

Delivery via email to: Marcie Davis <mdavis@luxelifeseniorliving.com>; Rachel Shearer <rshearer@ignitemedicalresorts.com>

July 22, 2024

License Number: AL1403

Ms. Marcie Davis, Administrator
Luxe Life Norman AI, Llc
1060 Rambling Oaks Drive
Norman, OK 73072

RE: Survey Event ID: YUYE11

Dear Ms. Davis:

On **June 28, 2024**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **June 28, 2024**.

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

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

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

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

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

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

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

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

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

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1403	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2024
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 from 06/26/24 through 06/28/24. Facility Census: 60 The abbreviations listed below will be used throughout this document. CMA - Certified Medication Aide CNA - Certified Nursing Assistant CNO - Chief Nursing Officer COPD - chronic obstructive pulmonary disease DCE - Director of Culture & Engagement F - fahrenheit HTN - hypertension Maint. - maintenance MAR - medication administration record MD - physician MG, mg - milligram O2 - oxygen RN - Registered Nurse	C 000		
C 322 SS=D	310.663-3-3(a)2 DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (2) nursing supervision during nursing intervention;	C 322		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

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C 322	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to describe the provisions for nursing supervision during smoking in the Individualized Service Plan for one (#2) of ten sampled residents whose Service Plans were reviewed. The Administrator identified 60 residents resided in the facility. Findings: A 'Smoking Policy', effective date 04/01/22, read in parts, " ...Any smoking-related privileges, restriction, and concerns (for example, need for close monitoring) shall be noted on the Individualized Service Plan ..." Resident #2 was named on the facility's list of residents that smoked cigarettes with supervision. Resident #2 had diagnoses that included COPD, muscle wasting, and O2 dependent. Resident #2's Individualized Service Plan did not address the provisions for nursing supervision provided during smoking. On 06/24/24 at 02:00 p.m., CMA #1 was asked the procedure for when Resident #2 went out to smoke. They stated staff turns off the O2 before lighting the cigarette and remains out there with the resident. Once Res #2 is done smoking the O2 is turned back on, they are brought back inside, and the cigarettes and lighter are returned to the medication cart. On 06/28/24 at 11:30 a.m., the CNO was asked	C 322		

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C 322	Continued From page 2 to review the Individualized Service Plan for Resident #2 and acknowledged it did not address the provisions for nursing supervision during smoking.	C 322		
C 328 SS=E	310:663-3-3(a)(8) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (8) planned programs for socialization, activities and exercise; and This Rule is not met as evidenced by: Based on record review and interview, the facility failed to describe the provisions for socialization, activities and exercise in the Individualized Service Plan for five (#2, 6, 7, 8, and #10) of ten sampled residents whose Individualized Service Plans were reviewed. The Administrator identified 60 residents resided at the facility. Findings: 1. Resident #2 was admitted 04/25/24 with diagnoses that included disorientation.	C 328		

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C 328	Continued From page 3 2. Resident #6 was admitted 02/29/24 with diagnoses that included dementia. 3. Resident #7 was admitted 07/18/23 with diagnoses that included dementia with other behavioral disturbance. 4. Resident #8 was admitted 12/31/20 with diagnoses that included cognitive communication deficit. 5. Resident #10 was admitted 02/10/22 with diagnoses that included vascular dementia. The residents' services plans contained no provisions of socialization, participation in activities, and daily exercise. On 06/28/24 at 11:10 a.m., the CNO was asked if the provisions to be made to ensure each resident's socialization, participation in activities, and daily exercise should be addressed in their Individualized Service Plans. They stated yes. The CNO was asked to review the Service Plans for the residents listed above. After reviewing the Service Plans, the CNO acknowledged provisions for socialization, activities, and exercise had not been addressed.	C 328		
C 329 SS=E	310.663-3-3(a)(9) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (9) provisions for evacuation of the building structure and	C 329		

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C 329	Continued From page 4 staff to meet the evacuation needs of residents. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to describe the provisions to meet the evacuation needs of the resident in their Individualized Service Plan for seven (#2, 4, 5, 7, 8, 9, and 10) of ten sampled residents whose Service Plans were reviewed. The Administrator identified 60 residents resided at the facility. Findings: The initial assessment for Resident #2, dated 04/25/24, documented the resident required the assistance of one person getting out of a chair or bed. The annual assessment for Resident #4, dated 03/19/24, documented the resident used a manual wheelchair for mobility and required the assistance of staff to move about the facility. The initial assessment for Resident #5, dated 05/17/24, documented the resident required the assistance of one person getting out of a chair or bed, used a manual wheelchair for mobility, and required the assistance of staff to move about the facility. The annual assessment for Resident #7, dated	C 329		

