



Delivery via email to: rharvey@ardmorevillage.com

July 1, 2024

License Number: AL1002

Ms. Rhonda Harvey, Administrator
Village Lodge Of Ardmore Village
1310 Knox Road
Ardmore, OK 73401

RE: Survey Event ID: 5YA611

Dear Ms. Harvey:

On **June 12, 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 **June 12, 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: IDRCoordinator@health.ok.gov

Or mail 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,

Tempal Killman

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

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 06/12/2024
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
C 000	INITIAL COMMENTS A relicensure survey was conducted on 06/11/24 through 06/12/24. Census: 46 Listed below are abbreviations that will be used throughout this document: ACMA - advanced certified medication aide EMAR - electronic medication administration record FSBS - finger stick blood sugar IDG - interdisciplinary group LPN - licensed practical nurse MAT - medication administration technician ST - start X - times	C 000		
C 532 SS=E	310:663-5-3(b) ASSESSMENT FORM (b) The comprehensive assessment includes the following information: (1) physical functional status; (2) mental functional status; (3) customary routine; (4) disease diagnosis; (5) oral/nutritional status; (6) medications; (7) devices and restraints; (8) special treatments; (9) skin condition; (10) psychosocial status; (11) sensory and physical impairments; and (12) medically defined conditions and prior medical history.	C 532		

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 532	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive assessments included the required components (diagnosis, medical history/mental history, and infections) for four (#3, 5, 6, and #8) of eight residents reviewed for comprehensive assessments. The administrator reported 46 residents resided in the facility. Findings: An "Ardmore Village Senior Living Resident Services Operations Manual", read in part, "...The evaluation and assessment process will comply with state regulations and company standards..." 1. Resident #3 was admitted on 12/05/23. A comprehensive assessment, dated 12/22/23, documented no diagnosis, medical history or mental health history. On 06/12/24 at 12:40 p.m., LPN #1 reported numerous blanks on Res #3's comprehensive assessment. 2. Resident #5 was admitted on 07/22/16. A comprehensive assessment, dated 07/12/23, documented no diagnosis, medical history or infections.	C 532		

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C 532	Continued From page 2 3. Resident #6 was admitted on 10/18/22. A comprehensive assessment, dated 10/10/23, documented no medical history or infections. 4. Resident #8 was admitted on 09/05/20. A comprehensive assessment, dated 09/06/23, documented no diagnosis, medical history or infections. On 06/11/24 at 4:30 p.m., LPN #1 reported Resident's #5, 6, and #8 comprehensive assessments were completed before she started working at the facility. LPN #1 reported the assessments documented no medical history or infections for Resident/s #5, 6, and #8. LPN #1 reported the assessment for resident #6 documented no diagnoses.	C 532		
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 ensure: a. a plan of care was developed for three (#6, 7, and #8), and	C 552		

Oklahoma State Department of Health

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C 552	Continued From page 3 b. a comprehensive assessment was completed within 14 days after admission for one (#7) of four residents reviewed for care plans and comprehensive admission assessments. The Administrator reported 46 residents resided in the facility. Findings: A "Resident Services Operations" manual, not dated, read in part "An overall interdisciplinary individual service plan is generated from the comprehensive assessment for each residents who moves into the community...The individual service plan describes the care or service that is to be given...The plan assures that each resident receives assistance that is individualized to everyday living needs that promote health and well being and guides..." 1. Resident #6 was admitted on 10/18/22. A annual comprehensive assessment, dated 10/10/23, documented Resident #6 required no assistance with ambulation or activities of daily living. On 06/11/24, Resident #6's medical record documented no resident care plan. 2. Resident #7 was admitted on 05/01/24. On 06/11/24, Resident #7's medical record documented no resident care plan or a completed comprehensive admission assessment. 3. Resident #8 was admitted on 09/05/20.	C 552		

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C 552	Continued From page 4 A annual comprehensive assessment, dated 09/06/23, documented resident #8 required assistance of one staff member with bathing. On 06/11/24 at 4:30 p.m., LPN #1 reported Resident's #6, 7, and #8's medical chart did not contain a care plan. LPN #1 reported Resident #7's medical chart did not contain a completed comprehensive admission assessment.	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 treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to: a. store medications and hazardous chemicals in a safe manner, and b. administer medications per physician orders for resident #9 reviewed for medication pass. The Administrator reported 46 resident resided in the facility. Findings: a. On 06/11/24 at 11:38, the medicine storage room located on the A1-13 Hall was not locked. The room had patient medication out on the counter, no staff were observed in the room or out on the counter. On 06/11/24 at 11:54 a.m., the janitor's room on the B14-B27 hall was not locked. The room was observed to have cleaning chemicals present, no staff were observed inside or near the room. On 06/11/24 at 11:56 a.m., the janitor's room on the A14-A27 hall was not locked. The room was observed to have cleaning chemicals present, no	C1505		

