

Delivery via email to: dwoodland@sandplumok.com

April 25, 2024

License Number: AL7229

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

RE: Survey Event ID: D4PZ11

Dear Ms. Woodland:

On **April 15, 2024**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **April 15, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,

Clorissa Nubine

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

Enclosure

INVESTIGATIVE REPORT

Facility: Sand Plum Assisted Living Community
Address: 9999 East 121st Street South
City, State, Zip: Bixby, OK 74008
Provider #: AL7229
Complaint #: OK00063644
Investigation Date(s): 04/09/24 through 04/11/24 and 04/15/24

ALLEGATION(S)
The center failed to ensure residents were not physically, verbally, or psychosocially abused and were not fearful of retaliation.
The center failed to ensure residents were assisted with toileting in a timely manner.
The center failed to ensure the call light system was in working order.
The center failed to ensure adequate staff to provide care for dependent residents.

An unannounced on-site investigation was initiated 04/09/2024 at 8:45 a.m.

A sample of ten residents, including any identified residents, 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 Summary of Complaint Investigation:

Residents were observed in their rooms, common areas, activity room, and dining room. Staff were observed responding to call lights, assisting residents as needed, and interacting with residents.

Staff were knowledgeable of the level of assistance residents required and of the facility's policies and procedures. Residents were interviewed about their care and the staff.

Record review consisted of policies and procedures, incident reports including facility investigations, electronic health records, resident charts, care plans, contracts, and assessments.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 04/16/2024

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/15/2024
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C 000	INITIAL COMMENTS A relicensure survey was conducted from 04/09/24 through 04/11/24 and 04/15/24. A complaint investigation (#OK00063644) was conducted in conjunction with the survey. Facility Census: 66 Listed below are abbreviations that will be used throughout this document. CMA - Certified Medication Aide DON - Director of Nursing F - Fahrenheit mg - milligram RN - Registered Nurse	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to: a. ensure hair restraints were utilized; b. maintain infection control during meal service; and c. monitor the dish machine to ensure it was working properly. The DON identified 64 residents who received nourishment from the kitchen. Findings:	C 391		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 391	Continued From page 1 The undated policy, "Cleaning and Sanitizing Food Contact Surfaces SOP", read in parts, "...For the high temperature dish machine: Ensure that food contact surfaces reach a surface temperature of 160F or above when using hot water to sanitize. Ensure the rinse temperature is above 120F...NOTE WHEN USING THE DISH MACHINE IF THE MACHINE DOESN'T GET TO TEMPERATURE IT WILL AUTOMATICALLY SWITCH TO CHLORINE SANITIZATION..." 1. On 04/09/24 at 9:29 a.m., cook #1 was observed preparing the noon meal. Cook #1 was observed to wear a beard restraint with their mustache uncovered. On 04/09/24 at 11:31 a.m., cook #1 was observed to plate the noon meal. Cook #1 was observed to wear a beard restraint with their mustache uncovered. On 04/11/24 at 10:22 a.m., cook #1 was observed preparing the noon meal. Cook #1 was observed to wear a beard restraint with their mustache, approximately one inch of the left side of their beard, and approximately two inches of the right side of the beard uncovered. On 04/11/24 at 10:23 a.m., cook #1 stated they only wore the beard restraint over their beard and was not aware they needed to cover their mustache. They stated they did not know the top of the beard on the right and left side had been uncovered. On 04/11/24 at 10:47 a.m., the dietary manager stated facial hair was to be covered. On 04/15/24 at 11:28 a.m., the administrator	C 391		

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C 391	Continued From page 2 stated the dietician had informed the facility the beard was to be covered but it was ok if the mustache was not covered. 2. On 04/09/24 at 11:31 a.m., cook #2 was observed to plate foods during the noon meal. Cook #2 was observed to don gloves and touch the plates, ladle handles, a bin with pats of butter, and the counter top. Cook #2 was then observed to place hot rolls on the plates with the same gloved hands. On 04/09/24 at 11:39 a.m., cook #2 was observed to plate vegetables and noodles onto the residents plates after touching plates, ladles, and the counter top. Cook #2 was observed to use their gloved hand to provide a barrier to keep the food from rolling off of the plates. On 04/09/24 at 11:44 a.m., cook #1 was observed to obtain tongs and place them on the tray of hot rolls. Cook #2 continued to plate the hot rolls with the same gloved hands. On 04/10/24 at 2:55 p.m., cook #2 stated they washed their hands and used gloves during meal service. They stated they changed their gloves if they became soiled. Cook #2 stated they had not realized they needed to utilize tongs for the rolls until cook #1 had mentioned it to them. Cook #2 stated they tried not to touch anything except hot rolls when plating with gloved hands to maintain infection control. On 04/11/24 at 10:11 a.m., the dietary manager stated they were to use tongs to plate hot rolls to keep their gloves clean. 3. Review of the "Temperature/Chemical Log (Dishmachine or pot/pan sink)" form, dated	C 391		

