
Delivery via email to: mwooldridge@luxelifeseniorkliving.com

June 15, 2023

License Number: AL1403

Ms. Mollie Wooldridge, Administrator
Luxe Life Norman AL, LLC
1060 Rambling Oaks Drive
Norman, OK 73072

RE: Survey Event ID: XZO711

Dear Ms. Wooldridge:

On **May 23, 2023**, agents from our office concluded a State Licensure survey with complaint investigations 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 23, 2023.

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

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

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

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

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

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

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

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

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

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT

Facility: Luxe Life Norman AL, LLC
Address: 1060 Rambling Oaks Drive
City, State, Zip: Norman, OK, 73072
Provider #: AL1403
Complaint #: OK00058618
Investigation Dates: 05/18/23 and 05/22/23 through 05/23/23

ALLEGATION

1. The center failed to administer medications according to physician's orders.

An unannounced on-site investigation was initiated 05/18/2023 at 9:00 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at various times throughout the survey. Staff were observed for providing medications to residents.

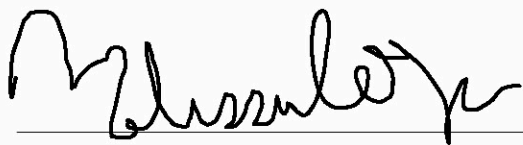
Residents' records were reviewed including physician orders, medication records, nursing notes, vital sign reports, and audit reports. Facility medication administration policy and procedures were reviewed.

Residents were interviewed related to medication administration.

Staff members were interviewed related to the facility policy on medication administration.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

A handwritten signature in black ink, appearing to read 'Melissa Cooper', is written over a horizontal line.

Melissa Cooper, Health Facility Surveyor

Date report completed: 05/24/2023

INVESTIGATIVE REPORT

Facility: LUXE LIFE NORMAN AL, LLC
Address: 1060 RAMBLING OAKS DRIVE
City, State, Zip: NORMAN, OK, 73072
Provider #: AL1403
Complaint #: OK00059099
Investigation Date(s): 05/18/23, 05/22/23-05/23/22

ALLEGATION(S)

- | |
|--|
| 1. The center failed to ensure residents' medication was not misappropriated. |
| 2. The center failed to ensure documentation was not falsified related to misappropriation of narcotic medication. |
| 3. The center failed to report the results of the investigation to the State Agency, OSDH. |

An unannounced on-site investigation was initiated 05/18/2023 at 09:00 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Tours were conducted upon entry and at random times throughout the survey. Residents were observed receiving medications. Staff were observing interacting with residents.

Resident records were reviewed including progress notes, medication administration records, physician orders, assessments, care plans, and vital signs. Facility records were reviewed including policies, incident reports, and employee files.

Residents were interviewed regarding medications, abuse, neglect, misappropriation, and resident records. Staff were interviewed regarding medications, abuse, neglect, misappropriation, and resident records.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Kc Claunch Digitally signed by Kc Claunch
Date: 2023.05.23 16:33:37
-05'00'

Kc Claunch, LPN CHFSII

Date report completed: 05/23/2023

INVESTIGATIVE REPORT

Facility: Luxe Life Norman AL, LLC
Address: 1060 Rambling Oaks Drive
City, State, Zip: Norman, OK, 73072
Provider #: AL1403
Complaint #: OK00059301
Investigation Dates 05/18/23 and 5/22/23 through 05/23/23.

ALLEGATION(S)

- | |
|--|
| 1. The facility neglected to ensure medications were administered as per physicians' orders. |
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An unannounced on-site investigation was initiated 05/18/2023 at 9:00 a.m.

A sample of 10 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at various times throughout the survey. Staff were observed for providing medications to residents.

Residents' records were reviewed including physician orders, medication records, nursing notes, vital sign reports, and audit reports. Facility policy and procedures were reviewed.

Residents were interviewed related to medication administration.

