
City, State, Zip: **Bixby, OK 74008**
Provider #: **AL7229**
Complaint #: **OK00057754**
Investigation Date(s): **09/16/21 and 09/20/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were not verbally and physically abused by staff.	**US**
2. The center failed to follow proper infection control procedures related to Covid 19.	**S**
3. The center failed to ensure residents could have visitors of choice/visitation was not limited.	**US**

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

An unannounced on-site investigation was initiated on Thursday, September 16, 2021 at 12:40 p.m.

A sample of five residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 unsubstantiated related to this allegation.

An investigation specific to concerns related to: abuse was conducted.

Residents were observed to be well cared for. Residents did not show signs of being afraid of care staff or administrative staff. Staff were responsive to the needs of the residents and interacted with the residents in a kind professional manner.

Multiple residents were interviewed and stated the staff treated them very well and helped them with their needs. The residents stated the staff were kind and gentle. The residents stated they had not been abused and had not seen any other resident being abused. The residents stated the administrator and or other staff had not verbally or physically abused a resident in the dining room. Staff stated they had not observed any staff verbally or physically abusing a resident.

The care notes of the sampled residents documented resident behaviors, resident incidents, resident to resident altercations, and the response taken by the staff. The notes did not document incidents of staff to resident abuse. The incident reports were reviewed. One report documented an altercation between two residents. The resident were separated and made safe. Assessments were completed. An investigation was completed and action was taken. The incident reports did not document any incidents of staff to resident abuse. The abuse policy documented the required elements of abuse prohibition.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 1505 for details.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to concerns related to: visitation was conducted.

Visitors were observed checking in when entering the facility and were screened for Covid -19 symptoms. Residents were observed with visitors. Visitors stayed with residents in the resident rooms.

Residents stated they had visitors at any time. They stated visitation was not restricted. Staff stated residents could have visitors on their patios or in the visitation room. Staff stated visitation was limited if residents were in quarantine. The DON stated the facility followed the state visitation grid for their visitation policy.

The visitation policy was reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation #1 and #3. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

C Blackwell

Celeste Blackwell, RN

Date report completed: 09/21/2021

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
	AL7229	A. BUILDING: _____ B. WING _____	C 09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND PLUM ASSISTED LIVING COMMUNITY	9999 EAST 121ST STREET SOUTH BIXBY, OK 74008

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C 000	INITIAL COMMENTS An abbreviated survey was conducted on 09/16/21 and 09/20/21 to investigate complaint #OK00057754.	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to provide care consistent with practice standards for completing Covid-19 testing for three (#1, #2, and #3) of three residents who were reviewed for Covid-19.
The facility identified 55 who lived in the facility.

Findings:

The non-nursing home testing grids for the state of Oklahoma documented residents with signs and symptoms should be tested regardless of vaccination status.

The CDC article "CDC 24/7: Saving Lives, Protecting People" 02/22/21, documented people with symptoms of Covid-19 should be tested. The article documented the symptoms of Covid -19 included fever, chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea.

1. The pre-admission assessment, dated 05/03/21, for resident #1 documented the resident was alert, oriented to person and place, and required limited assistance with activities of daily living.

The care notes, dated 09/07/21 at 11:04 a.m., documented the resident complained of headache, nausea, and body aches. The notes

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C1505	Continued From page 2 did not document a Covid-19 test was completed. On 09/16/21 at 11:15 a.m., the resident was observed and interviewed in her room. The resident was clean and groomed. The resident was agitated and pacing. The resident expressed anger for having been on quarantine. The resident stated she wasn't sick she just had to go to the bathroom. The resident stated she had not been tested for Covid. 2. The annual assessment, dated 10/01/20, for resident #2 documented the resident was alert/oriented and was independent for activities of daily living. The care notes, dated 09/07/21, documented the resident complained of nausea, body aches, and a headache. The notes did not document a Covid -19 test was completed. On 09/20/21 at 2:22 p.m., the resident was observed and interviewed. The resident was clean and groomed. The resident stated she had been on quarantine in the past two weeks. The resident stated she had not been tested for Covid and denied symptoms. 3. The 14 day assessment, dated 07/14/21, for resident #3 documented the resident was alert/oriented and was independent for activities of daily living. The care notes, dated 09/07/21, documented the resident complained of nausea, vomiting, body aches, and a low grade fever. The notes did not document a Covid-19 test was completed. The notes documented the resident was discharged to the hospital on 09/08/21 related to a fall.	C1505		