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C 391	Continued From page 3 February 2024, revealed the following: a. the dish machine had not reached the 150 degree F wash temperature five out of 87 opportunities and 24 opportunities were blank; and b. the dish machine had not reached the 180 degree F rinse temperature 63 out of 87 opportunities and 24 opportunities were blank. The form did not contain testing for chemical sanitation. Review of the "Temperature/Chemical Log (Dishmachine or pot/pan sink)" form, dated March 2024, revealed the following: a. the dish machine had not reached the 150 degree F wash temperature four out of 93 opportunities and 18 opportunities were blank; and b. the dish machine had not reached the 180 degree F rinse temperature 75 out of 87 opportunities and 18 opportunities were blank. The form did not contain testing for chemical sanitation. Review of the "Temperature/Chemical Log (Dishmachine or pot/pan sink)" form, dated 04/01/24 through 04/08/24, revealed the following: a. six out of 24 opportunities for the wash temperature were blank; and b. the dish machine had not reached the 180 degree F rinse temperature 18 out of 24 opportunities and six opportunities were blank. The form did not contain testing for chemical sanitation. On 04/09/24 at 12:09 p.m., the specification of	C 391		

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C 391	Continued From page 4 the dish machine was observed. The specification plate documented for hot water sanitizing the wash temperature was 150 degrees F and the rinse temperature was 180 degrees F. The specification plate documented for chemical sanitizing the wash and rinse temperatures were 120 degrees F and a minimum of 50 ppm for chlorine concentration. On 04/09/24 at 12:11 p.m., the dish machine was observed with the dietary manager. They stated the dish machine was a high temperature machine but if it did not reach the sanitizing temperature the machine would automatically dispense chemical sanitation. The dish machine was ran by the dietary manager and was observed to reach a wash temperature of 138 degrees F and a rinse temperature of 151 degrees F. The machine was observed to dispense chemical sanitation. The dietary manager ran and tested the dish machine three times before the test strips registered 100 ppm. On 04/09/24 at 12:15 a.m., the dietary manager was asked how they ensured proper sanitation with the dish machine. They stated it was a high temperature machine and knew when it switched to chemical sanitation because they could smell chlorine at times. The dietary manager was asked how they ensured proper chemical sanitation. They stated they used the test strips daily but did not document the values. They stated the weekend staff were supposed to monitor the dish machine for proper sanitation but they had not been completing the task.	C 391		
C 521 SS=E	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the	C 521		

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C 521	Continued From page 5 admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure admission assessments were completed for one (#8) of ten sampled residents whose assessments were reviewed. The DON identified 66 residents who resided in the facility. Findings: 1. Resident #8 had diagnoses which included nausea and was admitted to the facility on 12/18/23. Review of the electronic clinical record, the hard chart, and the assessment binders did not reveal a preadmission or admission assessment had been completed. On 04/11/24 at 11:04 a.m., the DON stated they could not find anymore assessments for Resident #8. On 04/15/24 at 2:39 p.m., the administrator stated they could not locate any further assessments. On 04/15/24 at 2:44 p.m., RN #1 stated they	C 521		

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C 521	Continued From page 6 signed off on assessments and completed some as needed. They stated they did not monitor to ensure assessments were completed.	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive assessments were completed for four (#6, 8, 9, and #10) of ten sampled residents whose assessments were reviewed. The DON identified 66 residents who resided in the facility. Findings: 1. Resident #6 had diagnoses which included Parkinson's disease and was admitted on 07/31/23. A preadmission assessment, dated 07/18/23, was provided by the facility. Review of the electronic clinical record, the hard	C 522		

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C 522	Continued From page 7 chart, and the assessment binders did not reveal a comprehensive assessment had been completed. 2. Resident #8 had diagnoses which included nausea and was admitted to the facility on 12/18/23. Review of the electronic clinical record, the hard chart, and the assessment binders did not reveal a comprehensive assessment had been completed. 3. Resident #9 had diagnoses which included ascending peripheral neuropathies and was admitted to the facility on 02/13/23. A preadmission assessment, dated 02/07/23, was provided by the facility. Review of the electronic clinical record, the hard chart, and the assessment binders did not reveal a comprehensive assessment had been completed. 4. Resident #10 had diagnoses which included osteoporosis and was admitted to the facility on 08/05/22. A preadmission assessment, dated 07/06/22, was provided by the facility. Review of the electronic clinical record, the hard chart, and the assessment binders did not reveal a comprehensive assessment had been completed. On 04/11/24 at 11:04 a.m., the DON stated they could not find anymore assessments for the listed residents.	C 522		