Staff members were interviewed related to the facility policy on medication administration.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Terri D. Burkhart Digitally signed by Terri D. Burkhart
Date: 2023.05.24 11:54:03 -05'00'

Terri Burkhart, BSN RN CHFS

Date report completed: 05/24/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1403	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/23/2023
NAME OF PROVIDER OR SUPPLIER LUXE LIFE NORMAN AL, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 RAMBLING OAKS DRIVE NORMAN, OK 73072		
(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 05/18/23 and 05/22/23 through 05/23/23. Complaint investigations (OK00058618, OK00059301, and OK00059099) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. BP - blood pressure CBC - complete blood count CMP - comprehensive metabolic panel COPD - chronic obstructive pulmonary disease EMAR - electronic medication administration record HTN - hypertension LPN- licensed practical nurse MAR - medication administration record mcg - micrograms mg - milligram QA - quality assurance OSDH - Oklahoma State Department of Health Res - Resident RN - registered nurse Tab - tablet TAR - treatment administration record	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:	C 391		

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 391	Continued From page 1 a. the kitchen/dining area was kept clean and maintained in good repair, and b. food products were properly labeled. The "Assisted Living Resident Condition and Care Overview" report, dated 05/18/23, documented 53 residents resided in the facility. Findings: On 05/18/23 at 10:37 a.m., a tour of the kitchen/dining area was conducted. The following observations were made: a. there was an accumulation of white residue on the ice dispenser in the dining area. The metal grate on the drain was rusted, b. there was black residue and material was peeling off of the wall behind the clean dish rack adjacent to the hand sink in the dish wash area, c. there was an accumulation of brown residue on the clean dish racks in the dish wash area, d. there was a gap between the back splash on the drain boards attached to the dish washer and the wall in the dish wash area. The drain board was not secure to the wall, e. there was an accumulation of black residue on the wall behind the drain boards attached to the dish washer, f. ceiling lights were burned out and/or not working, g. ceiling light covers cracked, and/or ceiling lights not properly shielded or shatterproof,	C 391		

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C 391	Continued From page 2 h. wall trim was missing off of the wall near the walk-in cooler door, i. there was an accumulation of food debris on the spice rack, j. there was an accumulation of brown and white residue inside of the ice machine, k. a floor tile was missing around the floor drain under the ice machine, l. three bulk food containers of a white dry product were not labeled in the food preparation area, and m. there was an accumulation of brown residue on the food storage racks in the food preparation area. On 05/18/23 at 11:32 a.m., the dietary executive director was asked how staff ensured the kitchen/dining area was kept clean and maintained in good repair. They stated staff cleaned daily and they reported maintenance concerns to the maintenance department. They stated they filled out a work order. The dietary executive director was asked the protocol for labeling food products. They stated food should be labeled. They DM was made aware of the above observations.	C 391		
C 397 SS=E	310:663-3-8(d)(4) FOOD STORAGE, PREPARATION AND SERVICE (4) Only clean, whole eggs with shell intact, pasteurized liquid, frozen, dry eggs, egg products and commercially prepared and packaged hard	C 397		

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C 397	Continued From page 3 boiled eggs may be used. All eggs shall be thoroughly cooked except pasteurized egg products or pasteurized in-shell eggs may be used in place of pooled eggs or raw or undercooked eggs. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure whole eggs with their shell intact were pasteurized for eggs served not thoroughly cooked. The "Assisted Living Resident Condition and Care Overview" report, dated 05/18/23, documented 53 residents resided in the facility. Findings: On 05/18/23 at 10:37 a.m., a tour of the kitchen was conducted. There were two, 15 dozen boxes and one flat of non-pasteurized whole eggs with their shells intact observed in the walk-in cooler. On 05/18/23 at 11:05 a.m., the executive chef was asked what the whole eggs with their shells intact in the walk-in cooler were used for. They stated the eggs were used to make scrambled eggs, over easy eggs or whatever the residents' preference was. They were asked if the whole eggs with their shells intact in the walk-in cooler were pasteurized. They stated more than likely they were. They were made aware there was no indication on the boxes or the eggs they were pasteurized. They were asked to provide documentation the eggs were pasteurized.	C 397		

