

Delivery via email to: ardmorevillageed@ardmore.com; amy@ardmore.com

June 7, 2023

License Number: AL1002

Ms. Amy Cohee
Village Lodge of Ardmore Village
1310 Knox Road
Ardmore, OK 73401

RE: Survey Event ID: OYT811

Dear Ms. Cohee:

On **May 19, 2023**, 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 May 19, 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,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/19/2023
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C 000	INITIAL COMMENTS A relicensure survey was conducted from 05/17/23 through 05/19/23. Listed below are abbreviations that will be used throughout this document: BKA- Below Knee Amputee BPH- Benign Prostatic Hyperplasia B/P- Blood Pressure CAD- Coronary Artery Disease CPR- Cardiopulmonary Resuscitation DM- Diabetes Mellitus Dx- Diagnosis EMAR- Electronic Medication Administration Record HCL - Hydrochlorothiazide HWD/LPN- Health and Wellness Director/Licensed Practical Nurse HTN- Hypertension LPN - Licensed Practical Nurse LTCA's- Long Term Care Aides MAR- Medication Administration Record MG- milligrams PO- by mouth RN- Registered Nurse SBP- Systolic Blood Pressure X- times	C 000		
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.	C 522		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 522	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to: a) complete an annual comprehensive assessment for three (#1, 6, and #7) of nine sampled residents reviewed for assessments; and, b) complete a comprehensive assessment within 14-days after admission for one (#9) of nine sampled residents reviewed for assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 50 residents resided in the center. Findings: 1. Resident #1's "Residence and Service Agreement and Addenda," dated 10/27/21, read in part, "... A Comprehensive Assessment will be completed within fourteen (14) days after admission and at least once every twelve months..." Resident #1's diagnoses included type 2 diabetes with chronic kidney disease, and chronic combined systolic and diastolic heart failure. A "14-day Assessment," dated 11/16/21, was located in the clinical record and the clinical record did not contain an annual assessment for 2023. 2. Resident #6 had diagnoses of Raynauds,	C 522		

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C 522	Continued From page 2 tremors, and BKA. Resident #6 was admitted on 04/23/21. There was no Annual Assessment in the clinical record for April of 2023. 3. Resident #7 had diagnoses of dementia, BPH, and HTN. Resident #7 was admitted on 04/23/21. There was no Annual Assessment in the clinical record for April of 2023. 4. Resident #9's diagnoses included congestive heart failure, hypotension, and heart failure. Resident #9's "Residence and Service Agreement and Addenda," dated 04/17/23, read in part, "... A Comprehensive Assessment will be completed within fourteen (14) days after admission and at least once every twelve months..." Resident #9's "Preadmission Assessment," dated 04/17/23, read in parts, "...Admit Date 04/21/23...low B/P... Alert x 4, confused at times, with fair judgment..." On 05/18/23 at 5:00 p.m., the Administrator/RN reported the 14-day comprehensive assessments had not been completed as required. On 05/19/23 at 9:00 a.m., the Administrator/RN reported an annual comprehensive assessment had not been completed for Residents #'s 1, 6, and 7 as required.	C 522		

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C 543	Continued From page 3	C 543		
C 543 SS=D	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. This Rule is not met as evidenced by: Based on record review and interview, it was determined the center failed to conduct a personal interview between the resident and/or resident's representative and the person completing the form for one (#4) of nine sampled residents reviewed for comprehensive assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 50 residents resided in the center. Findings: Resident #4's diagnoses included type 1 diabetes, hypertension, and breast cancer. A "Preadmission Assessment," dated 08/24/22, did not contain a signature from the resident and/or resident's representative. On 05/18/23 at 3:53 p.m., the Administrator/RN was asked if Resident #4's assessment was signed and did it include a personal interview with the resident or the resident's representative. She	C 543		

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C 543	Continued From page 4 stated, "No, it did not. We normally have them sign every assessment."	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 interview and record review, it was determined the center failed to use the assessment to develop an individualized plan of care for two (#4 and #9) of nine sampled residents reviewed for service plans/plan of care. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 50 residents resided in the center. Findings: 1. Resident #4's diagnoses included type I diabetes, hypertension, and breast cancer. Resident #4's "Annual Assessment," dated 08/24/22, read in parts, "...Alert x 4, confused at times, judgment good..." On 05/18/23 at 3:53 p.m., the Administrator/RN was asked if Resident #4's clinical record had a plan of care related to hypoglycemia and	C 552		

