OKLAHOMA
State Department
of Health

Delivery via email to: dwoodland@sandplumok.com

February 1, 2023

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: CMPF11

Dear Ms. Woodland:

On **January 26, 2023**, agents from our office concluded a State Licensure survey with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on January 26, 2023.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;

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

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 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 not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement 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 #: **OK00060038**
Investigation Dates: **01/19/2023, 01/23/2023 through 01/26/2023**

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to follow the guidelines provided by CMS regarding the protection of the residents with COVID exposure.	**S**
2. The center failed to notify families of the residents regarding their exposure to COVID and the requirements by the regulatory agency in regards to care and treatment.	**US**

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

An unannounced on-site investigation was initiated 01/19/2023 at 1:20 p.m.

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

The investigation was conducted following standards set by the 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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1502 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

Residents were observed in the hallways, dining room and common areas to be clean and dressed. No isolation

carts were observed in the facility and the administration stated there were no residents who were positive for COVID-19. Staff was observed assisting residents with activities of daily living and were wearing masks and using hand sanitizer.

Administration stated they keep family and residents up to date concerning their health status. Sampled residents stated the staff help them with activities of daily living and their needs were met.

Sampled residents' clinical record review documented residents and families received updates on changes in care. A six-month review of resident council minutes and grievances did not document incidents related to notification of COVID-19.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction POC. The 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 #2. No further action is required.

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

Thank you for bringing these concerns to our attention.

Anita Newman, LPN, CHFS

Date report completed: 01/27/2023

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 01/26/2023

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 A relicensure survey was conducted from 01/19/23 and 01/23/23 through 01/26/23. A complaint investigation (OK#00060038) was conducted in conjunction with the survey. Listed below are abbeviations that will be used throughout this document: DHS - Department of Human Services	C 000		
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C 921	Continued From page 1 and long term use of an anticoagulant. A review of the resident's clinical record revealed no documentation of a monthly medication review performed by the registered nurse or pharmacist. 2. Resident #6 had diagnoses which included hypertension, diabetes, coronary artery disease, and depression. A review of the resident's clinical record revealed no documentation of a monthly medication review performed by the registered nurse or pharmacist. 3. Resident #7 had diagnoses which included diabetes, chronic steroid use, chronic obstructive pulmonary disease, and chronic respiratory failure. A review of the resident's clinical record revealed no documentation of a monthly medication review performed by the registered nurse or pharmacist. On 01/26/23 at 5:00 p.m., the administrator was asked for documentation of the monthly medication review by a registered nurse or pharmacist. The administrator stated the registered nurse performed cart audits and reviewed residents' charts who had scheduled assessments for the month. By the end of survey, there was no documentation the residents' monthly medication review were performed by a registered nurse or pharmacist.	C 921		
C1502 SS=E	310:663-15-1 & 63 OS 1-1918(B)(2) RESIDENT RIGHTS - Communications/Mail	C1502		

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C1502	Continued From page 2 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)(2) (2) Every resident shall have the right to have private communications, including telephonic communications and visits and consultations with a physician or an attorney, and meetings of family and resident groups or any other person or persons of the resident's choice, and may send and promptly receive, unopened, the resident's personal mail; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, it was determined the facility failed to allow for private visitation with persons of the residents' choice for three (#1, #11 and #12) of three residents who were reviewed for visitation during a facility lock down for COVID-19. The administrator identified 55 residents residing in the facility. Findings:	C1502		

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C1502	Continued From page 3 On 01/19/23 at 1:25 p.m., the entry door to Sand Plum Assisted Living Center displayed a notice to the community and visitors which read in part, "...Due to the significant increase of respiratory illness and COVID in our city and Sand Plum's commitment to keeping our residents and staff safe, standard visiting is being suspended for a period of no less than 5 days pending clinical testing; however, we have developed a safe and simple visiting solution. We have a COVID safe visitation room and we have developed an accepted COVID safe porch/outside visitation opportunity, both of which are available to our residents and staff by appointment. Additionally, we are pleased to participate in the Essential Caregiver program...Visitation that is not scheduled and/or monitored by staff and visitors who do not check in at the front desk for COVID prevention processing may be asked to leave, reported to DHS, and/or have a hazard fee added to the resident's monthly statement. Additionally, inappropriate or unauthorized visitation will result in an unnecessary resident quarantine for a testing period of no less than 5-7 days pending results..." A letter to the facility staff, residents, families, and visitors, dated 12/14/22, read in part, "...Because of the recent and sudden escalation of COVID cases in our area, and to continue to protect our staff and residents, we are immediately instituting the following measure in our community...The essential caregiver program is temporarily suspended...All game rooms and gathering spaces are temporarily closed...There will be no apartment visits between residents...The dining hall will be temporarily closed...All non-critical physician appointments need to be rescheduled...Appointments must be on	C1502		