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C 397	Continued From page 4 On 05/18/23 at 11:32 a.m., the dietary executive director provided a product details record indicting the eggs they used were large, grade A shell eggs. There was no documentation the eggs were pasteurized. They stated eggs should be pasteurized when served undercooked.	C 397		
C1110 SS=D	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the QA committee met at least quarterly. The "Assisted Living Resident Condition and Care Overview" report, dated 05/18/23, documented 53 residents resided in the facility.	C1110		

Oklahoma State Department of Health

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C1110	Continued From page 5 Findings: On 05/18/23 at 12:57 p.m., the administrator was asked how often the QA committee met. She stated she was unsure and to check with the chief of nursing. On 05/18/23 at 1:15 p.m., the chief of nursing stated she was not sure how often the QA committee met. She stated she would check with the administrator. On 05/18/23 at 1:24 p.m., the chief of nursing stated QA was to meet quarterly. She stated the last QA meeting was on 01/24/23. When asked if the QA meeting had been held quarterly she stated it was not.	C1110		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and	C1505		

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C1505	Continued From page 6 treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure physician orders were followed for: a. checking BP for two (#7 and #9) of ten sampled residents reviewed for medications, and b. discontinuing a blood pressure medication, obtaining laboratory studies, and administration of an as needed BP medications for one (#5) of ten sampled residents reviewed for medications. The "Assisted Living Resident Condition and Care Overview" report, dated 05/18/23, documented 53 residents resided in the facility. Findings: 1. Res #9 had diagnoses which included HTN.	C1505		

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C1505	Continued From page 7 A physician order, dated 08/25/22, documented to administer Losartan potassium tablet 25 mg at bedtime for HTN. The order documented to hold the medication for BP less than 110 systolic or 60 diastolic. The February 2023 MAR documented the medication was administered without a BP reading 26 out of 28 opportunities. The March 2023 MAR documented the medication was administered without a BP reading 30 out of 31 opportunities. The April 2023 MAR documented the medication was administered without a BP reading three out of four opportunities. A physician order, dated 04/05/23, documented to discontinue the Losartan. On 05/23/23 10:55 a.m., the chief of nursing stated the blood pressure should have been documented daily on the MAR. They stated the blood pressures should have been checked and documented, but were not. 2. Res #5 had diagnoses which included pain, HTN, COPD, permanent atrial fibrillation, edema, and cerebrovascular accident affecting dominant side. A physician order, dated 10/06/21, documented to administer clonidine (hypotensive medication) 0.1 mg. Give 1 tablet by mouth every eight hours as needed for systolic blood pressure above 180. A physician order, dated 11/25/21, documented to administer amlodipine (calcium channel blocker) 2.5 mg one tab daily at 8 a.m.	C1505		

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C1505	Continued From page 8 A pharmacy recommendation, dated 02/28/22, documented to collect a CBC, CMP, and lipid panel. There was no documentation an order was made to collect a CBC, CMP, or lipid panel. The July 2022 MAR documented a systolic BP above 180 five times. There were no documented administrations of clonidine. The September 2022 MAR documented a systolic BP above 180 six times. There were no documented administrations of clonidine. A physician order, dated 10/25/22, documented to discontinue amlodipine 2.5 mg in morning and to administer amlodipine 2.5 mg one tab at bedtime. The October 2022 MAR documented the resident received amlodipine at 8 a.m. and 8 p.m. resulting in a double dose of the amlodipine from 10/26/22 through 10/31/22. It was documented a systolic BP above 180 one time. There were no documented administrations of clonidine. On 05/23/23 at 9:15 a.m., the chief of nursing was asked if the labs were ordered and collected. They stated they were not. The DON was asked if the labs should have been collected. They stated they should have been. On 05/23/23 at 11:40 a.m., the chief of nursing was asked if the resident received a double dose of amlodipine from 10/26/22 through 10/31/22. They stated they did. 3. Res #7 had diagnoses which included HTN.	C1505		