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C 552	Continued From page 5 hyperglycemia. The Administrator/RN reviewed the clinical record and reported they did not have a plan of care in the clinical record, and stated they would expect to see a plan of care for diabetes. 2. Resident #9's diagnoses included congestive heart failure, hypotension, and heart failure. Resident #9's "Preadmission Assessment," dated 04/17/23, read in parts, "...Admit Date 04/21/23...low B/P... Alert x 4, confused at times, with fair judgment..." On 05/18/23 at 5:00 p.m., the Administrator/RN was asked about resident #9's current plan of care. They reported a plan of care had not yet been completed for this resident and should include the resident's diagnoses.	C 552		
C 711 SS=E	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21.	C 711		

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C 711	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the center failed to obtain an annual fire marshal inspection. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 50 residents resided in the center. Findings: An "Annual Fire Marshal Report," dated 12/02/21, read in parts, "...Inspection Description: Fire and Life Safety Inspection...overall result passed..." On 05/17/23 at 11:22 a.m., a current fire marshal inspection report was requested. The Administrator/RN notified maintenance by telephone. They reported a new fire alarm panel had been installed and they should have had a fire marshal report in 2022 but this was not obtained. They reported the inspection had been scheduled for February 2023 but the fire marshal did not come and it would need to be rescheduled.	C 711		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions;	C 911		

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C 911	Continued From page 7 This Rule is not met as evidenced by: Based on record review and interview, the center failed to obtain a physician order for self-administration of medications, and failed to ensure two (#6 and #7) of two residents reviewed were evaluated for competency of self-administration. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 50 residents resided in the center. Findings: A "Medication Self-Administration by Resident" policy read in part, "...The Wellness coordinator will assess each self-medicated person on an annual basis to assure that there have been no cognitive or physical changes that would hinder the ability of the resident to self-medicate." Residents #6 and #7 were admitted to the facility on 04/23/21. The medical records for Residents #6 and #7 were reviewed and contained no "Medication Self-Administration Assessment." On 05/18/23 at 11:00 a.m., Resident #6 reported Home Health came once a week and set up her	C 911		

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C 911	Continued From page 8 and her husband's (Resident #7) medications in medication planner cases. Resident #6 stated her and her husband then self-administered their medications throughout the week. On 05/18/23 at 12:15 p.m., the Administrator reported both Resident #6 and #7 should have had a medication self-administration assessment. The Administrator reported the residents had been self-medicating since their admission on 04/23/21, and neither resident had been assessed.	C 911		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure monthly medication reviews were completed by the RN or pharmacy consultant at least monthly. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 50 residents resided in the center. Findings:	C 921		

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C 921	Continued From page 9 A "Medication Administration-Accountability" policy, not dated, read in part, "...Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist..." On 05/17/23 at 3:45 p.m., the Administrator/RN was asked to submit evidence for the monthly medication reviews. They stated, "I do not sign anything." They were asked how they could provide evidence for the RN monthly medication reviews, and reported they just looked at the EMAR. On 05/18/23 at 12:41 p.m., the Administrator/RN was asked how often the pharmacy consultant visited the center and they reported the pharmacy consultant visited quarterly.	C 921		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide evidence of CPR and first aid training for one (#3) of three sampled direct care staff members.	C 954		

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C 954	Continued From page 10 The Administrator/RN reported seven long term care aides were employed at the center. Findings: A "Special Training/Certification" policy, revised January 2022, read in parts, "...CPR Certification and First Aid Training: All...employees are encouraged and recommended to have current CPR certification and first aid training. CPR certification will be provided to all employees on a regular basis..." On 05/18/23 a 11:39 a.m., the Administrator/RN was asked to submit documentation for LTCA #3's CPR/1st aid training. On 05/19/23 at 9:37 a.m., the Administrator/RN reported they did not have documentation of LTCA #3's CPR/1st aid training and the staff member was unable to provide a current CPR card to verify proof of training.	C 954		
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	C1505		

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C1505	Continued From page 11 resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to: a) obtain signed physician orders for three (#9, 10, and #11) of sixteen sampled residents reviewed for medications; and, b) ensure medication was documented at the accurate dosage on the MAR, and have a current order, for one (#1) of sixteen sampled residents reviewed for medications. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23,	C1505		

