OKLAHOMA
State Department
of Health

Delivery via email to: JGuillory@sommersetneighborhood.com

May 15, 2023

License Number: AL1402

Ms. Jessica Guillory, Administrator
Sommerset Neighborhood
1601 Southwest 119th Street
Oklahoma City, OK 73170

RE: Survey Event ID: 0QHM11

Dear Ms. Guillory:

On **May 9, 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 9, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1402	A. BUILDING: _____ B. WING _____	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMMERSET NEIGHBORHOOD	1601 SOUTHWEST 119TH STREET OKLAHOMA CITY, OK 73170

(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 05/08/23 and 05/09/23. Listed below are abbreviations that will be used throughout this document. DM - dietary manager MAR - medication administration record mg - milligrams PRN - as needed Res -Resident	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure: a. the kitchen was kept clean and maintained in good repair, b. dishes were properly stored, and c. food products were properly labeled. The "Assisted Living Resident Condition and Care Overview" report, dated 05/08/23, documented 103 residents resided in the facility. Findings: On 05/08/23 at 9:48 a.m., a tour of the kitchen was conducted. The following observation were made:	C 391		

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C 391	Continued From page 1 a. there was an accumulation of black residue and food on the floor, walls, and on the dish machine in the dish wash area, b. the metal on the spray nozzle hose was torn and the rubber was exposed on the sink in the dish wash area, c. there was an accumulation of lint on the ceiling vents and the ceiling around the vents, d. ceiling lights were burned out and/or not working, e. the hand sink was separating from the wall, f. there was an accumulation of grease on the floor under the black rubber mat in front of the cook area, g. the label was faded and could not be easy read on a bulk food container of a white dry product in the serving area, h. multiple clear dome plate lids and sheet pans were stacked wet in the serving area, i. bowls and plates were stored with the food contact surface facing upward and were not inverted in the serving area, j. there was brown residue/rust on the legs of the three-compartment sink, and k. floor tiles were cracked/missing and water was pooling on the floor in the dish was area. On 05/08/23 at 10:15 a.m., the DM was asked how staff ensured the kitchen was kept clean and maintained in good repair. They stated staff	C 391		

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C 391	Continued From page 2 cleaned daily and they reported maintenance concerns to the maintenance department. They stated there was a maintenance document where they reported their concerns. The DM was asked how dishes were to be stored. They stated dishes were to be stored on shelves and there was a chemical used in the dish cycle aiding in drying the dishes. The DM was asked what was the protocol for labeling food products. They stated food should be labeled. The DM was shown the above observations and/or the above observations discussed.	C 391		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an admission assessment was completed within 30 days before or at the time of admission for one (#10) of 10 residents reviewed for admission assessments. The "Assisted Living Resident Condition and Care Overview" form, dated 05/08/23, documented 103 residents resided in the facility. Findings:	C 521		

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C 521	Continued From page 3 A "Resident Assessment Form", dated 01/06/23, was documented as a pre-admission form for Resident #10. Res #10 admitted to the facility on 02/09/23. The pre-admision form was completed 34 days prior to Resident #10 admission. On 05/09/23 at 10:59 a.m., wellness director #1 stated pre-admission assessments should be completed within 30 days of admission or on the day of admission. They stated Res #10's preadmission assessment was not completed within 30 days of admission.	C 521		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments were coordinated by an RN or physician for two (#5 and #10) of 10 residents reviewed for assessments. The "Assisted Living Resident Condition and Care Overview" form, dated 05/08/23, documented 103 residents resided in the facility. Findings: 1. Res #5's preadmission "Resident Assessment Form" dated 03/08/22, documented signatures	C 542		

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C 542	Continued From page 4 from the resident and two participating health professionals. No signature from an RN or physician was documented on the form. On 05/09/23 at 09:26 a.m., RN #1 stated they had not signed/coordinated the preadmission form for Res #5. 2. Res #10's preadmission "Resident Assessment Form", dated 01/06/23, documented signatures from the resident and one participating health professional. No signatire from and RN or physician was documented on the form. On 05/09/23 at 09:27 a.m., RN #1 stated they had not signed/coordinated the preadmission form for Res #10.	C 542		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and	C1505		