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C1505	Continued From page 6 staff were observed inside or near the room. On 06/11/24 at 12:27 p.m., the janitor's room door on B14-27 hall was not locked. The room was observed to have a housekeeping cart with open cleaning supplies on it. The room had cleaning supplies stored in the room, no staff were present in the room or near the room. On 06/11/24 at 12:43 p.m., housekeeper #1 reported the cleaning cart is kept in the janitor room locked up when not in use. On 06/11/24 at 12:43 p.m., the Administrator agreed the medication room door and the two janitor room doors were unlocked and should have been closed for resident safety. The Administrator reported the doors would be locked and staff would be in-serviced. An in-service training "Med Room/Cleaning Carts Locked, Best Practices Poison Control" document, dated 06/11/24, read in part "Given that many residents have Alzheimer's or dementia, the potential for accidental exposure to hazardous chemicals is not just a compliance issue but a severe health risk ...The best practices for safety ...Locked housekeeping carts: To mitigate risks, lock all housekeeping carts and/or ensure they're locked whenever not in use ...Locked med rooms/carts: Must be locked at all time ...Restricted access: Chemical storage areas should also remain locked at all times ..." b. The facility's "Resident Services Operations" manual, not dated, documented "A physician's order must be obtained if medications are to be crushed or placed in food to assist with swallowing or hiding medications.	C1505		

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C1505	Continued From page 7 On 06/11/24 at 3:40 p.m., MAT #4 was observed during medication pass, to open a capsule of omeprazole 20 mg, mix with applesauce, and administered with a spoon to resident #9. Resident #9's current doctor's orders, printed 06/12/24, documented omeprazole cap 20 mg 1 cap by mouth daily, start date 03/16/22. The doctor's orders documented no order to crush meds or place in meds in food to administer. On 06/12/24 at 09:30 a.m., LPN #1 reported resident not being able to find the order for resident #9's medication to be given in food. The LPN reported resident #9 should have an order documented on the doctor's orders to administer medication in food.	C1505		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and	C5010		

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C5010	Continued From page 8 assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure coordination of services with third party providers for two (#2 and #4) of two residents reviewed for hospice services. Findings: The "Assisted Living Resident Condition and Care Overview", dated 06/11/24, documented two residents received hospice services. The "Residence and Service Agreement and Addenda", for Res #2 and Res #4, read in part, "...Criteria for Residency...Require intermittent or unscheduled nursing care provided by both The Lodge staff and/or outside providers..." 1. Resident #2's "Hospice IDG Comprehensive Assessment and Plan of Care Update Report", read in part, "...Benefit Period Dates: 04/13/24 to 06/11/24...Diagnoses: Sarcopenia (musculoskeletal disease), essential hypertension, type 2 Diabetes Mellitus without	C5010		

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C5010	Continued From page 9 complications..." Resident #2's "Hospice Physician Order", order date: 07/14/23, read in part, "...Order Description: Begin FSBS 1X Weekly..." Resident #2's "Doctor's Orders", dated April 2024, read in part, "...Remind resident to get blood sugar before meal, ACMA can obtain manually...ST: 07/24/23..." On 06/12/24 at 11:42 a.m., MAT #1 was asked about Resident #2's FSBS. They reported the FSBS was only on Monday's and when the resident would refuse to obtain it, they would document they refused. On 06/12/24 at 11:46 a.m., LPN #1 reviewed the hospice order and the center's physician's orders for FSBS's. They reported the resident would obtain her finger stick and the staff would chart. The FSBS report from the eMAR was requested and they were unable to obtain the report. 2. A "Physician's Plan of Care", faxed to the center on 06/12/24, at 10:17 a.m., read in part, "...Alzheimer's disease with late onset...New Frequency Duration...Start date 03/28/24...End: 06/25/24...abnormal weight loss...Plan of Care...Problem: Activity/Mobility diminished due to disease progression...Mental function altered due to Alzheimer's...Nutrition/Hydration diminished due to disease process..." On 06/12/24 at 08:45 a.m., Resident #4's family member reported the resident previously received home health services but currently received hospice services for weight loss and the need for assistance with bathing.	C5010		