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NAME OF PROVIDER OR SUPPLIER LUXE LIFE NORMAN AL, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1060 RAMBLING OAKS DRIVE NORMAN, OK 73072		
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C1505	Continued From page 9 A physician order, dated 05/11/23, documented carvedilol (beta-blocker) 3.125 mg. Give half by mouth two times a day. Hold if systolic BP is less than 100. The May 2023 MAR documented carvedilol was administered 21 out of 21 opportunities. There was no documentation the resident's BP was obtained 20 out of 21 opportunities. On 05/22/23 at 3:17 p.m., the chief of nursing was asked where the resident's BP was documented. They stated on the MAR. They were shown the resident's MAR where there was no BP obtained. They stated they would look for additional documentation. On 05/22/23 at 3:21 p.m., the chief of nursing stated it did not look like BP was checked on the MAR to be obtained. They stated BP should have been obtained.	C1505			
C1914 SS=D	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on record review and interview, the facility	C1914			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1403	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/23/2023
NAME OF PROVIDER OR SUPPLIER LUXE LIFE NORMAN AL, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1060 RAMBLING OAKS DRIVE NORMAN, OK 73072		
(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
C1914	Continued From page 10 failed to report an allegation of misappropriation to the state agency for one (#4) of one sampled resident reviewed for misappropriation. The "Assisted Living Resident Condition and Care Overview" report, dated 05/18/23, documented 53 residents resided in the facility. Findings: Res #4 had diagnoses which included chronic pain and rheumatoid arthritis. A physician order, dated 02/11/22, documented to administer Norco tablet 5-325 mg every six hours as needed for chronic pain. The order was discontinued 02/18/22. The February 2022 MAR did not document any administrations of the as needed Norco. A facility incident report, dated 07/29/22, documented Res #4 received Norco on 02/25/22, 03/02/22, 03/04/22, 03/06/22, 03/07/22, 03/13/22, 03/17/22, 03/19/22, 03/26/22, 03/27/22, and 03/29/22 without a physician order. The incident report documented Res #4 stated they only received the medication on four of the listed dates. The March 2022 MAR did not document an active order for Norco. On 05/18/23 at 4:00 p.m., the chief of nursing was asked to provide the narcotic tracking records for Res #4 for January 2022 through November 2022. On 05/23/23 at 9:00 a.m., the chief of nursing stated she was unable to locate the narcotic	C1914		

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C1914	Continued From page 11 records for the Norco order. She was asked to provide the documentation of the investigation conducted in July 2022. On 05/23/23 at 10:26 a.m., the chief of nursing stated she was unable to locate the investigation conducted in July 2022. On 05/23/23 at 11:39 a.m., the chief of nursing was provided the facility incident report, she was asked if the incident described an allegation of misappropriation. She stated, "Yes." She stated she was not chief of nursing at the time of the report, but that it should have been reported to OSDH. There was no report of misappropriation for Res #4 in AppXtender.	C1914		
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. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports.	C1923		

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C1923	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to: a. ensure an individual inventory record was maintained for each schedule II medication prescribed for one (#4) of one sampled resident's reviewed for misappropriation, and b. ensure medications were administered per physician orders and within one hour of the scheduled time for one (#5) of ten sampled resident's whose medications were reviewed. The "Assisted Living Resident Condition and Care Overview" report, dated 05/18/23, documented 53 residents resided in the facility. Findings: 1. Res #4 had diagnoses which included chronic pain and rheumatoid arthritis. A physician order, dated 02/11/22, documented to administer Norco tablet 5-325 mg every six hours as needed for chronic pain. The order was discontinued 02/18/22. The MAR for February 2022 did not document any administrations of the as needed Norco. A facility incident report, dated 07/29/22, documented Res #4 received Norco on 02/25/22, 03/02/22, 03/04/22, 03/06/22, 03/07/22, 03/13/22, 03/17/22, 03/19/22, 03/26/22, 03/27/22, and	C1923		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1403	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/23/2023
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C1923	Continued From page 13 03/29/22 without a physician order. The incident report documented Res #4 stated she only received the medication on four of the listed dates. The MAR for March 2022 did not document an active order for Norco. On 05/18/23 at 4:00 p.m., the chief of nursing was asked to provide the narcotic tracking records for Res #4 for January 2022 through November 2022. On 05/23/23 at 9:00 a.m., the chief of nursing stated they were unable to locate the narcotic records for the Norco order. x2. Res #5 had diagnoses which included pain, hypertension, chronic obstructive pulmonary disease, permanent atrial fibrillation, edema, and cerebrovascular accident affecting dominant side. A physician order, dated 08/30/21, documented to administer vitamin D3 50 mcg at 8:00 a.m. for vitamin deficiency. A physician order, dated 08/30/21, documented to administer Zocor 20 mg at 9:00 p.m. for hyperlipidemia. A physician order, dated 09/02/21, documented to administer tramadol 50 mg at 6:00 a.m. for chronic pain. A physician order, dated 09/02/21, documented to administer levothyroxine 100 mcg at 6:00 a.m. for low thyroid hormone. A physician order, dated 09/03/21, documented to administer spironolactone 12.5 mg at 12:00 p.m. for edema.	C1923		