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C1505	Continued From page 12 documented 50 residents resided in the center. Findings: a) A "Medication Orders" policy, not dated, read in parts, "...Medications shall be administered only on a physician's order..." A "Medication Ordering and Receipt" policy, read in parts, "...If Lodge staff is administering the resident's medications, Lodge staff will be responsible for ordering and maintaining medications: A Resident Aide or LPN will complete a reorder form if needed, and place the completed form in the Wellness Coordinators's tray in the front office, or fax required information to the pharmacy. A copy of this form will be kept until the medication is delivered..." 1. Resident #9's diagnoses included congestive heart failure, hypotension, and heart failure. Resident #9's "Preadmission Assessment," dated 04/17/23, read in parts, "...Admit Date 04/21/23...low B/P... List all Current Medications...Midodrine... Dr. Office faxing... Alert x 4, confused at times, with fair judgment..." A "Physician's Order Sheet" for Resident #9, dated 05/17/23, read in parts, "...Midodrine HCL 5 mg tablet...Give 1 tablet by mouth 2 time (s) daily. 2 tabs if SBP <100, one tab if SBP is more than 100. No tabs for SBP over 115. Dx: Hypotension..." The center had no signed physician's orders for medications and/or for admission to the center. On 05/18/23 at 5:00 p.m., the Administrator/RN was asked if they had signed physician orders for resident #9 to admit to the center and they	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/19/2023
NAME OF PROVIDER OR SUPPLIER VILLAGE LODGE OF ARDMORE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 KNOX ROAD ARDMORE, OK 73401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 13 reported they did not have signed orders. The Administrator/RN reported the doctor's office had not faxed the signed physician orders for medications. 2. Resident #10 had diagnoses which included atherosclerotic heart disease, cerebrovascular disease, and peripheral vascular disease. On 05/17/23 at 11:30 a.m., a medication pass was initiated with MAT #1 and resident #10. Methadone 5 mg 1/2 tablet was administered to Resident #10. A "Medical Treatment Order" for resident #10, read in parts, "...Start on 02/08/23, take 2.5 mg of Methadone (5 mg tablet) by oral every AM...medication indication: Pain mild..." The order was in the resident's clinical record but was not signed by the attending physician. On 05/17/23 at 1:10 p.m., a medication pass was initiated with MAT #1 and resident #10. Lorazepam 0.5 mg 1/2 tablet was administered to Resident #10. A "Medical Treatment Order" for resident #10, read in parts, "...Start on 11/23/22, ...New Medication Take 0.25 mg of lorazepam (0.5 mg tablet) by oral 3 x Day...Medication Indication: Anxiety, Agitation..." The order was in the resident's clinical record but was not signed by the attending physician. 3. Resident #11 had diagnoses which included type 2 diabetes with chronic kidney disease, and chronic combined systolic and diastolic heart failure. Resident #11's "Physician's order," dated	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/19/2023
NAME OF PROVIDER OR SUPPLIER VILLAGE LODGE OF ARDMORE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 KNOX ROAD ARDMORE, OK 73401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 14 09/06/22, read in part, "...Reduce Ferrous Sulfate to (1) PO on Mon-Wed-Friday..." There was no other current physician order for this medication in the resident's chart. On 05/17/23 at 11:45 a.m., a medication pass was initiated with MAT #1 and Resident #11. Ferrous Sulfate 324 mg was held. MAT #1 reported the resident was out of the medication and they were waiting on a new prescription from the physician. On 05/17/23 at 3:40 p.m., the Administrator/RN was asked to check the May 2023 EMAR for Resident #11 for the Ferrous Sulfate. They reported they had not received the medication this month and eight doses were noted to be missed. On 05/19/23 at 10:10 a.m., the Administrator/RN stated the LPN had reported they were waiting on the physician, but the physician was no longer practicing so Resident #11's daughter would be getting the resident another appointment. 4. Resident #1 was observed during a medication pass. A pharmacy label for Resident #1 on the prescription bottle read in parts, "...Ferrous Sulfate 324 mg...Give 1 Tablet By Mouth 2 times Daily...Take with Food." Resident #1's MAR read in parts, "...Ferrous Sulfate 300 mg...Give 1 Tablet By Mouth 2 times Daily...Take with Food." On 05/19/23 at 3:35 p.m., the Administrator reported the MAR and the pharmacy label for the Ferrous sulfate should have documented the same medication dosage. The Administrator reported there should have been a current order	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/19/2023
NAME OF PROVIDER OR SUPPLIER VILLAGE LODGE OF ARDMORE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 KNOX ROAD ARDMORE, OK 73401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 15 in Resident #1's chart for the most recent dosage of Ferrous Sulfate 324 mg.	C1505		
C1972 SS=E	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide written documentation of abuse and neglect training for two (#1 and #2) of four sampled long term care aides (LTCA's) personnel files. The Administrator/RN reported seven long term care aides were employed at the center. Findings: A policy "Staff Training," not dated, read in parts, "... The Lodge shall provide staff, within (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same..." On 05/18/23 at 11:35 a.m., the Administrator/RN	C1972		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/19/2023
NAME OF PROVIDER OR SUPPLIER VILLAGE LODGE OF ARDMORE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 KNOX ROAD ARDMORE, OK 73401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1972	Continued From page 16 was asked to submit evidence for abuse and neglect training for LTCA #1 and #2. The Administrator/RN reported they had abuse and neglect training on 04/06/22, LTCA #1 was hired on 05/19/22, and LTCA #2 was hired on 05/16/22. The Administrator/RN reported LTCA #1 and LTCA #2 did not have abuse and neglect training.	C1972		