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C 329	Continued From page 5 10/01/23, documented the resident required the assistance of one person getting out of a chair or bed. The annual assessment for Resident #8, dated 09/13/23, documented the resident required the assistance of one person getting out of a chair or bed. The annual assessment for Resident #9, dated 01/25/24, documented the resident required the assistance of one person getting out of a chair or bed, used a manual wheelchair for mobility, and required the assistance of staff to move about the facility. The annual assessment for Resident #10, dated 03/17/24, documented the resident required the assistance of one person getting out of a chair or bed. On 06/28/24 at 11:10 a.m., the CNO was asked if the provisions to meet the evacuation needs of the resident should be addressed in each residents' Service Plan. They stated yes. The CNO was asked to review the Service Plans for the above residents. After reviewing the Individualized Service Plans, the CNO acknowledged provisions to meet their individual evacuation needs had not been addressed.	C 329		
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.	C 542		

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C 542	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the center failed to obtain a physician or registered nurse signature on the comprehensive assessments for seven (#1, 2, 4, 5, 7, 8, and #9) of ten sampled residents whose comprehensive assessments were reviewed. The Administrator identified 60 residents resided in the facility. Findings: An annual assessment for Resident #1, dated 08/20/23, did not include a physician or registered nurse signature. An initial assessment for Resident #2, dated 04/25/24, did not include a physician or registered nurse signature. An annual assessment for Resident #4, dated 03/19/24, did not include a physician or registered nurse signature. An initial assessment for Resident #5, dated 05/17/24, did not include a physician or registered nurse signature. An annual assessment for Resident #7, dated 10/01/23, did not include a physician or registered nurse signature. An annual assessment for Resident #8, dated 09/03/23, did not include a physician or registered nurse signature. An annual assessment for Resident #9, dated 03/17/24, did not include a physician or registered	C 542		

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C 542	Continued From page 7 nurse signature. On 06/28/24 at 11:07 a.m., the CNO was asked to review the assessments referenced above and acknowledged they did not contain the required signatures indicating they had been coordinated by the physician or a registered nurse.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the comprehensive assessment included a personal interview for eight (#1, 2, 3, 4, 5, 7, 8, and #10) of ten sampled residents whose comprehensive assessments were reviewed. The Administrator identified 60 residents resided in the facility. Findings: An annual assessment for Resident #1, dated 08/20/23, did not include a resident or representative interview. An initial assessment for Resident #2, dated	C 543		

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C 543	Continued From page 8 04/25/24, did not include a resident or representative interview. A re-admission assessment for Resident #3, dated 03/21/24, did not include a resident or representative interview. An annual assessment for Resident #4, dated 03/19/24, did not include a resident or representative interview. An initial assessment for Resident #5, dated 05/17/24, did not include a resident or representative interview. An annual assessment for Resident #7, dated 10/01/23, did not include a resident or representative interview. An annual assessment for Resident #8, dated 09/03/23, did not include a resident or representative interview. An annual assessment for Resident #10, dated 03/17/24, did not include a resident or representative interview. On 06/28/24 at 11:05 a.m., the CNO was asked to review the assessments referenced above and acknowledged they did not contain the required signature indicating the resident or their representative were interviewed.	C 543		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A.	C 701		

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C 701	Continued From page 9 Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure hot water temperatures were within safe limits. The Administrator identified 60 residents resided in the facility. Findings: On 06/26/24 at 1:00 p.m., the hot water temperature of the kitchenette sink in room 212 was 121.7 Fahrenheit. On 06/26/24 at 1:05 p.m., the hot water temperature of the kitchenette sink in room 207 was 140.5 Fahrenheit. On 06/26/24 at 1:10 p.m., the hot water temperature of the kitchenette sink in room 208 was 130.2 Fahrenheit. On 06/26/24 at 1:15 p.m., Maint. Supervisor was asked how often water temperatures in the resident rooms were checked. They stated weekly and reported that water temperatures in resident areas should be between 110-115 F per regulation. Maint. Supervisor verified water temperatures in room 207, 208, and 212 and stated they were unaware the temperatures were	C 701		