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C 522	Continued From page 8 On 04/15/24 at 2:39 p.m., the administrator stated they could not locate any further assessments for the listed residents. On 04/15/24 at 2:44 p.m., RN #1 stated they signed off on assessments and completed some as needed. They stated they did not monitor to ensure comprehensive assessments were completed. On 04/11/24 at 11:04 a.m., the DON stated they could not find anymore assessments for the listed residents. On 04/15/24 at 2:39 p.m., the administrator stated they could not locate any further assessments for the listed residents. On 04/15/24 at 2:44 p.m., RN #1 stated they signed off on assessments and completed some as needed. They stated they did not monitor to ensure comprehensive assessments were completed.	C 522		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments were signed by an RN or the resident's personal physician for two (#5 and #9) of ten sampled residents whose	C 542		

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C 542	Continued From page 9 assessments were reviewed. The DON identified 66 residents who resided in the facility. Findings: 1. Resident #5 had diagnoses which included hypertension. The preadmission assessment, dated 11/18/22, was not signed by an RN or the resident's personal physician. 2. Resident #9 had diagnoses which included ascending peripheral neuropathies. The preadmission assessment, dated 02/07/23, was not signed by an RN or the resident's personal physician. On 04/15/24 at 2:44 p.m., RN #1 stated they were responsible to sign off on the assessments. They stated they had not monitored to ensure assessments were signed by an RN or physician,	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.	C 543		

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C 543	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments included a personal interview with the resident or resident representative for three (#3, 4, and #6) of ten sampled residents whose assessments were reviewed. The DON identified 66 residents who resided in the facility. Findings: 1. Resident #3 had diagnoses which included dementia. The assessment, dated 09/18/23, did not contain a personal interview with the resident or the resident's representative. The assessment type was not indicated on the form. 2. Resident #4 had diagnoses which included hypertension. The annual assessment, dated 07/08/23, did not contain a personal interview with the resident or the resident's representative. 3. Resident #6 had diagnoses which included Parkinson's disease. The preadmission assessment, dated 07/18/23, did not contain a personal interview with the resident or the resident's representative. On 04/15/24 at 11:59 a.m., the administrator reviewed the assessments and stated the nurse should have completed a personal interview with the resident or resident representative but they	C 543		

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C 543	Continued From page 11 probably forgot to have them sign the assessment to indicate an interview was completed.	C 543		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop a service plan/care plan for two (#6 and #8) of ten sampled residents whose records were reviewed. The DON identified 66 resident who resided in the facility. Findings: The "Care Planning - Interdisciplinary Team" policy, dated September 2013, read in parts, "...Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident..." 1. Resident #6 had diagnoses which included Parkinson's disease and a history of cerebrovascular accident and was admitted to the facility on 07/28/23.	C 552		

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C 552	Continued From page 12 Review of the clinical record did not reveal a comprehensive care plan had been developed. 2. Resident #8 had diagnoses which included nausea and was admitted to the facility on 12/18/23. Review of the clinical record did not reveal a comprehensive care plan had been developed. On 04/15/24 at 4:01 p.m., the DON and resident care coordinator stated they were unable to locate comprehensive care plans for Resident #6 and Resident #8. They stated every resident should have a care plan but they were unable to locate any further care plans.	C 552			
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	C1505			

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C1505	Continued From page 13 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure physician orders were followed when administering medications for one (#11) of seven residents observed during medication administration. The resident care coordinator identified 56 residents who received medications from staff who resided in the facility. Findings: The "Administering Medications" policy, dated April 2019, read in parts, "...Medications are administered in accordance with prescriber orders...The following information is checked/verified for each resident prior to administering medications...Vital signs, if necessary..."	C1505		

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C1505	Continued From page 14 Resident #11 had diagnoses which included hypertension. A "Physician Order", dated 09/05/22, documented the resident was ordered carvedilol 18.75 mg by mouth twice daily at 8:00 a.m. and 8:00 p.m. The order documented to hold the medication if the systolic blood pressure was less than 125 or the pulse was less than 60. Review of the medication administration record, dated March 2024, revealed the following: a. the carvedilol was documented as administered five times out of 31 opportunities on the day shift when the documented systolic blood pressure was less than 125; b. there were six day shifts in which the blood pressure was not documented out of 31 opportunities; and c. there were 30 evening shifts in which the blood pressure was not documented out of 31 opportunities. On 04/10/24 at 9:21 a.m., CMA #1 was observed to administer medications to Resident #11. CMA #1 obtained the resident's vital signs and stated the blood pressure was 120/90. CMA #1 was observed to administer carvedilol 18.75 mg by mouth. Review of the medication administration record, dated 04/01/24 through 04/11/24 at 10:08 a.m., revealed the following: a. the carvedilol was documented as administered four times out of 11 opportunities on the day shift when the documented systolic blood pressure was less than 125; b. there were three day shifts in which the blood	C1505		