Delivery via email to: amy@ardmore.com; carla@ardmorevillage.com

June 22, 2023

License Number: AL1002

Ms. Amy Cohee
Village Lodge Of Ardmore Village
1310 Knox Road
Ardmore, OK 73401

RE: Survey Event OYT811

Dear Ms. Cohee:

On **May 19, 2023**, 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 **July 31, 2023**.

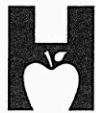
We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

enc



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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/20/2023

Facility Name: Village Lodge of Ardmore Village

License Number: AL1002

Survey Event ID: OYT811

Date Survey Completed: 5/19/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522

Based on: Based on record review and interview, the center failed to: a) complete an annual comprehensive assessment for three (#1, 6, and #7) of nine sampled residents reviewed for assessments; and, b) complete a comprehensive assessment within 14-days after admission for one (#9) of nine sampled residents reviewed for assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 05/17/23, documented 50 residents resided in the center.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Of the 4 Residents #6 and 7 had assessments overdue less than 30 days. Residents are husband and wife, admitted on the same date.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Annual and 14-day assessments for all four affected residents were completed on or before May 31, 2023.

Since all residents are required to have an assessment within 14 days of move in and annually thereafter, they all have the potential to be affected.

Upon move in, all residents will be added to the Resident Assessment Schedule. Will be reviewed bi-weekly to ensure that residents are assessed on a timely basis.

At quarterly QA meetings, the Resident Assessment Schedule will be reviewed to ensure the effectiveness of the measures that were put into place for timely assessments.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

7/15/2023

Administrator's Signature Administrator signature required.

OAC 310:663-25-4(F)

Date Enter a date of signature.