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C 701	Continued From page 10 so high.	C 701		
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were reviewed monthly by the RN or pharmacy consultant for ten (#1, 2, 3, 4, 5, 6, 7, 8, 9, and #10) of ten residents whose medications were reviewed. The Administrator identified 60 residents resided in the facility. Findings: There was no documentation Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, or #10's medications had been reviewed by an RN or pharmacist in 06/2023, 07/2023, 08/2023, 09/2023, 10/2023, 12/2023, 01/2024, 03/2024, or 04/2024. On 06/28/24 at 11:40 a.m., the CNO was asked if monthly medication reviews had been done by the RN or pharmacist for the months listed above. The CNO reported they had talked to RN #1 who	C 921		

1060 RAMBLING OAKS DRIVE
NORMAN, OK 73072

A review of the personnel files and computer-generated training records for CNA #1,

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C 953	Continued From page 12 CNA #2, CNA #3, CNA #4, CNA #5, CMA #2, CMA #3, and CMA #4 revealed no documentation they had completed dementia training. On 06/28/24 at 12:30 p.m., the CNO was asked to provide documentation of dementia training for CNA #1, CNA #2, CNA #3, CNA #4, CNA #5, CMA #2, CMA #3, and CMA #4. On 06/28/24 at 12:00 p.m., the CNO reported no documentation of dementia training was found for the staff identified above.	C 953		
C1321 SS=F	310:663-13-2(1) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (1) assisted living center's name and address; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Resident Service Contract contained the assisted living center's address for ten (#1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) of ten sampled residents. The Administrator identified 60 residents resided at the facility. Findings: The Resident Service Contract for residents #1, 2, 3, 4, 5, 6, 7, 8, 9, and #10 did not contain the facility address as part of the contract.	C1321		

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C1321	Continued From page 13 On 06/27/24 at 1:40 p.m., the Administrator was asked to identify where the facility address was listed in the Resident Service Contract for the residents listed above. They reviewed the contracts and acknowledged they did not contain the facility address.	C1321		
C1325 SS=F	310:663-13-2(5) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (5) dispute resolution and grievance procedures; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Resident Service Contract contained the assisted living center's grievance procedures for ten (#1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) of ten sampled residents. The Administrator identified 60 residents resided at the facility. Findings: The Resident Service Contract for residents #1, 2, 3, 4, 5, 6, 7, 8, 9, and #10 did not contain the facility grievance procedures as part of the contract. On 06/27/24 at 1:40 p.m., the Administrator was asked to identify where the facility grievance procedures was listed in the Resident Service	C1325		

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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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C1325	Continued From page 14 Contract for the residents listed above. They reviewed the contracts and acknowledged they did not contain the facility grievance procedures.	C1325		
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. This Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure residents were provided medication as ordered by the physician for one (#5) of 4 sampled residents observed during medication administration. The Administrator identified 60 residents resided in the facility.	C1923		

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C1923	Continued From page 15 Findings: Resident #5 had diagnoses which included HTN and atrial flutter. A physician's order, written 06/27/24, read, "Medrol Tablet Therapy Pack 4 MG (MethylPREDNISolone) Give 2 tablet by mouth two times a day for cellulitis/ skin infection until 06/27/2024 23:59 AND Give 1 tablet by mouth one time only for cellulitis/skin infection until 06/27/2024 23:59 AND Give 1 tablet by mouth one time only for cellulitis/ skin infection until 06/27/2024 23:59 AND Give 1 tablet by mouth three times a day for cellulitis/ skin infection until 06/28/2024 23:59 AND Give 2 tablet by mouth one time only for cellulitis/ skin infection until 06/28/2024 23:59 AND Give 1 tablet by mouth four times a day for cellulitis/ skin infection until 06/29/2024 23:59 AND Give 1 tablet by mouth three times a day for cellulitis/ skin infection until 06/30/2024 23:59 AND Give 1 tablet by mouth two times a day for cellulitis/ skin infection until 07/01/2024 23:59 AND Give 1 tablet by mouth one time only for cellulitis/ skin infection until 07/02/2024 23:59." June MAR documented Resident #5 was to receive Methylprednisolone 4mg pack give 1 tablet by mouth one time only for cellulitis/skin infection on 06/27/24 with hours of administration set to 'One Time'. On 06/27/24 at 8:32 a.m., CMA #6 was observed administering Medrol Tablet 4mg pack- 2 tablets by mouth at 8:32 a.m. to Resident #5. On 06/27/24 at 9:10 a.m., CMA #6 was asked if they had administered the correct dosage of Medrol to Resident #5 and stated the order was	C1923		