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C1505	Continued From page 15 pressure was not documented out of 11 opportunities; and c. there were ten evening shifts in which the blood pressure was not documented out of ten opportunities. On 04/11/24 at 11:17 a.m., CMA #1 reviewed the physician order, medication administration record, and vital signs for Resident #11 and stated they should have held the carvedilol per physician's order on 04/10/24. On 04/11/24 at 11:48 a.m., the DON reviewed the physician order, medication administration record, and vital signs for Resident #11 and stated the CMAs should have held the carvedilol per the physician's order related to the systolic blood pressure. The DON stated they were trying to figure out how to enter the order so vital signs could be documented with the evening dose.	C1505		
C5020 SS=E	63 O.S. 1-890.8(F)(3)(a-d) Care and Services - POC and Follow-up 3. The person or persons responsible for performing, monitoring and assuring compliance with the plan of accommodation shall be expressly specified in the plan of accommodation and shall include the assisted living center and any of the following: a. the personal or attending physician of the resident, b. a home care agency, c. a hospice, or d. other designated persons; The plan of accomodation shall be reviewed at least quarterly by a licensed health care professional.	C5020		

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STATE FORM

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C5020	Continued From page 17 documented the resident required on-going skilled nursing services from a 3rd party provider related to acute respiratory failure. The "Plan of Accommodation" read in parts, "...REVIEW OF RESOLUTION WILL BE CONDUCTED BY THE FOLLOWING PARTICIPANT ON AN ANNUAL OR AS NEEDED BASIS DUE TO CHANGE IN CONDITION..." Review of the clinical record did not reveal the plan of accommodation had been updated quarterly. 2. Resident #8 had diagnoses which included ascending peripheral neuropathies. The "Plan of Accommodation", dated 02/25/23, documented the resident required on-going skilled nursing services from a 3rd party provider related to therapeutic intervention from physical therapy. Review of the clinical record did not reveal the plan of accommodation had been updated quarterly. On 04/11/24 at 12:15 p.m., the administrator stated the nursing department was responsible to update the plans of accommodation. On 04/15/24 at 4:00 p.m., the DON stated a plan of accommodation was to be updated annually.	C5020		

Delivery via email to: dwoodland@sandplumok.com

May 21, 2024

License Number: AL7229

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

RE: Survey Event D4PZ11

Dear Ms. Woodland:

On **April 15, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 20, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Clorissa Nubine

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

Enclosure

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 04/09/24 through 04/11/24 and 04/15/24. A complaint investigation (#OK00063644) was conducted in conjunction with the survey. Facility Census: 66 Listed below are abbreviations that will be used throughout this document. CMA - Certified Medication Aide DON - Director of Nursing F - Fahrenheit mg - milligram RN - Registered Nurse	C 000	This 2567 is in response to the state identified deficient practices. 1. All residents were reviewed by the ED/Designee to ensure no negative outcomes secondary to the identified deficiencies by 5/15/2024. None were noted. All dietary staff will be in-serviced by the ED/DM/Designee by 5/20/2024 on the following: Hair Coverings-Head and facial hair must be completely covered by the provided PPE to ensure sanitation at any point past the service line /kitchen thresholds. Infection Control- Cross contamination prevention to include the appropriate use of gloves, spoodles, tongs, and utensils, etc., while cooking and/or serving.	5/20/2024
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to: a. ensure hair restraints were utilized; b. maintain infection control during meal service; and c. monitor the dish machine to ensure it was working properly. The DON identified 64 residents who received nourishment from the kitchen. Findings:	C 391	Sanitation- The importance of proper machine temperatures and checks to ensure dish sanitation as well as the temperature check requirements. Additionally, the need to ensure the temperature and/or chemical sanitation logs must be completed daily. A third-party company was called in to service the dishwasher and verify proper working order on 4/25/24. Service slip on file. This correction will be monitored for effectiveness by the DM/Designee daily until complaint but no less than 90 days and PRN thereafter on an On-going basis beginning 5/20/24. The completed audit form to be kept on file for review. The Quality Assurance and Program Improvement Committee consisting of the Executive Director, RN, Director of Nursing, Resident Care Coordinator, Marketing Director, Maintenance Director, Dietary Supervisor, and Activity Director, with oversight by an involved physician, has reviewed and accepted this Plan of Corrections as of 5/20/2024.	