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date

Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Resident First Name	Last Name	Unit	Move-in Date	Most Recent Assessment Date	Next Assessment Due Before
[REDACTED]	[REDACTED]	A-27	9/10/2010		
[REDACTED]	[REDACTED]	A-6	11/1/2013		
[REDACTED]	[REDACTED]	B-8	12/5/2013		
[REDACTED]	[REDACTED]	A-10	1/25/2015		
[REDACTED]	[REDACTED]	B-14	10/1/2016		
[REDACTED]	[REDACTED]	B-2	5/15/2017		
[REDACTED]	[REDACTED]	B-20	6/1/2017		
[REDACTED]	[REDACTED]	B-12	1/5/2018		
[REDACTED]	[REDACTED]	A-12	10/3/2018		
[REDACTED]	[REDACTED]	A-2	1/14/2019		
[REDACTED]	[REDACTED]	A-18	4/20/2019		
[REDACTED]	[REDACTED]	A-15	12/4/2019		
[REDACTED]	[REDACTED]	A-14	12/20/2019		
[REDACTED]	[REDACTED]	A-24	2/1/2020		
[REDACTED]	[REDACTED]	B-13	3/5/2020		
[REDACTED]	[REDACTED]	A-13	5/13/2020		
[REDACTED]	[REDACTED]	B-23	8/7/2020		
[REDACTED]	[REDACTED]	B-27	9/5/2020		
[REDACTED]	[REDACTED]	A-21	12/23/2020		
[REDACTED]	[REDACTED]	B-1	3/27/2021		
[REDACTED]	[REDACTED]	A-20	4/23/2021		
[REDACTED]	[REDACTED]	B-25	5/1/2021		
[REDACTED]	[REDACTED]	B-15	6/9/2021		
[REDACTED]	[REDACTED]	A-4	6/14/2021		
[REDACTED]	[REDACTED]	A-19	8/25/2021		
[REDACTED]	[REDACTED]	A-7	9/3/2021		
[REDACTED]	[REDACTED]	B-5/B-6	9/7/2021		
[REDACTED]	[REDACTED]	B-9	10/15/2021		
[REDACTED]	[REDACTED]	B-26	10/23/2021		
[REDACTED]	[REDACTED]	B-11	11/24/2021		
[REDACTED]	[REDACTED]	A-3	1/13/2022		
[REDACTED]	[REDACTED]	B-10	2/1/2022		
[REDACTED]	[REDACTED]	A-26	4/28/2022		
[REDACTED]	[REDACTED]	B-18	5/9/2022		
[REDACTED]	[REDACTED]	A-23	5/11/2022		
[REDACTED]	[REDACTED]	B-24	6/21/2022		
[REDACTED]	[REDACTED]	B-17	9/1/2022		
[REDACTED]	[REDACTED]	B-19	9/29/2022		
[REDACTED]	[REDACTED]	B-21	9/29/2022		
[REDACTED]	[REDACTED]	A-17	10/1/2022		
[REDACTED]	[REDACTED]	A-16	10/6/2022		

Robert	Carpenter	B-16	10/11/2022		
Adrienne	Heid	A-25	10/13/2022		
Gerald	Vannoy	A-11	1/1/2023		
Richard and Sue	Allen	A-1	4/1/2023		
Carolyn	Smith	A-5	4/1/2023		
Shirley	Hicks	B-22	4/17/2023		
Shirley	West	A-22	5/1/2023		
Danny	Steele	B-7	6/15/2023		
Shirley	Hicks	B-22			
		A-8/A-9			
		B-3			
		B-4			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/20/2023

Facility Name: Village Lodge of Ardmore Village

License Number: AL1002

Survey Event ID: OYT811

Date Survey Completed: 5/19/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 543

Based on: Based on record review and interview, it was determined the center failed to conduct a personal interview between the resident and/or resident's representative and the person completing the form for one (#4) of nine sampled residents reviewed for comprehensive assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: In the instance of Resident #4, the Administrator, Resident and Resident's son were all present at the assessment. It is agreed that the Resident or Resident Representative did not sign the Preadmission Assessment form.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

While we can't go back in time to correct the deficiency, Resident signed a statement, attached, affirming that she was present for the in-person assessment on 8-24-2022.

Because all residents (or their representative) must be present in person for assessments, all residents have the potential to be affected.

Resident files will have a checklist at the front ensuring all documents are completed properly prior to move-in. Checklist will be signed by Administrator, or designee, to confirm all documents have been completed properly.

At quarterly QA meetings, results of a random chart audit of 25% of resident charts will be shared. Chart audits will include (at a minimum) signed physician orders, medication reviews, assessments and service plans.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

7/15/2023

Administrator's Signature Administrator signature required.
OAC 310:663-25-4(F)

Date Enter a date of signature.

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

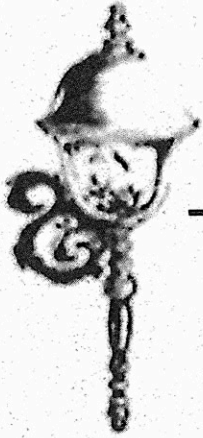
Addendum Date

Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.



The Lodge at Ardmore Village

*A Licensed Assisted Living Residence
In the tradition of excellence*

1310 Knox Road Ardmore, Oklahoma

*(580) 223-8400
Fax (580) 223-1761*

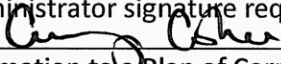
STATEMENT

I affirm that I was present (in-person) for the Preadmission Assessment completed on August 24, 2022. In the room that day were myself, my son, Chaz Cobb, and Ardmore Village Administrator, Amy Cohee.