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C1923	Continued From page 16 very confusing the way it was written. On 06/27/24 at 10:10 a.m., CNO was informed of observation during medication pass and asked if the correct dosage had been given per the physician's order. After reviewing the MD order and the MAR they stated the order is very confusing, it should have been clarified when it was received.	C1923		
C6000 SS=D	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are	C6000		

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C6000	Continued From page 17 conducted by the new employer in accordance with subsection I of this section. a. If an individual who is exempt under this subsection is subsequently found, upon seeking transfer to another employer, ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, then the individual is no longer exempt and shall be terminated from employment or denied employment. b. If an individual who is exempt under this subsection is subsequently found ineligible for employment, independent contract, or clinical privileges, as provided in subsection D of this section, based on disqualifying events occurring after November 1, 2012, then the individual is no longer exempt and shall be terminated from employment; and 2. An individual who is an independent contractor to an employer, if the services for which he or she is contracted are not directly related to the provision of services to a service recipient or if the services for which he or she is contracted allow for direct patient access to service recipients but are not performed on an ongoing basis. This exception includes, but is not limited to, an individual who independently contracts with the employer to provide utility, maintenance, construction, or communications services.	C6000		

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C6000	Continued From page 18 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a criminal history background check and an offender registry check was completed on hire for one (CMA #5) of five staff reviewed for criminal history background and offender registry checks. The Administrator identified 60 residents resided at the facility. Findings: CMA #5 had a hire date of 02/06/24. The OK Screen and Registry Evaluation for the CMA #5 was completed 05/30/24. Time Card Reports documented CMA #5 worked the 7am-3pm shift on Monday through Friday, from 02/12/24 to 05/31/24. On 06/28/24 at 12:09 p.m., the DCE was asked the policy for new hires completing background screening and offender registry checks. They stated these checks were completed on new hires before the start of employment. After reviewing the OK Screen and Registry Evaluation for CMA #5, the DCE acknowledged facility policy had not been followed.	C6000		

Delivery via email to: Marcie Davis <mdavis@luxelifeseniorliving.com>; Rachel Shearer <rshearer@ignitemedicalresorts.com>

August 23, 2024

License Number: AL1403

Ms. Marcie Davis, Administrator
Luxe Life Norman AI, LLC
1060 Rambling Oaks Drive
Norman, OK 73072

RE: Survey Event YUYE11

Dear Ms. Davis:

On **June 28, 2024**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C322, C328, C329, C542, C543, C701, C1923, and C6000:** The facility's plan does not address how they will prevent reoccurrence of the deficient practice (i.e. education).
- **C953, C1321, and C1325:** The plan does not explain what the facility did to correct the deficient practice.
- **C6000:** The facility's plan only addresses the Criminal History Background Check. It does not address the Offender Registry Check.

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

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 06/26/24 through 06/28/24. Facility Census: 60 The abbreviations listed below will be used throughout this document. CMA - Certified Medication Aide CNA - Certified Nursing Assistant CNO - Chief Nursing Officer COPD - chronic obstructive pulmonary disease DCE - Director of Culture & Engagement F - fahrenheit HTN - hypertension Maint. - maintenance MAR - medication administration record MD - physician MG, mg - milligram O2 - oxygen RN - Registered Nurse	C 000	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal or state law. The provider maintains that all alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents nor are they of such character as to limit the provider's capability to render adequate care. For the alleged deficiencies cited during the survey, the facility has or will develop and implement a facility wide system to assure correction and continue compliance within the regulations by 8/21/2024. This facility will also provide a complete copy of this list of alleged deficiencies to the Quality Assurance committee.	8/21/2024
C 322 SS=D	310.663-3-3(a)2 DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (2) nursing supervision during nursing intervention;	C 322	The facility will develop a comprehensive, individualized service plan for each resident that ensures the resident's physical, mental, and psychosocial well-being. Resident #2 ISP will be updated to include smoking provisions. This alleged deficiency had the potential to put one resident at risk. DON/Designee will audit ISP for each new resident, as well as all pre-existing ISP for current residents for 6 weeks. The DON/Designee will complete random audits, thereafter. Care plans will be updated daily in the IDT meetings. Any deficiencies will be corrected on the spot, and the findings of the quality- assurance checks will be documented and submitted to the monthly quality assurance team meetings for further review or corrective action.	8/21/2024