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C1923	Continued From page 14 A physician order, dated 09/03/21, documented to administer aspirin 81 mg at 12:00 p.m. for clot prevention. A physician order, dated 09/03/21, documented to administer Flomax 0.4 mg at 9:00 p.m. for benign prostatic hyperplasia. A physician order, dated 09/03/21, documented to administer vita fusion adult gummies give 2 gummies at 8:00 a.m. for hyperlipidemia. A physician order, dated 09/30/21, documented to administer Avodart 0.5 mg at 9:00 p.m. for benign prostatic hyperplasia. A physician order, dated 09/30/21, documented to administer Colace 100 mg at 8:00 a.m. for constipation. A physician order, dated 10/04/21, documented to administer Lyrica 100 mg at 8:00 a.m. and 8:00 p.m. for chronic pain. A physician order, dated 11/16/21, documented to administer amlodipine 2.5 mg at 8:00 a.m. for hypertension. A physician order, dated 12/21/21, documented to administer allopurinol 100 mg at 8:00 a.m. and 8:00 p.m. for chronic gout. A physician order, dated 03/04/22, documented to administer acetaminophen 500 mg at 8:00 a.m. and 8:00 p.m. for chronic pain. A physician order, dated 04/04/22, documented to administer torsemide 100 mg at 8:00 a.m. for edema.	C1923		

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C1923	Continued From page 15 A physician order, dated 04/04/22, documented to administer triamcinolone acetonide cream 0.1 % at 8:00 a.m. for rash. A physician order, dated 05/09/22, documented to administer coumadin 3 mg at 5:00 p.m. for permanent atrial fibrillation. A physician order, dated 05/19/22, documented to administer Breo ellipta aerosol Inhaler 100/125 mcg one puff at 8:00 a.m. for chronic obstructive pulmonary disease. A physician order, dated 06/04/22, documented to administer carvedilol 3.125 mg at 8:00 a.m. and 5:00 p.m. for essential hypertension. A June 2022 MAR documented: a. carvedilol was administered greater than one hour early six out of 60 opportunities. b. allopurinol was administered greater than one hour early 12 out of 60 opportunities. c. Lyrica was administered greater than one hour early 11 out of 30 opportunities. d. aspirin was administered greater than one hour early eight out of 30 opportunities. e. coumadin was administered greater than one hour early 7 out of 30 opportunities. f. acetaminophen was administered greater than one hour early 13 out of 60 opportunities. g. spironolactone was administered greater than one hour early eight out of 30 opportunities.	C1923		

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C1923	Continued From page 16 h. Avodart was administered greater than one hour early 12 out of 30 opportunities. i. Flomax was administered greater than one hour early 12 out of 30 opportunities. j. Zocor was administered greater than one hour late 12 out of 30 opportunities. A June 2022 MAR documented: a. levothyroxine was not administered five out of 30 opportunities. b. acetaminophen was not administered one out of 30 opportunities. c. allopurinol was not administered one out of 30 opportunities. d. Lyrica was not administered one out of 30 opportunities. e. Zocor was not administered one out of 30 opportunities. f. Flomax was not administered one out of 30 opportunities. g. tramadol was not administered five out of 30 opportunities. h. Avodart was not administered two out of 30 opportunities. A June 2022 MAR documented: a. levothyroxine was administered greater than one hour late seven out of 30 opportunities.	C1923		