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C1505	Continued From page 3 On 09/20/21 at 3:59 p.m., the director of nurses (DON) stated resident #1, #2 and #3 had complained of symptoms to the certified nurse aide (CNA) and the certified medication aide (CMA). The DON stated at that time he was off sick with Covid. The DON stated the residents were not tested for Covid-19 because the facility did not have testing supplies. He stated the residents were placed on quarantine. On 09/20/21 at 6:34 p.m., the administrator stated the facility had not had to test staff or residents for many months. She stated she attempted to get testing supplies from the facility's laboratory suppliers. She stated testing supplies did not arrive for several days.	C1505		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain accurate vital sign records for three (#1, #3, and #5) of five residents whose vital signs were reviewed. The facility identified 55 residents who lived in the facility. Findings:	C1951		

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C1951	Continued From page 4 The vital sign records for residents #1, #3, and #5 were blank. The medication and treatment administration records for 09/2021 for resident #1, #3, and #5 were reviewed. The administration records did not document temperature assessment for the residents. On 09/16/20 and 09/20/21 multiple residents were interviewed. The residents stated staff took their temperatures and asked about symptoms twice a day. On 09/20/21 at 3:59 p.m., the director of nurses state he checked the electronic medical records for the residents. He stated no vital signs were documented for the residents.	C1951		

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Ms. Dani Woodland, Executive Director
Sand Plum Assisted Living Community
9999 East 121st Street South
Bixby, OK 74008-2551

Survey Event ID: 3J9K11

Dear Ms. Woodland:

On **September 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 **October 22, 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: 2021.10.21 08:43:01 -05'00'

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

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C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505	1. All residents to include the state identified residents were audited by the DON/Designee on 10/1/21 for negative effects of the state identified deficient practice. None were noted. 2. While the residents in question were quarantined per the COVID/ infection control protocol after self reported symptoms, a lack of COVID testing supplies resulted in delayed testing; thereby, resulting in the deficient practice. Testing supplies were ordered immediately and recieved by 10/1/21. In an effort to correct this deficient practice, testing supplies were ordered in bulk and will be kept in the community on a continual basis beginning 10/1/21. 3. Staff will be in-serviced by the DON/Designee on the proper testing and supply requirement no later than 10/22/21 as evident by the provided documentation to be kept on file for review. 4. The corrective actions will be implemented no later than 10/22/21 and be monitored/audited weekly by the DON/designee for no les than 90 days or until compliant and then monthly and PRN thereafter on an on-going basis.	

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C1505	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide care consistent with practice standards for completing Covid-19 testing for three (#1, #2, and #3) of three residents who were reviewed for Covid-19. The facility identified 55 who lived in the facility. Findings: The non-nursing home testing grids for the state of Oklahoma documented residents with signs and symptoms should be tested regardless of vaccination status. The CDC article "CDC 24/7: Saving Lives, Protecting People" 02/22/21, documented people with symptoms of Covid-19 should be tested. The article documented the symptoms of Covid -19 included fever, chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea. 1. The pre-admission assessment, dated 05/03/21, for resident #1 documented the resident was alert, oriented to person and place, and required limited assistance with activities of daily living. The care notes, dated 09/07/21 at 11:04 a.m., documented the resident complained of headache, nausea, and body aches. The notes	C1505	5. This plan of correction was reviewed and accepted by the Quality Assurance Committee consisting of the DON, RCC, Executive Director, Marketing Director, Maintenance Director, Activities Director, Dietary Manager, and contracted RN by 10/22/21.	10/22/21