Oklahoma State Department of Health

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

Reed Shuman

Administrator

TITLE

7/31/2024

(X6) DATE

Oklahoma State Department of Health

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C 322	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to describe the provisions for nursing supervision during smoking in the Individualized Service Plan for one (#2) of ten sampled residents whose Service Plans were reviewed. The Administrator identified 60 residents resided in the facility. Findings: A 'Smoking Policy', effective date 04/01/22, read in parts, " ...Any smoking-related privileges, restriction, and concerns (for example, need for close monitoring) shall be noted on the Individualized Service Plan ..." Resident #2 was named on the facility's list of residents that smoked cigarettes with supervision. Resident #2 had diagnoses that included COPD, muscle wasting, and O2 dependent. Resident #2's Individualized Service Plan did not address the provisions for nursing supervision provided during smoking. On 06/24/24 at 02:00 p.m., CMA #1 was asked the procedure for when Resident #2 went out to smoke. They stated staff turns off the O2 before lighting the cigarette and remains out there with the resident. Once Res #2 is done smoking the O2 is turned back on, they are brought back inside, and the cigarettes and lighter are returned to the medication cart. On 06/28/24 at 11:30 a.m., the CNO was asked	C 322		

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C 322	Continued From page 2 to review the Individualized Service Plan for Resident #2 and acknowledged it did not address the provisions for nursing supervision during smoking.	C 322		
C 328 SS=E	310:663-3-3(a)(8) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (8) planned programs for socialization, activities and exercise; and This Rule is not met as evidenced by: Based on record review and interview, the facility failed to describe the provisions for socialization, activities and exercise in the Individualized Service Plan for five (#2, 6, 7, 8, and #10) of ten sampled residents whose Individualized Service Plans were reviewed. The Administrator identified 60 residents resided at the facility. Findings: 1. Resident #2 was admitted 04/25/24 with diagnoses that included disorientation.	C 328	The facility will develop a comprehensive, individualized service plan (ISP) for each resident that ensures the resident's physical, mental, and psychosocial well-being. All active resident's ISP will be updated to include provisions of socialization, participation in activities, and daily exercise. This alleged deficiency had the potential to put 5 residents at risk. DON/Designee will audit ISP for each new resident, as well as all pre-existing ISP for current residents for 6 weeks. The DON/Designee will complete random audits, thereafter. Care plans will be updated daily in the IDT meetings. Any deficiencies will be corrected on the spot, and the findings of the quality- assurance checks will be documented and submitted to the monthly quality assurance team meetings for further review or corrective action. The facility will be in substantial compliance by 8/21/24.	8/21/2024

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C 328	Continued From page 3 2. Resident #6 was admitted 02/29/24 with diagnoses that included dementia. 3. Resident #7 was admitted 07/18/23 with diagnoses that included dementia with other behavioral disturbance. 4. Resident #8 was admitted 12/31/20 with diagnoses that included cognitive communication deficit. 5. Resident #10 was admitted 02/10/22 with diagnoses that included vascular dementia. The residents' services plans contained no provisions of socialization, participation in activities, and daily exercise. On 06/28/24 at 11:10 a.m., the CNO was asked if the provisions to be made to ensure each resident's socialization, participation in activities, and daily exercise should be addressed in their Individualized Service Plans. They stated yes. The CNO was asked to review the Service Plans for the residents listed above. After reviewing the Service Plans, the CNO acknowledged provisions for socialization, activities, and exercise had not been addressed.	C 328		
C 329 SS=E	310:663-3-3(a)(9) DESCRIPTION OF SERVICES (a) The assisted living center shall describe the service to be provided or arranged in the assisted living center with respect to the following services: (9) provisions for evacuation of the building structure and	C 329	The facility will develop a comprehensive, individualized service plan (ISP) for each resident that ensures the resident's physical, mental, and psychosocial well-being. All active resident's ISP will be updated to include provision for evacuation of the building structure and staff to meet the needs of residents. This alleged deficiency had the potential to put 7 residents at risk.	8/21/2024