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Lani Woodland

Executive Director

5/9/2024

STATE FORM

6899

D4PZ11

If continuation sheet 1 of 18

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C 391	Continued From page 1 The undated policy, "Cleaning and Sanitizing Food Contact Surfaces SOP", read in parts, "...For the high temperature dish machine: Ensure that food contact surfaces reach a surface temperature of 160F or above when using hot water to sanitize. Ensure the rinse temperature is above 120F...NOTE WHEN USING THE DISH MACHINE IF THE MACHINE DOESN'T GET TO TEMPERATURE IT WILL AUTOMATICALLY SWITCH TO CHLORINE SANITIZATION..." 1. On 04/09/24 at 9:29 a.m., cook #1 was observed preparing the noon meal. Cook #1 was observed to wear a beard restraint with their mustache uncovered. On 04/09/24 at 11:31 a.m., cook #1 was observed to plate the noon meal. Cook #1 was observed to wear a beard restraint with their mustache uncovered. On 04/11/24 at 10:22 a.m., cook #1 was observed preparing the noon meal. Cook #1 was observed to wear a beard restraint with their mustache, approximately one inch of the left side of their beard, and approximately two inches of the right side of the beard uncovered. On 04/11/24 at 10:23 a.m., cook #1 stated they only wore the beard restraint over their beard and was not aware they needed to cover their mustache. They stated they did not know the top of the beard on the right and left side had been uncovered. On 04/11/24 at 10:47 a.m., the dietary manager stated facial hair was to be covered. On 04/15/24 at 11:28 a.m., the administrator	C 391		5/20/2024

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C 391	Continued From page 2 stated the dietician had informed the facility the beard was to be covered but it was ok if the mustache was not covered. 2. On 04/09/24 at 11:31 a.m., cook #2 was observed to plate foods during the noon meal. Cook #2 was observed to don gloves and touch the plates, ladle handles, a bin with pats of butter, and the counter top. Cook #2 was then observed to place hot rolls on the plates with the same gloved hands. On 04/09/24 at 11:39 a.m., cook #2 was observed to plate vegetables and noodles onto the residents plates after touching plates, ladles, and the counter top. Cook #2 was observed to use their gloved hand to provide a barrier to keep the food from rolling off of the plates. On 04/09/24 at 11:44 a.m., cook #1 was observed to obtain tongs and place them on the tray of hot rolls. Cook #2 continued to plate the hot rolls with the same gloved hands. On 04/10/24 at 2:55 p.m., cook #2 stated they washed their hands and used gloves during meal service. They stated they changed their gloves if they became soiled. Cook #2 stated they had not realized they needed to utilize tongs for the rolls until cook #1 had mentioned it to them. Cook #2 stated they tried not to touch anything except hot rolls when plating with gloved hands to maintain infection control. On 04/11/24 at 10:11 a.m., the dietary manager stated they were to use tongs to plate hot rolls to keep their gloves clean. 3. Review of the "Temperature/Chemical Log (Dishmachine or pot/pan sink)" form, dated	C 391		5/20/2024

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C 391	Continued From page 3 February 2024, revealed the following: a. the dish machine had not reached the 150 degree F wash temperature five out of 87 opportunities and 24 opportunities were blank; and b. the dish machine had not reached the 180 degree F rinse temperature 63 out of 87 opportunities and 24 opportunities were blank. The form did not contain testing for chemical sanitation. Review of the "Temperature/Chemical Log (Dishmachine or pot/pan sink)" form, dated March 2024, revealed the following: a. the dish machine had not reached the 150 degree F wash temperature four out of 93 opportunities and 18 opportunities were blank; and b. the dish machine had not reached the 180 degree F rinse temperature 75 out of 87 opportunities and 18 opportunities were blank. The form did not contain testing for chemical sanitation. Review of the "Temperature/Chemical Log (Dishmachine or pot/pan sink)" form, dated 04/01/24 through 04/08/24, revealed the following: a. six out of 24 opportunities for the wash temperature were blank; and b. the dish machine had not reached the 180 degree F rinse temperature 18 out of 24 opportunities and six opportunities were blank. The form did not contain testing for chemical sanitation. On 04/09/24 at 12:09 p.m., the specification of	C 391		5/20/2024

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C 391	Continued From page 4 the dish machine was observed. The specification plate documented for hot water sanitizing the wash temperature was 150 degrees F and the rinse temperature was 180 degrees F. The specification plate documented for chemical sanitizing the wash and rinse temperatures were 120 degrees F and a minimum of 50 ppm for chlorine concentration. On 04/09/24 at 12:11 p.m., the dish machine was observed with the dietary manager. They stated the dish machine was a high temperature machine but if it did not reach the sanitizing temperature the machine would automatically dispense chemical sanitation. The dish machine was ran by the dietary manager and was observed to reach a wash temperature of 138 degrees F and a rinse temperature of 151 degrees F. The machine was observed to dispense chemical sanitation. The dietary manager ran and tested the dish machine three times before the test strips registered 100 ppm. On 04/09/24 at 12:15 a.m., the dietary manager was asked how they ensured proper sanitation with the dish machine. They stated it was a high temperature machine and knew when it switched to chemical sanitation because they could smell chlorine at times. The dietary manager was asked how they ensured proper chemical sanitation. They stated they used the test strips daily but did not document the values. They stated the weekend staff were supposed to monitor the dish machine for proper sanitation but they had not been completing the task.	C 391		5/20/2024
C 521 SS=E	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the	C 521		