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C1923	Continued From page 17 b. tramadol was administered greater than one hour late seven out of 30 opportunities. A July 2022 MAR documented: a. amlodipine was administered greater than one hour late 12 out of 31 opportunities. b. aspirin was administered greater than one hour late six out of 31 opportunities. c. Avodart was administered greater than one hour late 15 out of 31 opportunities. d. carvedilol was administered greater than one hour late 27 out of 62 opportunities. e. spironolactone was administered greater than one hour late eight out of 31 opportunities. f. allopurinol was administered greater than one hour late 29 out of 62 opportunities. g. Lyrica was administered greater than one hour late 25 out of 62 opportunities. h. Colace was administered greater than one hour late 13 out of 31 opportunities. i. acetaminophen was administered greater than one hour late 27 out of 62 opportunities. j. torsemide was administered greater than one hour late 13 out of 31 opportunities. k. Breo ellipta inhaler was administered greater than one hour late 13 out of 31 opportunities. l. vita fusion was administered greater than one	C1923		

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C1923	Continued From page 18 hour late 12 out of 31 opportunities. m. vitamin D3 was administered greater than one hour late 12 out of 31 opportunities. n. triamcinolone acetonide cream was administered greater than one hour late 12 out of 31 opportunities. o. coumadin was administered greater than one hour late four out of 31 opportunities. p. tramadol was administered greater than one hour late two out of 31 opportunities. q. Zocor was administered greater than one hour late 15 out of 31 opportunities. r. Flomax was administered greater than one hour late 15 out of 31 opportunities. s. levothyroxine was administered greater than one hour late one out of 31 opportunities. A September 2022 MAR documented: a. amlodipine was administered greater than one hour late one out of 30 opportunities. b. Lyrica was administered greater than one hour late one out of 30 opportunities. c. acetaminophen was administered greater than one hour late one out of 30 opportunities.. d. carvedilol was administered greater than one hour late 22 out of 30 opportunities. e. Colace was administered greater than one hour late one out of 30 opportunities	C1923		

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C1923	Continued From page 19 f. Breo ellipta inhaler was administered greater than one hour late two out of 30 opportunities. g. vita fusion was administered greater than one hour late one out of 30 opportunities. h. vitamin D3 was administered greater than one hour late one out of 30 opportunities. i. triamcinolone acetonide cream was administered greater than one hour late two out of 30 opportunities. j. torsemide was administered greater than one hour late one out of 30 opportunities. k. allopurinol was administered greater than one hour late one out of 30 opportunities. On 05/23/23 at 11:48 a.m., the chief of nursing was asked if Res #5 recieved medications early, late, or omitted in June, July, and September, 2022. They stated the resident had late, early, and omitted medications.	C1923			
C1952 SS=E	310:663-19-3(b) MAINTENANCE OF RECORDS (b) Each resident's records shall be retained for at least five (5) years after the resident's transfer, discharge or death. Destruction of records shall be done in a manner to preserve resident confidentiality. This Rule is not met as evidenced by: Based on record review and interview, the facility	C1952			

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C1952	Continued From page 20 failed to ensure residents records were maintained for at least five years for one (#4) of ten sampled residents whose records were reviewed. The "Assisted Living Resident Condition and Care Overview" report, dated 05/18/23, documented 53 residents resided in the facility. Findings: Res #4 had diagnoses which included chronic pain and rheumatoid arthritis. A physician order, dated 02/11/22, documented to administer Norco tablet 5-325 mg every six hours as needed for chronic pain. The order was discontinued 02/18/22. The February 2022 MAR did not documented any administrations of the as needed Norco. A facility incident report, dated 07/29/22, documented Res #4 received Norco on 02/25/22, 03/02/22, 03/04/22, 03/06/22, 03/07/22, 03/13/22, 03/17/22, 03/19/22, 03/26/22, 03/27/22, and 03/29/22 without a physician order. The incident report documented Res #4 stated they only received the medication on four of the listed dates. The March 2022 MAR did not document an active order for Norco. On 05/18/23 at 4:00 p.m., the chief of nursing was asked to provide the narcotic tracking records for Res #4 for January 2022 through November 2022. On 05/23/23 at 9:00 a.m., the chief of nursing	C1952		