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C1502	Continued From page 4 Tuesdays and you must be transported via the community transport or personal vehicle or you will require 5-7 day quarantine...Any resident and/or family member in violation of these procedures/laws will be required to quarantine and will be subject to additional COVID exposure fees...As we cannot allow in person visitation and/or outings, we are continuing our COVID room visits by appointment only ..." On 01/19/23 at 1:55 p.m., resident #11 stated they were not allowed visitors who lived outside of the facility. On 01/19/23 at 2:00 p.m., resident #1 stated they were only allowed to visit with people outside. On 01/19/23 at 2:06 p.m., resident #12 stated visitors were not allowed. On 01/24/23 at 4:45 p.m., the administrator stated the facility was following a year old COVID-19 outbreak visitation protocol. The administrator stated when the facility went on lock down, they initiated staff to perform one on one activities and visits with residents. The administrator stated families could schedule visits conducted outside with residents or schedule a visit in the facility's COVID visitation room. The administrator stated residents were not allowed to have family or visitors inside their private rooms during the lock down.	C1502		

OKLAHOMA
State Department of Health

Delivery via email to: dwoodland@sandplumok.com

March 28, 2023

License Number: AL7229

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

RE: Survey Event CMPF11

Dear Ms. Woodland:

On **January 26, 2023,** agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **Tag C1502 -** The Plan of Correction does not state what education and/or in-services are being provided and Quality Assurance ongoing monitoring is not addressed.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

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C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, it was determined the facility failed to perform monthly medication reviews for three (Res #5, #6, and #7) of three residents whose clinical records were reviewed for medication administration. The administrator identified 55 residents residing in the facility. Findings. 1. Resident #5 had diagnoses which included acute kidney failure, metabolic encephalopathy,	C 921	1. The DON/designee rounded on all residents to include those identified by the state and found no indication of negative effects secondary to the states written deficient practice. 2. Sand Plum does have a weekly RN contracted who conducts assessments, IDT's, cart audits, order review of both new and exisiting medication and physician orders, admissions audits, and monitors clinical documentation; however, they document their actions via monthly invoices and contractual agreement rather than on each individual. Beginning 2/1/23, the RN/pharmacist will initial the monthly orders once they are verified and entered for additional documented proof of review. This will be evident by the initialed monthly orders to be kept on file for review. 3. This correction will be implemented no later than 2/1/23. The DON/Designee will audit this practice to ensure implementation for no less than once weekly for a period of 12 weeks to remain on-going. Audits will be kept on file for review. 4. The Quality Assurance and Performance Improvement (QAPI) committee consisting the Executive Director, RN, DON, RCC, CNA/ACMA Marketing Director, Activities Director, Dietary Manager, and Maintenance Director have reviewed and approved this plan of correction. This correction will be reviewed monthly for no less than 12 weeks or until compliant and then PRN on an on-going basis.	

OKLAHOMA
State Department of Health

Delivery via email to: dwoodland@sandplumok.com

April 12, 2023

License Number: AL7229

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

Survey Event ID: CMPF11

Dear Ms. Woodland:

On **January 26, 2023,** a Relicensure survey and a complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **February 1, 2023**.

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,

Tempal Killman
Digitally signed by Tempal Killman
Date: 2023.04.12 15:16:55 -05'00'

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

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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 921	Continued From page 1 and long term use of an anticoagulant. A review of the resident's clinical record revealed no documentation of a monthly medication review performed by the registered nurse or pharmacist. 2. Resident #6 had diagnoses which included hypertension, diabetes, coronary artery disease, and depression. A review of the resident's clinical record revealed no documentation of a monthly medication review performed by the registered nurse or pharmacist. 3. Resident #7 had diagnoses which included diabetes, chronic steroid use, chronic obstructive pulmonary disease, and chronic respiratory failure. A review of the resident's clinical record revealed no documentation of a monthly medication review performed by the registered nurse or pharmacist. On 01/26/23 at 5:00 p.m., the administrator was asked for documentation of the monthly medication review by a registered nurse or pharmacist. The administrator stated the registered nurse performed cart audits and reviewed residents' charts who had scheduled assessments for the month. By the end of survey, there was no documentation the residents' monthly medication review were performed by a registered nurse or pharmacist.	C 921	The submission of these corrections is in no way an admission and/or agreement with the state identified deficiencies.	2/1/2023
C1502 SS=E	310:663-15-1 & 63 OS 1-1918(B)(2) RESIDENT RIGHTS - Communications/Mail	C1502	1. All residents to include parties identified by the state were rounded on by the DON/Designee and no negative effects were noted as a result of the state identified deficient practice.	