Oklahoma State Department of Health

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C5010	Continued From page 10 On 06/12/24 at 8:55 a.m., LPN #1 was asked about the third-party provider for Resident #4. They reported they currently received home health services. On 06/12/24 at 9:09 a.m., the sign in sheet documented hospice was providing visits to Resident #1. LPN #1 was not aware the resident had changed from home health services to hospice services. They reported they coordinated care when the agency staff would stop by the office, but it was not documented. On 06/12/24 at 9:41 a.m., LPN #1 notified the hospice agency and they would fax the hospice plan of care to the center today.	C5010		

Delivery via email to: rharvey@ardmorevillage.com

July 15, 2024

License Number: AL1002

Ms. Rhonda Harvey, Administrator
Village Lodge of Ardmore Village
1310 Knox Road
Ardmore, OK 73401

RE: Survey Event 5YA611

Dear Ms. Harvey:

On **June 12, 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 **July 10, 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,

Tempal Killman

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

Enclosure



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/2/2024

Facility Name: Village Lodge of Ardmore Village

License Number: AL1002

Survey Event ID: 5YA611

Date Survey Completed: 6/12/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C532

Based on: Rule not met as evidenced by: Resident #3 was admitted on 12/05/23. Comp Assessment dated 12/22/23 documented no diagnosis, medical history or mental health history. #5 admitted on 07/22/16 comp assessment dated 07/12/23 documented no diagnosis, medical history or infections. #6 admitted on 10/18/22 comp assessment 10/10/23 no medical history or infections. #8 admitted on 09/05/20 comp assessment dated 09/06/23 no diagnosis, medical history or infections.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This AL recently had a clinical leadership team turnover. Currently working through all processes and correcting where applicable.

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

OAC 310:663-25-4(F)

Administrator signature required.

Ronda Wainry

Date 7/1/2024

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.](#)

C532

All Areas Must Be Addressed, "N/A" if not applicable.

* Denotes items required for Admission Assessment.

Facility Name The lodge at ardmore Admission Date _____
Assessment Date 12/22/23

Resident Name _____ Room #: _____ Date of Birth: _____
Assessment Type (circle one): Preadmission 14 day Annual Significant Change

*Disease Diagnoses and Medically Defined Conditions:

Atrial flutter, HTN, stage 3 kidney disease, dementia with behavioral disturbance, Hx smoke, Hyperlipidemia, Vertebrobasilar artery syndrome

*History of Infections and Prior Medical History:

0 infections / CAD, hypothyroidism, reactive airway disease

*List All Current Medications and dosages (list additional medications on separate page if needed):

See attach

*Mental / Cognitive Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe) (circle one)

Alert / Non-Alert / Oriented x Confused / Confused at Times / Forgetful

Judgment: G F P

Resident has 2 full caregivers / sisters

*Mental Health History / Mental Retardation or Developmental Disabilities:

Dementia with behavioral disturbance

*Physical Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Mobility: G F / P

Strength: G F / P

Gait: G F / P

Range of Motion: Full / Limited / Contractures (describe) _____

Weight Bearing: Yes / No (describe) _____

Ambulatory Without Assistance / With Staff Assistance (describe) _____

Bedfast / Chairfast / Geri-chair / Walker / Wheelchair per Self / With Staff Assistance

*List Number of Persons Required to Assist Resident with Activities of Daily Living to Include:

Bathing 1 Eating 0 Dressing 0 Transferring 0 Toileting 0 Ambulation 0

Devices/Restraints (Describe):

Side rails used? Yes No

Restraint Devices (Describe) _____ Utilized When and Why (describe) _____



All Areas Must Be Addressed, "N/A" if not applicable.

* Denotes items required for Admission Assessment.