Chelah Cobb

Date

	Move in Check List
	Resident Name: _____ Unit: _____
	Move In Date: _____
	Resident Service Agreement
	Authorization for Release of Personal Health
	and Medical Information
	Service Plan /Plan of Care - Must be Signed
	Assessment- Must be Signed
	Physician order - Must be Signed
	Med List - Must Signed
	Personal Information Authorization
	Power of Attorney ☐ N/A
	Advanced Directive ☐ N/A
	DNR ☐ Refused
	Insurance Cards
	Drivers License
	Social Security
	Emergency Contact Information
	Document check completed by:
	X _____
	Print: _____
	Reviewed by: _____
	Administrator/Designee

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 6/20/2023		
	Facility Name: Village Lodge of Ardmore Village		
	License Number: AL1002		
	Survey Event ID: OYT811		
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 552	Based on: Based on interview and record review, it was determined the center failed to use the assessment to develop an individualized plan of care for two (#4 and #9) of nine sampled residents reviewed for service plans/plan of care.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS	
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		Service plan/plan of care for residents #4 and #9 have been completed and placed in residents' chart.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Since all residents are required to have a service plan/plan of care, all residents have the potential to be affected.	
OSDH Response: Element accepted Yes ☐ No ☐			
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		Upon move in, residents will have a checklist in their file with plan of care and/or service plan on it. Administrator or designee will confirm that the plan of care/service plan has been completed and is in the file.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		At quarterly QA meetings, results of a random chart audit of 25% of resident charts will be shared. Chart audits will include (at a minimum) signed physician orders, medication reviews, assessments and service plans. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/31/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. 		Date Enter a date of signature. 6-21-2023	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

LODGE at ARDMORE VILLAGE
CHART AUDIT

Resident Unit	Move-In Date	Chart Contents	Properly Completed
		Initial Assessment within 14 days of move in	Yes / No
		Annual / Significant Change Assessment Date:	
		Service Plan - Most Recent Date:	
		Self-Administration of Meds?	Yes / No
		- Signed Physician Order for Med Self Admin	Yes / No
		Medication Orders Signed by Physician	Yes / No
		Monthly Medication Review Most Recent Date:	

NOTES:

Completed By:

Date:



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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/20/2023

Facility Name: Village Lodge of Ardmore Village

License Number: AL1002

Survey Event ID: OYT811

Date Survey Completed: 5/19/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 711

Based on: Based on record review and interview, the center failed to obtain an annual fire marshal inspection.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Inspection was scheduled for February 2023. Fire Marshal did not appear.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Annual fire marshal inspection completed by Ardmore City Fire Department on 5/30/2023. Facility passed each area.

Since the facility is required to have a annual fire marshal inspection, they all have the potential to be affected.

Facility maintenance manager will schedule fire marshal inspection annually, within 30 days of the expiration of the previous year's inspection.

Facility Manager, responsible for assuring inspections are timely completed, will present the inspection report to the QA committee annually.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

6/30/2023

Administrator's Signature Administrator signature required.

OAC 310:663-25-4(F)

Date Enter a date of signature.

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.

Facility in Compliance by: Click here to enter a date.

Ardmore City Fire Department

Occupancy: **Ardmore Village Lodge**

Occupancy ID: **ARDM14**

Address: **1310 KNOX RD Ardmore OK 73401**



Form: Basic Plus

Inspection Type: **Annual**

Inspection Date: **5/30/2023**

By: **Lee , Timothy W (3081)**

Time In: **16:02**

Time Out: **16:02**

Authorized Date: **Not Authorized** By:

Next Inspection Date: **No Inspection Scheduled**

Inspection Description:

Fire and Life Safety Inspection

Inspection Topics:

Exterior

Are address numbers visible from the street?

An easily identifiable address aids the fire department in responding to a call at your facility.

Status: PASS

Notes:

Is property easily accessed by fire department?

Roads accessible to the property are important for fire department access.

Status: PASS

Notes:

Is adequate water supply available for fire suppression?

An established water supply is extremely important for fire suppression.

Status: PASS

Notes:

Exits

Repair or maintain exit doors and hardware to operate properly.

Well maintained exit doors and panic hardware provide safe and easy egress from a building.