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C 521	Continued From page 5 admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure admission assessments were completed for one (#8) of ten sampled residents whose assessments were reviewed. The DON identified 66 residents who resided in the facility. Findings: 1. Resident #8 had diagnoses which included nausea and was admitted to the facility on 12/18/23. Review of the electronic clinical record, the hard chart, and the assessment binders did not reveal a preadmission or admission assessment had been completed. On 04/11/24 at 11:04 a.m., the DON stated they could not find anymore assessments for Resident #8. On 04/15/24 at 2:39 p.m., the administrator stated they could not locate any further assessments. On 04/15/24 at 2:44 p.m., RN #1 stated they	C 521	1.All residents will be reviewed by the DON/Designee by 5/20/24 to ensure no negative outcomes secondary to the identified assessment deficiency. Any identified negative outcomes will be Immediately rectified by a complete re-Assessment with care plan follow up to Ensure on-going quality care. This will be Evident by the completed re-assessments To be kept on file for review. 2.The responsible staff to include all Licensed staff whose scope of practice Includes assessments will be in-serviced By the ED/Designee on the assessment Requirements, such as timeframes, resident and/or responsible party participation & requirements to include Comprehensive Care Plans, Accommodations of Care with quarterly review, and RN review by 5/20/24 as evident by the signed inservice form as well as the compliant assessments, Care Plans, and Accommodations of Care to be kept on file for review.	5/20/2024

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C 521	Continued From page 6 signed off on assessments and completed some as needed. They stated they did not monitor to ensure assessments were completed.	C 521	3.This correction will be monitored for Effectiveness by the DON/ED/Designee Upon each admit on an on-going basis For no less than 90 days. Follow up Assessments to include 14 days, significant change, and annual assessments, will be monitored weekly until compliant but no less than 90 days as will be evident by the completed audit form to be kept on file for review.	5/20/2024
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive assessments were completed for four (#6, 8, 9, and #10) of ten sampled residents whose assessments were reviewed. The DON identified 66 residents who resided in the facility. Findings: 1. Resident #6 had diagnoses which included Parkinson's disease and was admitted on 07/31/23. A preadmission assessment, dated 07/18/23, was provided by the facility. Review of the electronic clinical record, the hard	C 522	The Quality Assurance and Program Improvement Committee consisting of The Executive Director, RN, Director of Nursing, Resident Care Coordinator, Marketing Director, Maintenance Director, Dietary Supervisor, and Activity Director, With oversight by an involved physician, Has reviewed and accepted this Plan of Corrections as of 5/20/2024.	

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NAME OF PROVIDER OR SUPPLIER SAND PLUM ASSISTED LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 9999 EAST 121ST STREET SOUTH BIXBY, OK 74008		
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C 522	Continued From page 7 chart, and the assessment binders did not reveal a comprehensive assessment had been completed. 2. Resident #8 had diagnoses which included nausea and was admitted to the facility on 12/18/23. Review of the electronic clinical record, the hard chart, and the assessment binders did not reveal a comprehensive assessment had been completed. 3. Resident #9 had diagnoses which included ascending peripheral neuropathies and was admitted to the facility on 02/13/23. A preadmission assessment, dated 02/07/23, was provided by the facility. Review of the electronic clinical record, the hard chart, and the assessment binders did not reveal a comprehensive assessment had been completed. 4. Resident #10 had diagnoses which included osteoporosis and was admitted to the facility on 08/05/22. A preadmission assessment, dated 07/06/22, was provided by the facility. Review of the electronic clinical record, the hard chart, and the assessment binders did not reveal a comprehensive assessment had been completed. On 04/11/24 at 11:04 a.m., the DON stated they could not find anymore assessments for the listed residents.	C 522	1.All residents will be reviewed by the DON/Designee by 5/20/24 to ensure no negative outcomes secondary to the identified assessment deficiency. Any identified negative outcomes will be Immediately rectified by a complete re-Assessment with care plan follow up to Ensure on-going quality care. This will be Evident by the completed re-assessments To be kept on file for review. 2.The responsible staff to include all Licensed staff whose scope of practice Includes assessments will be in-serviced By the ED/Designee on the assessment Requirements, such as timeframes, resident and/or responsible party participation & requirements to include Comprehensive Care Plans, Accommodations of Care with quarterly review, and RN review by 5/20/24 as evident by the signed inservice form as well as the compliant assessments, Care Plans, and Accommodations of Care to be kept on file for review.	5/20/2024