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C1502	Continued From page 2 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)(2) (2) Every resident shall have the right to have private communications, including telephonic communications and visits and consultations with a physician or an attorney, and meetings of family and resident groups or any other person or persons of the resident's choice, and may send and promptly receive, unopened, the resident's personal mail; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, it was determined the facility failed to allow for private visitation with persons of the residents' choice for three (#1, #11 and #12) of three residents who were reviewed for visitation during a facility lock down for COVID-19. The administrator identified 55 residents residing in the facility. Findings:	C1502	2. On December 12th, 2022, Dani Woodland, AOR, reached out to the OKDHS for updated information on the current COVID protocols as Sand Plum had it's first confirmed positive COVID case. I was transferred to the "Covid" department where I spoke with a young man who informed me that the procedures I had been instructed on in the past were still in place. Furthermore, I reached out to OKALA via email and got no response. Additionally, the State Ombudsman, Chris Cruzenski has made several visits to the community during this time and did not only adhere to the quarantine policies but made no mention of changes. Finally, the weekly COVID reports sent to the state indicated the communities COVID practices in detail with no response or correction provided. 3. The deficient practice was immediately corrected by the ending of the COVID community quarantine on 1/19/23. We have been provided the updated COVID information and will ensure it's implementation if there should be another outbreak. This was observed by the state surveyors. To ensure complaince moving forward, the COVID procedures will be reviewed by the ED/DON monthly for reporting and an attempt to find a reliable state resource State Department to assit. 4. In an effort to ensure resident rights, resident socialization, and prevent isolation, during the COVID quarantine, all residents were provided daily activity, communication, and interaction. Additionally, Sand Plum created two new private spaces to include an indoor COVID safe visiting apartment, and a private office wherein we purchased the ability to provide internet or televists. Furthermore, we purchased and provided seating for families and visitors for safe outdoor visitation weather permitting. At no time were any families or visitors denied access to private visitation. 5. The state proposed deficient pracitce was immediataly corrected by ending of the COVID quarantine on 1/19/23. We have been provided the updated COVID information and will ensure it's implementation if there should be another outbreak. This was observed by the state surveyors. 6.The staff were educated on 1/27/23 on the state proposed deficiencies and the updated COVID information provided by the surveyors. This will be kept on file for state review. 7.The Quality Assurance and Performance Improvement team (QAPI) committee consisting of the Executive Director, DON, RN, Maintenance Supervisor, Dietary Director, Activities Director, have reviewed and agrees with this pla+n of correction.	2/1/2023

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C1502	Continued From page 3 On 01/19/23 at 1:25 p.m., the entry door to Sand Plum Assisted Living Center displayed a notice to the community and visitors which read in part, "...Due to the significant increase of respiratory illness and COVID in our city and Sand Plum's commitment to keeping our residents and staff safe, standard visiting is being suspended for a period of no less than 5 days pending clinical testing; however, we have developed a safe and simple visiting solution. We have a COVID safe visitation room and we have developed an accepted COVID safe porch/outside visitation opportunity, both of which are available to our residents and staff by appointment. Additionally, we are pleased to participate in the Essential Caregiver program...Visitation that is not scheduled and/or monitored by staff and visitors who do not check in at the front desk for COVID prevention processing may be asked to leave, reported to DHS, and/or have a hazard fee added to the resident's monthly statement. Additionally, inappropriate or unauthorized visitation will result in an unnecessary resident quarantine for a testing period of no less than 5-7 days pending results..." A letter to the facility staff, residents, families, and visitors, dated 12/14/22, read in part, "...Because of the recent and sudden escalation of COVID cases in our area, and to continue to protect our staff and residents, we are immediately instituting the following measure in our community...The essential caregiver program is temporarily suspended...All game rooms and gathering spaces are temporarily closed...There will be no apartment visits between residents...The dining hall will be temporarily closed...All non-critical physician appointments need to be rescheduled...Appointments must be on	C1502		2/1/2023

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C1502	Continued From page 4	C1502		2/1/2023

Tuesdays and you must be transported via the community transport or personal vehicle or you will require 5-7 day quarantine...Any resident and/or family member in violation of these procedures/laws will be required to quarantine and will be subject to additional COVID exposure fees...As we cannot allow in person visitation and/or outings, we are continuing our COVID room visits by appointment only ..."

On 01/19/23 at 1:55 p.m., resident #11 stated they were not allowed visitors who lived outside of the facility.

On 01/19/23 at 2:00 p.m., resident #1 stated they were only allowed to visit with people outside.

On 01/19/23 at 2:06 p.m., resident #12 stated visitors were not allowed.

On 01/24/23 at 4:45 p.m., the administrator stated the facility was following a year old COVID-19 outbreak visitation protocol. The administrator stated when the facility went on lock down, they initiated staff to perform one on one activities and visits with residents. The administrator stated families could schedule visits conducted outside with residents or schedule a visit in the facility's COVID visitation room. The administrator stated residents were not allowed to have family or visitors inside their private rooms during the lock down.

OKLAHOMA
State Department
of Health

Delivery via email to: dwoodland@sandplumok.com

July 26, 2023

License Number: AL7229

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

RE: Survey Event CMPF12

Dear Ms. Woodland:

On **June 21, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 26, 2023,** have now been corrected effective **February 1, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 06/21/23. The facility was in substantial compliance.	{C 000}		

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