Facility Name The Lodge at Ardmore

Admission Date _____

Assessment Date 7/12/2023

Resident Name _____

Room # _____

Date of Birth: _____

Assessment Type (circle one): Preadmission

14 day

Annual

Significant Change

*Disease Diagnoses and Medically Defined Conditions:

see attach Heart failure, chronic kidney disease stage 3
pacemaker, hyperlipidemia, atrial fib

*History of Infections and Prior Medical History:

GERD, Hypertensive disorder, Vertigo, abdominal bloating

*List All Current Medications and dosages (list additional medications on separate page if needed):

see attach

*Mental /Cognitive Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe) (circle one)

Alert / Non-Alert / Oriented x 3

Confused / Confused at Times / Forgetful

Judgment: G / F / P

*Mental Health History / Mental Retardation or Developmental Disabilities:

Depressive disorder

*Physical Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Mobility: G / F / P

Strength: G / F / P

Gait: G / F / P

Range of Motion: Full / Limited / Contractures (describe) _____

Weight Bearing: Yes / No (describe) _____

Ambulatory Without Assistance / With Staff Assistance (describe) _____

Bedfast / Chairfast / Geri-chair / Walker / Wheelchair per Self / With Staff Assistance

*List Number of Persons Required to Assist Resident with Activities of Daily Living to Include:

Bathing 0 Eating 0 Dressing 0 Transferring 0 Toileting 0 Ambulation 0

Devices/Restraints (Describe):

Side rails used? Yes / No

Restraint Devices (Describe) _____

Utilized When and Why (describe) _____

All Areas Must Be Addressed, "N/A" if not applicable.

* Denotes items required for Admission Assessment.

Facility Name The Lodge at Armore

Admission Date

Assessment Date 10-10-23

Resident Name

Room #: Date of Birth:

Assessment Type (circle one): Preadmission

14 day

Annual

Significant Change

*Disease Diagnoses and Medically Defined Conditions:

HTN, hyperlipidemia, macular degeneration, sleep apnea, DM
CVD, CHF, arthritis, Heart failure

*History of Infections and Prior Medical History:

Chronic pain, allergic rhinitis, bladder osteoarthritis

*List All Current Medications and dosages (list additional medications on separate page if needed):

see attach

*Mental / Cognitive Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe) (circle one)

Alert / Non-Alert / Oriented x 4

Confused / Confused at Times / Forgetful

Judgment G F / P

*Mental Health History / Mental Retardation or Developmental Disabilities:

*Physical Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Mobility: G / F / P

Strength: G / F / P

Gait: G / F / P

Range of Motion: Full / Limited / Contractures (describe)

Weight Bearing: Yes / No (describe)

Ambulatory Without Assistance / With Staff Assistance (describe)

Bedfast / Chairfast / Geri-chair / Walker / Wheelchair per Self / With Staff Assistance

*List Number of Persons Required to Assist Resident with Activities of Daily Living to Include:

Bathing 0 Eating 0 Dressing 0 Transferring 0 Toileting 0 Ambulation 0

Devices/Restraints (Describe):

Side rails used? Yes No

Restraint Devices (Describe)

Utilized When and Why (describe)



**OKLAHOMA
State Department
of Health**

Recommended Assisted Living
Resident Assessment Form

Oklahoma State Department of Health
Long Term Care Service
123 Robert S. Kerr Ave., Suite 1702
Oklahoma City, OK 73102-6404
Phone: (405) 426-8200

C 532
#8

All Areas Must Be Addressed, "N/A" if not applicable.

* Denotes items required for Admission Assessment.

Facility Name The Lodge at Ardmore Village Admission Date 7/6/23
Assessment Date 7/6/23

Resident Name _____ Room #: _____ Date of Birth: _____
Assessment Type (circle one): Preadmission 14 day Annual Significant Change

*Disease Diagnoses and Medically Defined Conditions:

See attached Dementia, HTN, insomnia, Depression
disorder, chronic pain, diverticulitis of colon

*History of Infections and Prior Medical History:

anxiety, depression, dementia, hyperlipidemia, infections

*List All Current Medications and dosages (list additional medications on separate page if needed):

See attached

*Mental / Cognitive Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe) (circle one)

Alert / Non-Alert / Oriented x 2 Confused Confused at Times / Forgetful Judgment: G / F (P)

*Mental Health History / Mental Retardation or Developmental Disabilities:

*Physical Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Mobility: G / F / P Strength: G / F / P Gait: G / F / P

Range of Motion: Full / Limited / Contractures (describe) _____

Weight Bearing: Yes / No (describe) _____

Ambulatory Without Assistance / With Staff Assistance (describe) _____

Bedfast / Chair fast / Geri-chair / Walker / Wheelchair per Self / With Staff Assistance

*List Number of Persons Required to Assist Resident with Activities of Daily Living to Include:

Bathing 1 Eating 0 Dressing 0 Transferring 0 Toileting 0 Ambulation 0

Devices/Restraints (Describe):

Side rails used? Yes / No

Restraint Devices (Describe) _____ Utilized When and Why (describe) _____

C 532

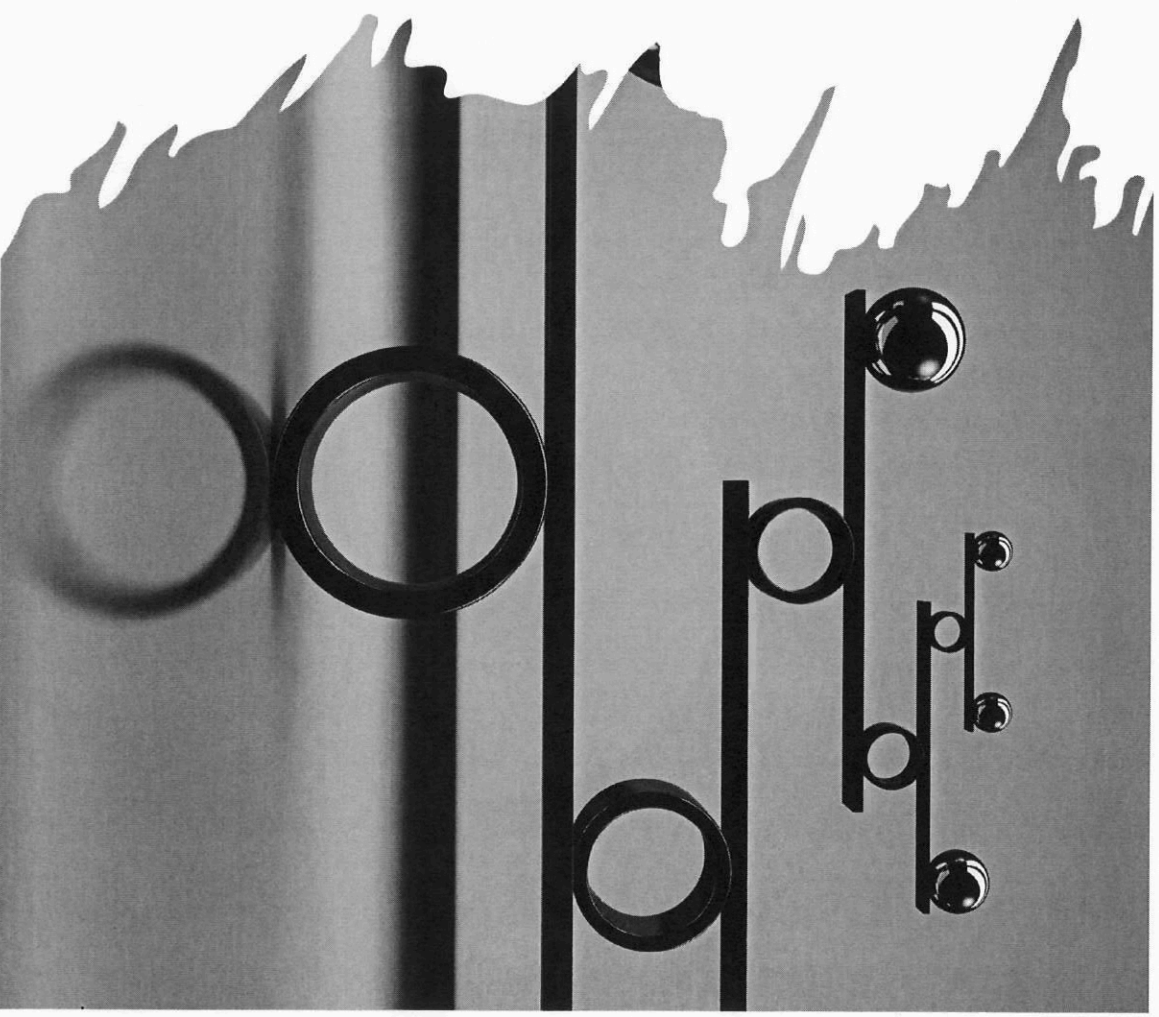
James

June 2024

Ardmore Village The Lodge
Quality Assurance
14-Day Assessment Review

QA Comprehensive Resident Centered Care Plans & Resident Assessments

- Intent
- Promote continuity of care
- Communication among care staff
- Increase resident safety
- Safeguard against adverse events that are most likely to occur right after admission
- Ensure the resident and representative if applicable are informed of the initial plan for delivery of care and services by written summary of a 14 day assessment. This is imperative after admission which provides a baseline care plan.
- The care plan should strike a balance between conditions and risks affecting the resident's health and safety, and what is important to him or her; within the limitations of the care plan timeframe.