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C 522	Continued From page 8 On 04/15/24 at 2:39 p.m., the administrator stated they could not locate any further assessments for the listed residents. On 04/15/24 at 2:44 p.m., RN #1 stated they signed off on assessments and completed some as needed. They stated they did not monitor to ensure comprehensive assessments were completed. On 04/11/24 at 11:04 a.m., the DON stated they could not find anymore assessments for the listed residents. On 04/15/24 at 2:39 p.m., the administrator stated they could not locate any further assessments for the listed residents. On 04/15/24 at 2:44 p.m., RN #1 stated they signed off on assessments and completed some as needed. They stated they did not monitor to ensure comprehensive assessments were completed.	C 522	3.This correction will be monitored for Effectiveness by the DON/ED/Designee Upon each admit on an on-going basis For no less than 90 days. Follow up Assessments to include 14 days, significant change, and annual assessments, will be monitored weekly until compliant but no less than 90 days as will be evident by the completed audit form to be kept on file for review. The Quality Assurance and Program Improvement Committee consisting of The Executive Director, RN, Director of Nursing, Resident Care Coordinator, Marketing Director, Maintenance Director, Dietary Supervisor, and Activity Director, With oversight by an involved physician, Has reviewed and accepted this Plan of Corrections as of 5/20/2024.	5/20/2024
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments were signed by an RN or the resident's personal physician for two (#5 and #9) of ten sampled residents whose	C 542	1.All residents will be reviewed by the DON/Designee by 5/20/24 to ensure no negative outcomes secondary to the identified assessment deficiency. Any identified negative outcomes will be Immediately rectified by a complete re- Assessment with care plan follow up to Ensure on-going quality care. This will be Evident by the completed re-assessments To be kept on file for review	

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C 542	Continued From page 9 assessments were reviewed. The DON identified 66 residents who resided in the facility. Findings: 1. Resident #5 had diagnoses which included hypertension. The preadmission assessment, dated 11/18/22, was not signed by an RN or the resident's personal physician. 2. Resident #9 had diagnoses which included ascending peripheral neuropathies. The preadmission assessment, dated 02/07/23, was not signed by an RN or the resident's personal physician. On 04/15/24 at 2:44 p.m., RN #1 stated they were responsible to sign off on the assessments. They stated they had not monitored to ensure assessments were signed by an RN or physician,	C 542	2.The responsible staff to include all Licensed staff whose scope of practice Includes assessments will be in-serviced By the ED/Designee on the assessment Requirements, such as timeframes, resident and/or responsible party participation & requirements to include Comprehensive Care Plans, Accommodations of Care with quarterly review, and RN review by 5/20/24 as evident by the signed inservice form as well as the compliant assessments, Care Plans, and Accommodations of Care to be kept on file for review. 3.This correction will be monitored for Effectiveness by the DON/ED/Designee Upon each admit on an on-going basis For no less than 90 days. Follow up Assessments to include 14 days, significant change, and annual assessments, will be monitored weekly until compliant but no less than 90 days as will be evident by the completed audit form to be kept on file for review. The Quality Assurance and Program Improvement Committee consisting of The Executive Director, RN, Director of Nursing, Resident Care Coordinator, Marketing Director, Maintenance Director, Dietary Supervisor, and Activity Director, With oversight by an involved physician, Has reviewed and accepted this Plan of Corrections as of 5/20/2024.	5/20/2024
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.	C 543		

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C 543	Continued From page 10 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments included a personal interview with the resident or resident representative for three (#3, 4, and #6) of ten sampled residents whose assessments were reviewed. The DON identified 66 residents who resided in the facility. Findings: 1. Resident #3 had diagnoses which included dementia. The assessment, dated 09/18/23, did not contain a personal interview with the resident or the resident's representative. The assessment type was not indicated on the form. 2. Resident #4 had diagnoses which included hypertension. The annual assessment, dated 07/08/23, did not contain a personal interview with the resident or the resident's representative. 3. Resident #6 had diagnoses which included Parkinson's disease. The preadmission assessment, dated 07/18/23, did not contain a personal interview with the resident or the resident's representative. On 04/15/24 at 11:59 a.m., the administrator reviewed the assessments and stated the nurse should have completed a personal interview with the resident or resident representative but they	C 543		5/20/2024

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C 543	Continued From page 11 probably forgot to have them sign the assessment to indicate an interview was completed.	C 543		5/20/2024
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop a service plan/care plan for two (#6 and #8) of ten sampled residents whose records were reviewed. The DON identified 66 resident who resided in the facility. Findings: The "Care Planning - Interdisciplinary Team" policy, dated September 2013, read in parts, "...Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident..." 1. Resident #6 had diagnoses which included Parkinson's disease and a history of cerebrovascular accident and was admitted to the facility on 07/28/23.	C 552	1.All residents will be reviewed by the DON/Designee by 5/20/24 to ensure no negative outcomes secondary to the identified assessment deficiency. Any identified negative outcomes will be Immediately rectified by a complete re- Assessment with care plan follow up to Ensure on-going quality care. This will be Evident by the completed re-assessments To be kept on file for review. 2.The responsible staff to include all Licensed staff whose scope of practice Includes assessments will be in-serviced By the ED/Designee on the assessment Requirements, such as timeframes, resident and/or responsible party participation & requirements to include Comprehensive Care Plans, Accommodations of Care with quarterly review, and RN review by 5/20/24 as evident by the signed inservice form as well as the compliant assessments, Care Plans, and Accommodations of Care to be kept on file for review.	