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C1952	Continued From page 21 stated she was unable to locate the narcotic records for the Norco order. She was asked how long records should be maintained. She stated seven years. She was asked if Res #4's records were maintained. She stated it did not appear so.	C1952		
C5010 SS=D	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 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.	C5010		

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C5010	Continued From page 22 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure coordination of care with home health services for one (#3) of one sampled resident reviewed for home health services. The "Assisted Living Resident Condition and Care Overview" report, dated 05/18/23, documented 53 residents resided in the facility. Findings: Res #3 had diagnoses which included non-pressure wounds. A home health certification and plan of care report, start of service 03/16/23, documented the skilled nurse was to perform wound care. A home health visit note, dated 03/16/23, documented the resident's cognition was intact. A physician order, dated 04/21/23, read in part, "USING ASEPTIC TECHNIQUE CLEANSE WOUND WITH WOUND CLEANSER PAT DRY APPLY MEDI HONEY COVER WITH CALCIUM ALGINATE AG [silver] COVER WITH TELFA SECURE WITH TAPE 3X [times] A WEEK". The order was changed on 05/15/23. Home health visit notes, dated 04/21/23 to 05/15/23, documented the week dates 04/30/23 to 05/06/23 and 05/07/23 to 05/13/23 there were two skilled nurse visits each week.	C5010		

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C5010	Continued From page 23 There was no documentation wound care was provided three times a week. A home health visit note, dated 05/15/23, documented the wound was improving. On 05/18/23 at 10:30 a.m., Res #3 was observed with a bandage on their right shin. They stated they had hit their leg on their wheelchair. On 05/23/23 at 10:11 a.m., the chief of nursing was asked to locate documentation the resident was seen by home health three times a week for wound care 04/30/23 to 05/06/23 and 05/07/23 to 05/13/23. On 05/23/23 at 12:01 p.m., the chief of nursing stated they were not able to locate documentation the resident had been seen three times a week by the skilled nurse for wound care. They were asked how the resident's care was coordinated between the facility and home health. They stated there was third party visit note sheets that were to be completed each time a visit was conducted. They stated the facility was responsible for reviewing the notes.	C5010			

Delivery via email to: mwooldridge@luxelifeseniorliving.com

June 29, 2023

License Number: AL1403

Ms. Mollie Wooldridge, Administrator
Luxe Life Norman AL, LLC
1060 Rambling Oaks Drive
Norman, OK 73072

RE: Survey Event XZO711

Dear Ms. Wooldridge:

On **May 23, 2023**, agents from our office completed an Assisted Living Center survey with complaint investigations at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C391:** The plan of correction included no indication who will conduct compliance rounds or how often. There is no indication who will be responsible for daily work order monitoring. There is no indication who will do weekly sanitation audits or for how long.
- **C1505:** The plan of correction included no indication who will complete monthly reviews for physician orders. Is monitoring monthly adequate to ensure corrective measures are sustained or ensure compliance?
- **C1923:** The plan of correction did not identify who will monitor daily medication count during shift change to ensure compliance and for how long will monitoring continue.
- **C1952:** The plan of correction included no indication who will monitor or for how long until compliance.
- **C5010:** The plan of correction did not identify who will perform form reviews after each visit and for how long to ensure compliance.

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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services



Oklahoma State
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/27/2023

Facility Name: Luxe Life Senior Living/Memory Care

License Number: AL1403

Survey Event ID: XZ0711

Date Survey Completed: 5/23/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: Based on observation and interview, the facility failed to ensure:
kitchen/dining area was kept clean and maintained in good repair and food products
were properly labeled

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction constitutes the written allegation of compliance for the deficiencies cited during a survey ending on 5/23/23 at Luxe Life Senior Living/Memory Care. However, submission of this plan of correction is not an admission that a deficiency exists or that one as cited correctly. The plan of correction is submitted to meet the requirements established by state and federal law.