What is Person Centered Care

The facility focuses on the resident as the center of control, and supports each resident in making his or her own choices.

This includes making an effort to understand: What each resident is communicating, verbally and nonverbally
identifying what is important to each resident with regard to daily routines and preferred activities
having an understanding of the resident's life before coming to reside in the assisted living facility.

Documentation

Goals, objectives and include interventions that address his or her current needs. It must be based on the admission orders, information about the resident available from the transferring provider, and discussion with the resident and resident representative, if applicable.

14 Day Assessments

- The facility must develop and implement a 14-day assessment for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

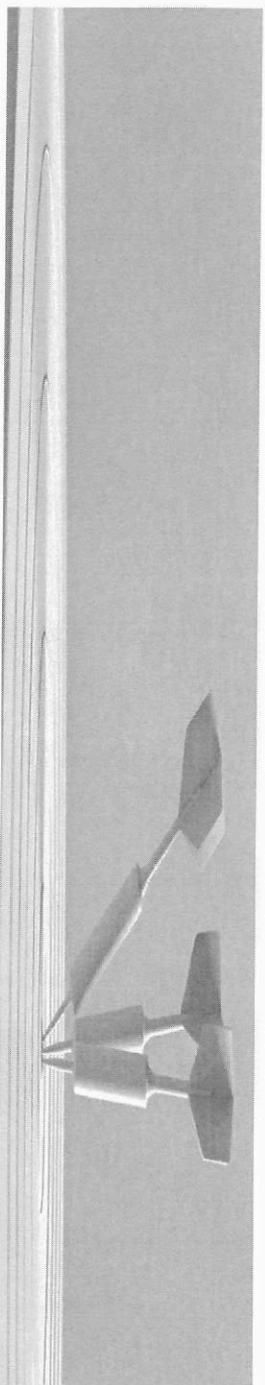
- Care Plans Summary
- The initial goals of the resident
- A summary of the resident's current medications and dietary instructions.
- Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
- Any updated information based on the details of the comprehensive care plan, as necessary.

The summary must be in a language and conveyed in a manner the resident and/or representative can understand.

The format and location of the summary is at the facility's discretion, however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable.

The facility may choose to provide a copy of the care plan itself as the summary, as long as it meets all of the requirements of the summary.

Goals



- In the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes must be incorporated into an updated summary provided to the resident and his or her representative, if applicable.
- Once the comprehensive care plan has been developed and implemented, and a summary of the updates given to the resident, the facility is no longer required to revise/update the written summary of the care plan. Rather, each resident will remain actively engaged in his or her care planning process through the resident's rights to participate in the development of, and be informed in advance of changes to the care plan; see the care plan; and sign the care plan after significant changes.



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/2/2024

Facility Name: Village Lodge of Ardmore Village

License Number: AL1002

Survey Event ID: 5YA611

Date Survey Completed: 6/12/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C552

Based on: Rule not met evidenced by: failed to ensure a plan of care was developed for three (#6, 7, and #8 and a comp assessment was completed within 14 days after admission for one (#7) of four residents reviewed for care plans and comprehensive admission assessments. #6 admitted on 10/18/22 annual dated 10/10/23 on 06/11/24 resident no resident care plan. #7 admitted on 05/01/24 no care plan or comp admission assessment, #8 admitted on 09/05/20 annual assessment 09/06/23 resident required assistance of one staff with bathing. #6 #7 and #8 did not contain a care plan. #7 did not contain a compl comprehensive admission assessment.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Recent clinical leadership turnover. New team has reviewed all assessments and ensured applicable care plans are in place.

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

OAC 310:663-25-4(F)

Administrator signature required.

Shirley Harvey

Date Enter a date of signature.