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C 552	Continued From page 12 Review of the clinical record did not reveal a comprehensive care plan had been developed. 2. Resident #8 had diagnoses which included nausea and was admitted to the facility on 12/18/23. Review of the clinical record did not reveal a comprehensive care plan had been developed. On 04/15/24 at 4:01 p.m., the DON and resident care coordinator stated they were unable to locate comprehensive care plans for Resident #6 and Resident #8. They stated every resident should have a care plan but they were unable to locate any further care plans.	C 552	3.This correction will be monitored for Effectiveness by the DON/ED/Designee Upon each admit on an on-going basis For no less than 90 days. Follow up Assessments to include 14 days, significant change, and annual assessments, will be monitored weekly until compliant but no less than 90 days as will be evident by the completed audit form to be kept on file for review. The Quality Assurance and Program Improvement Committee consisting of The Executive Director, RN, Director of Nursing, Resident Care Coordinator, Marketing Director, Maintenance Director, Dietary Supervisor, and Activity Director, With oversight by an involved physician, Has reviewed and accepted this Plan of Corrections as of 5/20/2024.	5/20/2024
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	C1505	1.All residents will be reviewed by the DON /Designee by 5/20/24 to ensure no negative outcomes secondary to the identified deficiency. None were noted. The associated CMA was immediately provided education but chose to leave employment of her own recognizance. 2.All staff responsible for medication administration will be re-inserviced by the DON/Designee by 5/20/2024 on the Medication Administration requirements to include strict adherence to the physician order and parameters to include vitals upon the administration of any medication.	

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C1505	Continued From page 13 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure physician orders were followed when administering medications for one (#11) of seven residents observed during medication administration. The resident care coordinator identified 56 residents who received medications from staff who resided in the facility. Findings: The "Administering Medications" policy, dated April 2019, read in parts, "...Medications are administered in accordance with prescriber orders...The following information is checked/verified for each resident prior to administering medications...Vital signs, if necessary..."	C1505	3.This correction will be monitored for effectiveness by the DON/Designee daily for one week, bi-weekly for no less than 3 weeks, then weekly and PRN on an on-going basis until complaint but no less than 8 weeks. This will be evident by the completed MAR w/ notes and the completed audit form to be kept on file for review. The Quality Assurance and Program Improvement Committee consisting of The Executive Director, RN, Director of Nursing, Resident Care Coordinator, Marketing Director, Maintenance Director, Dietary Supervisor, and Activity Director, With oversight by an involved physician, Has reviewed and accepted this Plan of Corrections as of 5/20/2024.	5/20/2024

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C1505	Continued From page 14 Resident #11 had diagnoses which included hypertension. A "Physician Order", dated 09/05/22, documented the resident was ordered carvedilol 18.75 mg by mouth twice daily at 8:00 a.m. and 8:00 p.m. The order documented to hold the medication if the systolic blood pressure was less than 125 or the pulse was less than 60. Review of the medication administration record, dated March 2024, revealed the following: a. the carvedilol was documented as administered five times out of 31 opportunities on the day shift when the documented systolic blood pressure was less than 125; b. there were six day shifts in which the blood pressure was not documented out of 31 opportunities; and c. there were 30 evening shifts in which the blood pressure was not documented out of 31 opportunities. On 04/10/24 at 9:21 a.m., CMA #1 was observed to administer medications to Resident #11. CMA #1 obtained the resident's vital signs and stated the blood pressure was 120/90. CMA #1 was observed to administer carvedilol 18.75 mg by mouth. Review of the medication administration record, dated 04/01/24 through 04/11/24 at 10:08 a.m., revealed the following: a. the carvedilol was documented as administered four times out of 11 opportunities on the day shift when the documented systolic blood pressure was less than 125; b. there were three day shifts in which the blood	C1505		5/20/2024

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C1505	Continued From page 15 pressure was not documented out of 11 opportunities; and c. there were ten evening shifts in which the blood pressure was not documented out of ten opportunities. On 04/11/24 at 11:17 a.m., CMA #1 reviewed the physician order, medication administration record, and vital signs for Resident #11 and stated they should have held the carvedilol per physician's order on 04/10/24. On 04/11/24 at 11:48 a.m., the DON reviewed the physician order, medication administration record, and vital signs for Resident #11 and stated the CMAs should have held the carvedilol per the physician's order related to the systolic blood pressure. The DON stated they were trying to figure out how to enter the order so vital signs could be documented with the evening dose.	C1505		5/20/2024
C5020 SS=E	63 O.S. 1-890.8(F)(3)(a-d) Care and Services - POC and Follow-up 3. The person or persons responsible for performing, monitoring and assuring compliance with the plan of accommodation shall be expressly specified in the plan of accommodation and shall include the assisted living center and any of the following: a. the personal or attending physician of the resident, b. a home care agency, c. a hospice, or d. other designated persons; The plan of accomodation shall be reviewed at least quarterly by a licensed health care professional.	C5020		