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C1505	Continued From page 2 did not document a Covid-19 test was completed. On 09/16/21 at 11:15 a.m., the resident was observed and interviewed in her room. The resident was clean and groomed. The resident was agitated and pacing. The resident expressed anger for having been on quarantine. The resident stated she wasn't sick she just had to go to the bathroom. The resident stated she had not been tested for Covid. 2. The annual assessment, dated 10/01/20, for resident #2 documented the resident was alert/oriented and was independent for activities of daily living. The care notes, dated 09/07/21, documented the resident complained of nausea, body aches, and a headache. The notes did not document a Covid -19 test was completed. On 09/20/21 at 2:22 p.m., the resident was observed and interviewed. The resident was clean and groomed. The resident stated she had been on quarantine in the past two weeks. The resident stated she had not been tested for Covid and denied symptoms. 3. The 14 day assessment, dated 07/14/21, for resident #3 documented the resident was alert/oriented and was independent for activities of daily living. The care notes, dated 09/07/21, documented the resident complained of nausea, vomiting, body aches, and a low grade fever. The notes did not document a Covid-19 test was completed. The notes documented the resident was discharged to the hospital on 09/08/21 related to a fall.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7229	A. BUILDING: _____ B. WING _____	C 09/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND PLUM ASSISTED LIVING COMMUNITY	9999 EAST 121ST STREET SOUTH BIXBY, OK 74008

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C1505	Continued From page 3 On 09/20/21 at 3:59 p.m., the director of nurses (DON) stated resident #1, #2 and #3 had complained of symptoms to the certified nurse aide (CNA) and the certified medication aide (CMA). The DON stated at that time he was off sick with Covid. The DON stated the residents were not tested for Covid-19 because the facility did not have testing supplies. He stated the residents were placed on quarantine. On 09/20/21 at 6:34 p.m., the administrator stated the facility had not had to test staff or residents for many months. She stated she attempted to get testing supplies from the facility's laboratory suppliers. She stated testing supplies did not arrive for several days.	C1505		10/22/21
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain accurate vital sign records for three (#1, #3, and #5) of five residents whose vital signs were reviewed. The facility identified 55 residents who lived in the facility. Findings:	C1951	1. All residents to include the state identified residents were audited by the DON/Designee on 10/1/21 for negative effects of the state identified deficient practice. None were noted. 2. Although staff have been regularly checking resident vitals monthly and per physician order, they failed to appropiately document findings in the community EMR or otherwise, resulting in the deficient practice. In an effort to correct this deficient practice, all vitals will be documented monthly, per physician orders, and PRN in the EMR directly by the participating staff member beginning 10/1/21 to remain on-going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SAND PLUM ASSISTED LIVING COMMUNITY	9999 EAST 121ST STREET SOUTH BIXBY, OK 74008

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C1951	Continued From page 4 The vital sign records for residents #1, #3, and #5 were blank. The medication and treatment administration records for 09/2021 for resident #1, #3, and #5 were reviewed. The administration records did not document temperature assessment for the residents. On 09/16/20 and 09/20/21 multiple residents were interviewed. The residents stated staff took their temperatures and asked about symptoms twice a day. On 09/20/21 at 3:59 p.m., the director of nurses state he checked the electronic medical records for the residents. He stated no vital signs were documented for the residents.	C1951	3. Staff will be in-serviced by the DON /Designee on the requirement for proper documentation and record keeping no later than 10/22/21 as evident by the documentation to be kept on file for review. 4. These corrective actions will be implemented no later than 10/22/21 and be audited/monitored by the DON /designee for effectivness daily for a period of 14 days, weekly for no less than 10 weeks or until compliant and then monthly and PRN thereafter on an on-going basis. 5. This plan of correction was reviewed and accepted by the Quality Assurance Committee consisting of the DON, RCC, Executive Director, Marketing Director, Maintenance Director, Activities Director, Dietary Manager, and contracted RN by 10/22/21.	10/22/21

OKLAHOMA
State Department
of Health

Delivery via email to: dwoodland@sandplumok.com

December 19, 2022

License Number: AL7229

Ms. Dani Woodland, Administrator
Sand Plum Assisted Living Community
9999 East 121st Street South
Bixby, OK 74008-2551

Survey Event ID: 3J9K12

Dear Ms. Woodland:

On **December 14, 2022,** an offsite complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **September 20, 2021,** have now been corrected effective **December 31, 2021.**

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

Sincerely,

Katie Stagner

Katie Stagner, 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
	AL7229	A. BUILDING: _____ B. WING _____	R 12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAND PLUM ASSISTED LIVING COMMUNITY	9999 EAST 121ST STREET SOUTH BIXBY, OK 74008

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was completed on 12/14/22. 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