7/10/2024

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 Assisted Living
@ Ardmore Village**

Phone: 580-223-8400

Fax: 580-223-6125

Physician/Health Care Provider Plan of Care

Resident's Name	Date of Physic	/HCP Visit
Physician/HCP Name D. SAMPSON Wagner	Phone Number	
Physician/HCP Name	Fax Number	

Primary Medications/PRN

See attached

Parameter BP (range)/Pulse if applicable

115/60 to 180/100

Allergies (Medication, Environmental, Food)

Lipitor

Current Treatments:

See attached

Resident's Name	Date of P	ician/HCP Visit
-----------------	-----------	-----------------

Medication Administration

Resident Assistants administer medications. A physician/HCP must order PRN and all over-the-counter medications.

Please check one:



May self-administer medications. Medications must be kept in resident's room and taken without staff supervision.



Staff-administer the medications. Medications must be stored in a central location and administered by staff only.

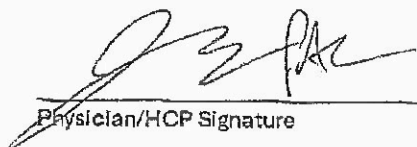
Diet: (Please indicate the diet desired from the options listed below)
--

Available Diets
☒ Regular Diet

Available Thickened Liquids
☐ Nectar Thick Liquids ☐ Honeythick Liquids
Daily=once, bid=twice

Supplements ___daily___bid___tid___qid
 tid=three times daily, qid= four times daily

Resident's Name	Date of Physician/HCP Visit
Therapy Services Therapy services can be made available to residents of assisted living facilities. These services must be ordered by a physician/HCP to be initiated. Resident evaluation and treatment as indicated. Check all that apply: ☐ Home Health ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy	
Related to the following: <i>This section may be completed by the nurse.</i> Assistive Devices <u>CRAP to be worn Nightly</u> Other Instructions: Appropriateness for Assisted Living Setting This person's needs can be met in the Assisted Living Center setting. Additionally, this person does not pose a threat to themselves or others.	



Physician/HCP Signature

6-24-24

Date

TRANSMISSION VERIFICATION REPORT

TIME : 07/10/2024 14:09
NAME :
FAX :
TEL :
SER. # : U63274C9J683178

DATE, TIME
FAX NO. /NAME
DURATION
PAGE(S)
RESULT
MODE

07/10 14:08
5802206428
00:00:55
03
OK
STANDARD

C552 #7

The Lodge Assisted Living

@ Ardmore Village

Phone: 580-223-8400

Fax: 580-223-6125

Physician/Healthcare Provider Plan of Care

Resident's Name	Date of Physician/HCP Visit
Physician/HCP Name Ellis	Phone Number
Physician/HCP Name	Fax Number 580-220-6428

Primary Medications/PRN

Parameter BP (range)/Pulse if applicable

Allergies (Medication, Environmental, Food)

TRANSMISSION VERIFICATION REPORT

TIME : 07/09/2024 21:53
 NAME :
 FAX :
 TEL :
 SER.# : U63274C9J683178

DATE, TIME	07/09 21:53
FAX NO./NAME	5802206428
DURATION	00:00:55
PAGE(S)	03
RESULT	OK
MODE	STANDARD

The Lodge Assisted Living

@ Ardmore Village

Phone: 580-223-8400

Fax: 580-223-6125

Physician/Healthcare Provider Plan of Care

Resident's Name	Date of Physician/HCP Visit
Physician/HCP Name EWIS	Phone Number
Physician/HCP Name	Fax Number 580-220-6428

Primary Medications/PRN

Parameter BP (range)/Pulse if applicable

Allergies (Medication, Environmental, Food)

The Lodge Assisted Living**@ Ardmore Village**

Phone: 580-223-8400

Fax: 580-223-6125

Physician/Healthcare Provider Plan of Care

Resident's Name	Date of Physician/HCP Visit
Physician/HCP Name EWIS	Phone Number
Physician/HCP Name	Fax Number 580-220-6428

Primary Medications/PRN**Parameter BP (range)/Pulse if applicable****Allergies (Medication, Environmental, Food)****Current Treatments:**

Resident's Name	Date of Physician/HCP Visit
-----------------	-----------------------------

Medication Administration

Resident Assistants administer medications. A physician/HCP must order PRN and all over-the-counter medications.

Please check one:

☐

May self-administer medications. Medications may be kept in resident's room and taken without staff supervision.

☐

Staff-administer the medications. Medications are stored in a central location and administered by staff only.,

Diet: (Please indicate the diet desired from the options listed below.)