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C1505	Continued From page 5 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 record review and interview, the facility failed to ensure blood pressure medications were held in accordance with physician orders for one (#9) of 10 residents reviewed for physician orders. The "Assisted Living Resident Condition and Care Overview" form, dated 05/08/23, documented 103 residents resided in the facility. Findings: Res #9 had diagnoses which included hypertension. A physician order, dated 08/26/21, documented to administer amlodipine 5 mg one time a day for hypertension and hold for blood pressure less than 110/60.	C1505		

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C1505	Continued From page 6 A physician order, dated 08/26/21, documented to administer lisinopril 20 mg one time a day for hypertension and hold for blood pressure less than 110/60. A physician order, dated 08/26/21, documented to administer metoprolol 12.5 mg one time a day for hypertension and hold for blood pressure less than 110/60. On 03/26/23, the MAR documented the amlodipine was not held for a blood pressure of 89/54. On 04/20/23, the MAR documented the lisinopril and metoprolol were not held for a blood pressure of 89/58. On 05/09/23 at 12:04 p.m., wellness director #2 stated the blood pressure medications should have been held on 03/26/23 and 04/20/23, but were not.	C1505		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites.	C1923		

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C1923	Continued From page 7 (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure PRN medication records were accurate, and included indication and/or effectiveness for one (#3) of 10 sampled residents reviewed for medications. The "Assisted Living Resident Condition and Care Overview" report, dated 05/08/23, documented 103 residents resided in the facility. Findings: Res #3 had diagnoses which included pain. A physician order, dated 02/16/23, documented Norco (pain medication) 5/325 mg one tab two times a day as needed. The February 2023 MAR and narcotic record were reviewed. It was documented Norco was administered at 8:00 a.m. on 02/17/23. There was no indication for the medication being administered on the MAR. The narcotic record documented Norco was administered at 7:00 p.m. on 02/22/23. There was no documentation the medication was administered on the MAR which included the indication for the medication being administered and the effectiveness. The March 2023 MAR and narcotic record were	C1923		

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C1923	Continued From page 8 reviewed. The narcotic record documented Norco was administered at 8:10 a.m. on 03/11/23. There was no documentation the medication was administered on the MAR which included the indication for the medication being administered and the effectiveness. On 05/08/23 at 2:55 p.m., wellness coordinator #1 was asked what was the protocol for administering PRN narcotics. They stated the date, time, staff initials, and result should be documented when the medication was administered on the MAR. They stated there should also be a narcotic record for the medication. They were shown the resident's February and March 2023 MARs and narcotic records for Norco. The stated they should have been on both records.	C1923		

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June 15, 2023

License Number: AL1402

Ms. Jessica Guillory, Administrator
Sommerset Neighborhood
1601 Southwest 119th Street
Oklahoma City, OK 73170

RE: Survey Event 0QHM11

Dear Ms. Guillory:

On **May 9, 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 have been corrected and you were in substantial compliance by **June 8, 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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/23/2013** **Facility Name:** Sommerset Assisted Living **License Number:** AL 1402 **Survey Event ID:** 0QHM11 **Date Survey Completed: 5/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 391	Based on: facility failed to ensure the kitchen was kept clean and maintained in good repair, dishes were properly stored, and food products were properly labeled.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Dishroom area was addressed and cleaned after surveryors exited on day 1. The lint in vents were cleaned by maint. Director after surveyors exited for day 1 of survey. The ceiling lights were replaced after surveyors exited for day 1 of survey.The grease under the floor mats were cleaned after surveyors exited for day 1 of survey.The faded label was replace on day 1 of survey.

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?	a. this was cleaned after surveyors exited on day one of survey. Moving forward the floor, walls, and dish machine will be cleaned after each shift.This will be monitored daily by the dietary supervisor. Any non-compliance will result in a written reprimand. Survey findings were addressed via in-service meeting with kitchen staff on 5/16/23. b.A new spray nozzle hose has been ordered and will be installed. c. These have been cleaned by the maintenance director. Moving forward, the maintenance director will observe the ceiling vents and ceiling around the vents weekly. If needed, they will be cleaned. Routine cleaning will occur quarterly when filters are changed. d. Ceiling lights were replaced prior to survey exit. Maintenance director will observe ceiling lights weekly while checking ceiling vents. e. Separating kitchen sink will be repaired by May 31st. f. Black mats will be removed from kitchen. Kitchen floor will mopped after each shift, on a check list, signed off by a cook as completed each shift. g.this label was corrected during survey. Storage bin labels will be checked weekly by dietary supervison, on a check list to ensure they are legible. h. facility will order new dishwash racks. Clear dome plate lids will be left to dry in the new dishracks until dry, and before stacking.Kitchen supervisor will monitor daily on a check list. i. Plates and bowls will be stored to dry in racks until dry, then will be stored inverted. Kitchen supervisor will monitor for compliance daily and document on checklist. j. maintenance director will sand/repaint the legs on the 3 compartment sink by May 31st. k. maintenance director will replace cracked/missing floor tiles in dish wash room by May 31st.

OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	See comments above
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?	See comments above. There will be a daily checklist of daily, weekly,monthly, and quarterly tasks. This checklist will be monitored by the dietary supervisor daily and submitted to the executive director weekly.
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.	A. see content above. B. see attached QA tool C. The kitchen supervior's check lists will be maintained for surveyor review. The quarterly QA tools are already maintained for surveyor review. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/8/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Jessica Guillory** OAC 310:663-25-4(F)	**Date 5/23/2023**

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.

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/23/2023** **Facility Name:** Sommerset Neighborhood **License Number:** AL 1402 **Survey Event ID:** 0QHM11 **Date Survey Completed: 5/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 521	Based on: failure to ensure an admission assessment was completed within 30 days before or at the time of admission on resident #10

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This resident's assessment was 3 days out of compliance due to his delay of move in for 3 days. The assessment remained accurate, a plan of care was developed in a timely manner, and assessment still reflects the resident's condition. Facility did fail to re-assess after the 3 day delay in move-in.

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?	RN reviewed resident #10's admissions assessment on date of survey exit. It's not possible to back date the assessment to be within regulatory time frame. This assessment would have been timely, but the resident delayed his move in 3 days, assessment was 3 days out of compliance, and facility did not complete a new assessment upon admission. Comprehensive assessment was timely and completed within 5 days of admission.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Wellness Directors will be responsible and report back to the Administrator the following: each current resident's record will be reviewed to ensure that all admission assessments were completed within the regulatory time frame.
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?	Administrator provided in-service training to Licensed nurses, Marketing director, and Wellness Directors on survey exit 5/9/23 to review types of assessments, review of regulation, and conduct of assessment. Repeated in-service program on 5/11/23. Admission and comprehensive assessments will be provided to the Administrator immediately after completion. Administrator will verify that each assessment type was completed within the regulatory time-frame and sign the assessment as a participating health professional to indicate confirmation that the timeframe is in compliance.
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;	Moving forward, the R.N. will provide each completed assessment to the executive director. The executive director will check to ensure that all admission assessments were completed 30 days prior to, or date of admission. The executive director will sign the assessment as a participating healthcare professional to indicate that it

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.	was completed within the regulatory timeframe. See QA tool. This tool is already used quarterly. The initial review for compliance and quarterly QA tools will be retained for review by surveyors. 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?	6/8/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Jessica Guillory** OAC 310:663-25-4(F)	**Date 5/23/2023**

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.

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/11/2023** **Facility Name:** Sommerset Neighborhood **License Number:** AL 1402 **Survey Event ID:** 0QHM11 **Date Survey Completed: 5/10/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 542	Based on: facility failed to ensure assessments were coordinated by an R.N. or physician for two residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: All prior surveys accepted the Pre-admission tool completed by a trained person and not necessarily coordinated or conducted by an RN or physician. During survey, regulations were reviewed with surveyors and facility accepted regulation as written that ALL assessments must be conducted OR coordinated by an R.N. or physician. Facility has always been compliant with this regulation as it applies to the comprehensive assessment, and will now apply the regulation to the pre/admission assessment.