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 ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

A cleaning schedule has been put into place and all dietary staff have been educated on their responsibilities. Maintenance and repairs have been corrected. Staff have been educated regarding placing work orders with maintenance when this issue occurs again. Shatterproof bulbs have been placed in the light fixtures where needed in the kitchen. Trim near the walk-in cooler door has been replaced. The floor around drain will be repaired and sealed.

All residents have the potential to be affected by this practice.

Education regarding the new cleaning schedules have been put into place and are monitored routinely. The process for placing work orders for maintenance issues have been put into place and education has occurred with both dietary staff and maintenance staff. Work orders are monitored daily.

Compliance rounds will be conducted routinely and all issues will be addressed as they occur.

Weekly sanitation audits will be conducted

Sanitation audits and work orders will be reviewed during quarterly QA meetings to review findings and determine if changes to these systems should be made.

Records of sanitation audits and work orders will be kept for review.

5. On what date will corrective action be completed?		7/6/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Melle Waddles</i>		Date 6/27/223	
OAC 310:663-25-4(F)			
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: ☐ Date of next follow-up: ☐ Surveyor: ☐ Surveyor: ☐			
If Plan of Correction is unacceptable, the reasons are as follows: ☐ Date of next follow-up: ☐			
Facility in Compliance by: ☐ Date of next follow-up: ☐			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/27/2023

Facility Name: Luxe Life Senior Living/Memory Care

License Number: AL1403

Survey Event ID: XZ0711

Date Survey Completed: 5/23/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C397

Based on: Based on observation and interview, the facility failed to ensure: whole eggs with their shell intact were pasteurized eggs for eggs not thoroughly cooked.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction constitutes the written allegation of compliance for the deficiencies cited during a survey ending on 5/23/23 at Luxe Life Senior Living/Memory Care. However, submission of this plan of correction is not an admission that a deficiency exists or that one as cited correctly. The plan of correction is submitted to meet the requirements established by state and federal law.

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 *Mellen Woodal*

OAC 310:663-25-4(F)

Date 6/27/2023

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

Submitted by

Enter name of person who submitted addendum

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: 6/27/2023 Surveyor: Surver

If Plan of Correction is unacceptable, the reasons are as follows: *Not here to enter text*
Facility in Compliance by: *Not here to enter text*



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/27/2023

Facility Name: Luxe Life Senior Living/Memory Care

License Number: AL1403

Survey Event ID: XZ0711

Date Survey Completed: 5/23/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1110

Based on: record review and interview the facility failed to ensure the QA committee met at least quarterly.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction constitutes the written allegation of compliance for the deficiencies cited during a survey ending on 5/23/23 at Luxe Life Senior Living/Memory Care. However, submission of this plan of correction is not an admission that a deficiency exists or that one as cited correctly. The plan of correction is submitted to meet the requirements established by state and federal law.

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

QA meeting was held 5/23 – 3 months after ownership began. A calendar invite has been set up for all members of QA Committee so that meetings will be held the third Wednesday of January, April, July, and October.

All residents have the potential to be affected by this practice.

QA meetings are now posted on QA members calendars.

QA meetings will be scheduled for January, April, July and October. They will be scheduled for noon on the third Wednesday of those months.

Incident reports, weight loss, etc will be monitored during those meetings.

All members of the QA team will have those dates added to their calendars.

Chief Nursing Officer will be responsible for bringing all information pertaining to nursing issues. Dietary Manager will be responsible for bringing all issues regarding food, cleaning, etc. Maintenance Director will be responsible for bringing any issues regarding building safety and work orders. Staffing Coordinator will bring all issues regarding staff to those meetings. Executive Director will maintain records of those meetings and bring any other issues not mentioned above.

7/6/2023

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Mollie Woodruff</i>		Date 6/27/2023	
OAC 310:663-25-4(F)			
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	6/27/2023	Submitted by	Mollie Woodruff
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: 6/27/2023 Surveyor: M. Taylor			
If Plan of Correction is unacceptable, the reasons are as follows: Cite rule or regulation.			
Facility in Compliance by: 6/27/2023			