Available Diets

☐

Regular Diet

Available Thickened Liquids

☐

Nectar Thick Liquids

☐
☐

Honey thick Liquids

☐

House Supplements __daily__bid__tid__qid

Daily=once, bid=twice, tid=three times daily, qid = four times daily



**OKLAHOMA
State Department
of Health**

**Recommended Assisted Living
Resident Assessment Form**

Oklahoma State Department of Health
Long Term Care Service
123 Robert S. Kerr Ave., Suite 1702
Oklahoma City, OK 73102-6404
Phone: (405) 426-8200

C 552
#8

All Areas Must Be Addressed, "N/A" if not applicable.

* Denotes items required for Admission Assessment.

Facility Name The Lodge at Ardmore Village Admission Date 9/6/23
Resident Name [redacted] Room #: 1 Date of Birth: 1
Assessment Type (circle one): Preadmission 14 day Annual Significant Change

*Disease Diagnoses and Medically Defined Conditions:

See attached Dementia, HTN, insomnia, Depression disorder, Chronic pain, diverticulitis of colon

*History of Infections and Prior Medical History:

Anxiety, depression, dementia, hyperuricemia, infections

*List All Current Medications and dosages (list additional medications on separate page if needed):

See attached

*Mental / Cognitive Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe) (circle one)

Alert / Non-Alert / Oriented x 2 Confused Confused at Times / Forgetful

Judgment: G / F / P

*Mental Health History / Mental Retardation or Developmental Disabilities:

*Physical Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Mobility: G / F / P

Strength: G / F / P

Gait: G / F / P

Range of Motion: Full / Limited / Contractures (describe)

Weight Bearing: Yes / No (describe)

Ambulatory Without Assistance / With Staff Assistance (describe)

Bedfast / Chair fast / Geri-chair / Walker / Wheelchair per Self / With Staff Assistance

*List Number of Persons Required to Assist Resident with Activities of Daily Living to Include:

Bathing 1 Eating 0 Dressing 0 Transferring 0 Toileting 0 Ambulation 0

Devices/Restraints (Describe):

Side rails used? Yes / No

Restraint Devices (Describe) Utilized When and Why (describe)

-SAMPLE-

FAX

The Lodge Assisted Living

1310 Knox Road

Ardmore, Ok 73401

580-223-8400

580-223-6125 Fax

From: _____

To: _____

Fax: _____

Date: _____

Resident: _____

DOB: _____

Pages (Including Cover Sheet)

pg 1 of 4

Refill Request:

Tag

C552

Comments:

This cover sheet and the
attached must be submitted
on all new move ins (AL)

This is given to the primary care
doctor. We must receive before any
resident is allowed to move in -

NOTICE OF CONFIDENTIALITY

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The Lodge Assisted Living**@ Ardmore Village**

Phone: 580-223-8400

Fax: 580-223-6125

Physician/Healthcare Provider Plan of Care

Resident's Name	Date of Physician/HCP Visit
Physician/HCP Name	Phone Number
Physician/HCP Name	Fax Number

Primary (List All)

C552

Secondary (List All)**Allergies (Medication, Environmental, Food)****Current Treatments:**

Resident's Name

Date of Physician/HCP Visit

Medication Administration

Resident Assistants administer medications. A physician/HCP must order PRN and all over-the-counter medications.

Please check one:

0552

☐

May self-administer medications. Medications may be kept in resident's room and taken without staff supervision.

☐

Staff-administer the medications. Medications are stored in a central location and administered by staff only.,

Diet: (Please indicate the diet desired from the options listed below.)

Available Diets

☐

Regular Diet

Available Thickened Liquids

☐

Nectar Thick Liquids

☐☐

Honey thick Liquids

☐

House Supplements __daily__bid__tid__qid

Daily=once, bid=twice, tid=three times daily, qid = four times daily

Resident's Name

Date of Physician/HCP Visit

Therapy Services

Therapy services can be made available to residents of assisted living. These services must be ordered by a physician/HCP to be initiated.

Resident evaluation and treatment as indicated. Check all that apply:

☐

Home Health

☐

Physical Therapy

☐

Occupational Therapy

☐

Speech Therapy

2552

Related to the following:

This section may be completed by the nurse.

Assistive Devices

Other Instructions:

Appropriateness for Assisted Living Setting

This person's needs can be met in the Assisted Living Center setting. Additionally, this person does not pose a threat to themselves or others.

Physician/HCP Signature

Date