Status: PASS

Notes:

Remove obstructions from exits, aisles, corridors, and stairways.

Clear exit access is essential to prevent panic or accidental falling of occupants during evacuation.

Status: PASS

Notes:

Remove storage from beneath exit stairs.

Items stored beneath stairs present a fire risk that can endanger persons using that escape route.

Status: PASS

Notes:

Unlock all exit doors during business hours.

Locked exit doors make it impossible for occupants to escape safely and quickly.

Status: PASS

Notes:

Provide exit signs with letters at least 6 inches high on a contrasting background.

Clearly identified exits enable persons to quickly and safely leave the building in an emergency.

Status: PASS

Notes:

Remove unapproved locks or latches from exit doors.

Exit doors must be free to open without delay in the event of an emergency.

Status: PASS

Notes:

Exit Lighting

Repair lighted exit signs or emergency lighting.

Exit signs and emergency illumination are essential during evacuations. The exit sign will indicate to occupants the correct door to reach safely.

Status: PASS

Notes:

Provide lighting for exits, aisles, corridors, and stairways.

Well lighted exit ways prevent panic, and provide safer egress for occupants.

Status: PASS

Notes:

Fire Extinguishers

Count extinguishers where readily available, not more than 5 feet above floor.

Extinguishers must be easily within reach of all occupants, but not where they will be subject to damage.

Status: PASS

Notes:

Post signs indicating location where extinguishers are not readily visible.

Where extinguishers are not clearly visible, signs help occupants find the equipment in a hurry.

Status: PASS

Notes:

Portable fire extinguishers are due for annual maintenance on:

Annual maintenance will provide for properly charge and serviced extinguishing devices, and assure proper operation if needed to fight a small fire.

Status: PASS

Notes:

Provide extinguisher(s) of a 10 lb. minimum rating.

Extinguishers provided need to be appropriate to the type of hazard.

Status: PASS

Notes:

Fire Protection Access and Equipment

Install approved protective covers on fire department hose connection.

Protective covers must be installed on the supply connection to prevent accumulations of debris that might inhibit the system's effectiveness.

Status: PASS

Notes:

Provide and maintain smoke detectors in proper operating condition.

The proper installation and maintenance of smoke detectors is of the utmost importance. In the event of a fire, they will notify occupants, and, in some cases, may automatically notify the Fire Department.

Status: PASS

Notes:

The fire protection system(s) is/are due for confidence testing and certification. Please see the attached report.

Life safety and fire protection equipment must be properly inspected and tested from time to time to assure its effective operation.

Status: PASS

Notes:

Maintain access to and operation of standpipes, fire hose, sprinkler valves, fire hydrants, fire extinguishers, and other fire protection equipment

Fire protection equipment must have clear access and be operational at all times to be effective in an emergency.

Status: PASS

Notes:

Provided minimum 4 inches high address numbers so they are visible from the street.

Address numbers are critical to help emergency personnel find people who may need some sort of aid. The numbers must contrast with their background for greatest visibility.

Status: PASS

Notes:

Remove obstructions and provide access in fire lanes.

Large fire apparatus need room to effectively maneuver in the event of an emergency.

Status: PASS

Notes:

Fire Separations

Keep attic and scuttle covers closed, and ceiling tiles in place.

Ceilings are an integral part of the building's fire protection. If kept in place, the ceiling will protect roof structures from premature collapse.

Status: PASS

Notes:

Remove obstructions from fire doors and maintain to operate properly.

Fire and smoke doors should not be blocked open or obstructed or fire and smoke will easily travel through the opening and cause excessive risk to life and property.

Status: PASS

Notes:

Seal unapproved openings with approved material.

Flame, smoke, and hot gases can easily travel through holes and pipe chases, thus creating more damage and a hazard to occupants.

Status: PASS

Notes:

Housekeeping

Arrange storage in orderly manner to provide for exiting and fire department access.

Good housekeeping makes an area safer for occupants and contributes less fuel to a fire. When storage is orderly, fire fighters can get fast access to minimize fire damage.

Status: PASS

Notes:

Remove or store rubbish, waste material, oily rags in closed metal containers.

Safety containers for oily and greasy rags are designed to prevent spontaneous ignition of their contents. Other highly flammable wastes must be separated from sources of ignition.

Status: PASS

Notes:

Clean grease filters and hood/duct system over cooking equipment.