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?	RN reviewed and signed the admission assessments for residents 5,7, &10 at survey exit on 5/9/23 It's not possible to back date the admission assessments that did not have RN signature for coordination of assessments. They were complete and signed by person completing, but not the RN for coordinating the assessment.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Wellness Directors will be responsible and report back to the Administrator the following: each current resident's record will be reviewed to ensure that all admission assessments were signed as coordinated or conducted by the RN.
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?	Administrator provided in-service training to Licensed nurses, Marketing director, and Wellness Directors on survey exit 5/9/23 to review types of assessments, review of regulation, and conduct of assessment. Repeated in-service program on 5/11/23. Admission and comprehensive assessments will be provided to the Administrator immediately after completion. Administrator will verify that each assessment type was coordinated or conducted by the RN and the Administrator will sign the assessment as a participating health professional to indicate confirmation that RN conducted or coordinated the assessment.
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;	After the initial review of each resident's assessments, the wellness director will provide the administrator and R.N. a report of findings. Moving forward, all admission and comprehensive assessments will be provided to the executive director for review. Executive director will

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.	ensure that the assessments have been coordinated or conducted by the R.N. as evidenced by signature on the form. The executive director will sign the assessment as a participating individual to demonstrate review and compliance. The initial survey QA assessment will be retained for surveyor review. Monitoring will continue during the quarterly QA review and those tools are currently retained for review by surveyors. See attached QA tool. 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?	6/8/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Jessica Guillory OAC 310:663-25-4(F)	**Date 5/23/2023**

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.

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OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/23/2023** **Facility Name:** Sommerset Neighborhood **License Number:** AL 1402 **Survey Event ID:** 0QHM11 **Date Survey Completed: 5/10/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505	Based on: facility failed to ensure blood pressure medications were held in accordance with physician's orders for one resident.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Although this occurred, and was cited, there was no negative outcome to the resident.

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?	In-service training provided by administrator to wellness directors and all medication admin staff on 5/10/23 to discuss regulatory concerns, medication admin practices and POC. A medication error report will be completed for the affected resident. Wellness directors have identified all residents who have VS dependent medications and will review each resident's MAR daily to ensure staff have administered VS dependent medications in compliance with physician's orders/policy. Any variance will result in a written reprimand and re-training for the employee involved.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	See #1
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?	On a daily basis, wellness directors will review the MARs of each resident who has VS dependent medications to ensure that the VS dependent medications have been administered in accordance with physician's orders/policy. Any variance will result in a written reprimand and re-training for the employee involved.
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.	See attached abbreviated QA tool specific for VS dependent medication audit. Wellness directors will conduct daily audits as previously indicated and submit the abbreviated QA tool with any additional findings/documentation to the administrator weekly. These audits will continue at least 4 weeks, but until determined by the administrator that is acceptable to resume quarterly QA audits. Records will be kept by the administrator to evidence correction. 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?	6/8/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Jessica Guillory OAC 310:663-25-4(F)	**Date 5/23/2023**

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.

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

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/23/2023** **Facility Name:** Sommerset Neighborhood **License Number:** AL 1402 **Survey Event ID:** 0QHM11 **Date Survey Completed: 5/9/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923	Based on: facility failed to ensure PRN medications records were accurate, and included indication and/or effectiveness for one resident

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?	In-service training provided by the administrator to wellness directors and medication staff addressing regulatory findings, facility policy, and POC. It is not possible to back date the documentation on the affected resident's MAR.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	See #3
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?	Wellness directors will review each resident's MAR on a daily basis to assess whether a prn medication was administered. If a prn medication was administered, the wellness director will review the MAR to assure that all required supporting documentation is present. If a variance is found, the responsible staff member will be given a written reprimand, and re-trained.
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.	The correction will be monitored using an abbreviated QA tool specific to documentation of prn medications. See attached tool. This QA tool will be submitted to the administrator weekly, with any supporting documentation for variances.The audits will continue for at least 4 weeks or until the administrator determines it is acceptable to resume the usual quarterly QA process. The monitoring records will be retained by the administrator to evidence correction. 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?	6/8/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Jessica Guillory OAC 310:663-25-4(F)	**Date 5/23/2023**

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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.			

OKLAHOMA
State Department
of Health

Delivery via email to: JGuillory@sommersetneighborhood.com

August 9, 2023

License Number: AL1402

Ms. Jessica Guillory, Administrator
Sommerset Neighborhood
1601 Southwest 119th Street
Oklahoma City, OK 73170

RE: Survey Event 0QHM12

Dear Ms. Guillory:

On **July 14, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 9, 2023,** have now been corrected effective **June 8, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1402	A. BUILDING: _____ B. WING _____	R 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMMERSET NEIGHBORHOOD	1601 SOUTHWEST 119TH STREET OKLAHOMA CITY, OK 73170

(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 An offsite/paper revisit was conducted on 07/14/23. The facility was in substantial compliance.	{C 000}		

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