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C 329	Continued From page 4 staff to meet the evacuation needs of residents. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to describe the provisions to meet the evacuation needs of the resident in their Individualized Service Plan for seven (#2, 4, 5, 7, 8, 9, and 10) of ten sampled residents whose Service Plans were reviewed. The Administrator identified 60 residents resided at the facility. Findings: The initial assessment for Resident #2, dated 04/25/24, documented the resident required the assistance of one person getting out of a chair or bed. The annual assessment for Resident #4, dated 03/19/24, documented the resident used a manual wheelchair for mobility and required the assistance of staff to move about the facility. The initial assessment for Resident #5, dated 05/17/24, documented the resident required the assistance of one person getting out of a chair or bed, used a manual wheelchair for mobility, and required the assistance of staff to move about the facility. The annual assessment for Resident #7, dated	C 329	DON/Designee will audit ISP for each new resident, as well as all pre-existing ISP for current residents for 6 weeks. The DON/Designee will complete random audits, thereafter. Care plans will be updated daily in the IDT meetings. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted to the monthly quality assurance team meetings for further review or corrective action. The facility will be in substantial compliance by 8/21/24.	

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C 329	Continued From page 5 10/01/23, documented the resident required the assistance of one person getting out of a chair or bed. The annual assessment for Resident #8, dated 09/13/23, documented the resident required the assistance of one person getting out of a chair or bed. The annual assessment for Resident #9, dated 01/25/24, documented the resident required the assistance of one person getting out of a chair or bed, used a manual wheelchair for mobility, and required the assistance of staff to move about the facility. The annual assessment for Resident #10, dated 03/17/24, documented the resident required the assistance of one person getting out of a chair or bed. On 06/28/24 at 11:10 a.m., the CNO was asked if the provisions to meet the evacuation needs of the resident should be addressed in each residents' Service Plan. They stated yes. The CNO was asked to review the Service Plans for the above residents. After reviewing the Individualized Service Plans, the CNO acknowledged provisions to meet their individual evacuation needs had not been addressed.	C 329		
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.	C 542	It is the policy of this facility to have assessments coordinated and signed by a registered nurse for the resident's personal physician. This alleged deficiency had the potential to put all residents at risk.	

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C 542	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the center failed to obtain a physician or registered nurse signature on the comprehensive assessments for seven (#1, 2, 4, 5, 7, 8, and #9) of ten sampled residents whose comprehensive assessments were reviewed. The Administrator identified 60 residents resided in the facility. Findings: An annual assessment for Resident #1, dated 08/20/23, did not include a physician or registered nurse signature. An initial assessment for Resident #2, dated 04/25/24, did not include a physician or registered nurse signature. An annual assessment for Resident #4, dated 03/19/24, did not include a physician or registered nurse signature. An initial assessment for Resident #5, dated 05/17/24, did not include a physician or registered nurse signature. An annual assessment for Resident #7, dated 10/01/23, did not include a physician or registered nurse signature. An annual assessment for Resident #8, dated 09/03/23, did not include a physician or registered nurse signature. An annual assessment for Resident #9, dated 03/17/24, did not include a physician or registered	C 542	DON/Designee will audit assessments for each new resident, as well as all pre-existing assessments for current residents for 6 weeks. The DON/Designee will complete random audits, thereafter. Care plans will be updated daily in the IDT meetings. Any deficiencies will be corrected on the spot, and the findings of the quality- assurance checks will be documented and submitted to the monthly quality assurance team meetings for further review or corrective action. The facility will be in substantial compliance by 8/21/24.	8/21/2024

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C 542	Continued From page 7 nurse signature. On 06/28/24 at 11:07 a.m., the CNO was asked to review the assessments referenced above and acknowledged they did not contain the required signatures indicating they had been coordinated by the physician or a registered nurse.	C 542		
C 543 SS=E	310.663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the comprehensive assessment included a personal interview for eight (#1, 2, 3, 4, 5, 7, 8, and #10) of ten sampled residents whose comprehensive assessments were reviewed. The Administrator identified 60 residents resided in the facility. Findings: An annual assessment for Resident #1, dated 08/20/23, did not include a resident or representative interview. An initial assessment for Resident #2, dated	C 543	It is the policy of this facility to interview resident's or resident's representative. This alleged deficiency had the potential to put all residents at risk. DON/Designee will audit assessments for each new resident, as well as all pre-existing assessments for current residents weekly for 6 weeks. The DON/Designee will complete random audits, thereafter. Any deficiencies will be corrected on the spot, and the findings of the quality- assurance checks will be documented and submitted to the monthly quality assurance team meetings for further review or corrective action. The facility will be in substantial compliance by 8/21/24.	8/21/2024