Regular cleaning of the hood, duct, and filters will eliminate flammable grease build-up and provide proper ventilation of hood through the exhaust outlet.

Status: PASS

Notes:

Provide approved waste containers for combustible waste.

Heavy duty or metal containers are necessary to confine a fire in the receptacle to prevent it spreading to the building.

Status: PASS

Notes:

Remove storage to at least 18 inches below level of sprinklers (36 inches for storage piled over 12 feet high)

Storage too close to a sprinkler will not allow the water spray to properly penetrate the fire and extinguish it.

Status: PASS

Notes:

Chain all compressed gas cylinders in an upright position and provide protective caps.

Compressed gas cylinders, empty or full, can take off like a rocket in any direction if they fail and rupture.

Status: PASS

Notes:

Boiler, mechanical, and electrical panel rooms shall not be used for storage.

Combustible materials in these equipment rooms often get put too close to sources of heat and a fire will likely result.

Status: PASS

Notes:

Post and enforce 'No Smoking' signs.

'No Smoking' areas are designated because the use of smoking materials in those areas could cause a fire.

Status: PASS

Notes:

Reduce storage height to at least 2 feet below ceiling.

In the event of a fire, fire fighters may need to open a hole in the roof to let heat and smoke out. Storage and other obstructions will prevent rapid ventilation efforts.

Status: PASS

Notes:

Move the dumpster at least 5 feet from the building or overhangs.

Dumpsters are a common fire target of vandals. Moving the dumpster away will reduce the risk of a fire spreading to the building.

Status: PASS

Notes:

Flammable Liquids

Discontinue use of Class 1 liquids (gasoline, etc.) for cleaning.

These liquids are highly volatile and can be easily ignited by sparks, pilot lights, or other sources of heat.

Status: PASS

Notes:

Storage in excess of 10 gallons shall be in an approved cabinet.

In the event of a fire, flammable liquids can readily accelerate its spread. Confining the stored liquids to secure cabinets will limit this fire exposure.

Status: PASS

Notes:

Discontinue pouring from containers exceeding 5 gallons or provide pump taking suction from top.

Larger flammable liquid containers are difficult to handle, and their contents are easily spilled. Pumps taking suction from the top restrict the amount likely to be discharged accidentally.

Status: PASS

Notes:

Store liquids away from exits, aisles, corridors, or stairways.

The accelerating effect of flammable liquids in a fire can quickly make safe exit impossible.

Status: PASS

Notes:

Use only approved safety can for portable dispensing of flammable liquids.

Safety containers for flammable or combustible liquids are designed to prevent flammable fumes from escaping or accidental spills.

Status: PASS

Notes:

Electrical

Discontinue use of extension cords in lieu of permanent wiring.

Temporary wire does not afford the durability, safety, and protection from shock or fire that is found in the construction of an enclosed electrical system.

Status: PASS

Notes:

Maintain at least 30 inches clearance in front of electrical panel.

Access to electrical panels must be cleared to allow for general inspection and emergency shutdown.

Status: PASS

Notes:

Each outlet box shall have a cover faceplate or fixture canopy.

Covers protect people from being shocked by exposed wires, prevent spread of electrical current, and heat and flame during short circuits.

Status: PASS

Notes:

Discontinue use of non-approved multi-plug adapters.

Multi-plug adapters invite the overuse of the circuit that can result in overheating and a fire.

Status: PASS

Notes:

Maintain wiring in good condition and protect from damage.

Worn or broken wires and plugs present a fire hazard and risk of electrical short circuit that can result in a fire.

Status: PASS

Notes:

Additional Time Spent on Inspection:

Category	Start Date / Time	End Date / Time
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Notes: No Additional time recorded

Total Additional Time: 0 minutes

Inspection Time: 0 minutes

Total Time: 0 minutes

Summary:

Overall Result: Passed

Inspector Notes:



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/20/2023

Facility Name: Village Lodge of Ardmore Village

License Number: AL1002

Survey Event ID: OYT811

Date Survey Completed: 5/19/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 911

Based on: Based on record review and interview, the center failed to obtain a physician order for self-administration of medications, and failed to ensure two (#6 and #7) of two residents reviewed were evaluated for competency of self-administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained?

Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Administrator signature required.

OAC 310:663-25-4(F)

Date Enter a date of signature.

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date

Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: [Surveyor](#)

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