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C 543	Continued From page 8 04/25/24, did not include a resident or representative interview. A re-admission assessment for Resident #3, dated 03/21/24, did not include a resident or representative interview. An annual assessment for Resident #4, dated 03/19/24, did not include a resident or representative interview. An initial assessment for Resident #5, dated 05/17/24, did not include a resident or representative interview. An annual assessment for Resident #7, dated 10/01/23, did not include a resident or representative interview. An annual assessment for Resident #8, dated 09/03/23, did not include a resident or representative interview. An annual assessment for Resident #10, dated 03/17/24, did not include a resident or representative interview. On 06/28/24 at 11:05 a.m., the CNO was asked to review the assessments referenced above and acknowledged they did not contain the required signature indicating the resident or their representative were interviewed.	C 543		
C 701 SS=E	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A.	C 701	It is the policy of this facility to ensure hot water does not exceed 115 degrees Fahrenheit. Prior to the exit conference, all resident apartments water temperatures were below 115 degrees Fahrenheit.	8/21/2024

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C 701	Continued From page 9 Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure hot water temperatures were within safe limits. The Administrator identified 60 residents resided in the facility. Findings: On 06/26/24 at 1:00 p.m., the hot water temperature of the kitchenette sink in room 212 was 121.7 Fahrenheit. On 06/26/24 at 1:05 p.m., the hot water temperature of the kitchenette sink in room 207 was 140.5 Fahrenheit. On 06/26/24 at 1:10 p.m., the hot water temperature of the kitchenette sink in room 208 was 130.2 Fahrenheit. On 06/26/24 at 1:15 p.m., Maint. Supervisor was asked how often water temperatures in the resident rooms were checked. They stated weekly and reported that water temperatures in resident areas should be between 110-115 F per regulation. Maint. Supervisor verified water temperatures in room 207, 208, and 212 and stated they were unaware the temperatures were	C 701	This alleged deficiency had the potential to put all residents at risk. Director of EVS/Designee will check water temperature for each room prior to resident's moving in, as well as all occupied apartments weekly for current residents for 6 weeks. The Director of EVS/Designee will complete random audits, thereafter. Any deficiencies will be corrected on the spot, and the findings of the quality assurance checks will be documented and submitted to the monthly quality assurance team meetings for further review or corrective action. The facility will be in substantial compliance by 8/21/24.	8/21/2024

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C 701	Continued From page 10 so high.	C 701		
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the center failed to ensure medications were reviewed monthly by the RN or pharmacy consultant for ten (#1, 2, 3, 4, 5, 6, 7, 8, 9, and #10) of ten residents whose medications were reviewed. The Administrator identified 60 residents resided in the facility. Findings: There was no documentation Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, or #10's medications had been reviewed by an RN or pharmacist in 06/2023, 07/2023, 08/2023, 09/2023, 10/2023, 12/2023, 01/2024, 03/2024, or 04/2024. On 06/28/24 at 11:40 a.m., the CNO was asked if monthly medication reviews had been done by the RN or pharmacist for the months listed above. The CNO reported they had talked to RN #1 who	C 921	It is the policy of this facility to ensure medications are reviewed monthly by an RN or pharmacist. This alleged deficiency had the potential to put all residents at risk. DON/Designee will audit monthly to ensure medications are reviewed monthly by RN or pharmacist. The DON/Designee will complete random audits, thereafter. Any deficiencies will be corrected on the spot, and the findings of the quality- assurance checks will be documented and submitted to the monthly quality assurance team meetings for further review or corrective action. The facility will be in substantial compliance by 8/21/24.	8/21/2024

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C 953	Continued From page 12 CNA #2, CNA #3, CNA #4, CNA #5, CMA #2, CMA #3, and CMA #4 revealed no documentation they had completed dementia training. On 06/28/24 at 12:30 p.m., the CNO was asked to provide documentation of dementia training for CNA #1, CNA #2, CNA #3, CNA #4, CNA #5, CMA #2, CMA #3, and CMA #4. On 06/28/24 at 12:00 p.m., the CNO reported no documentation of dementia training was found for the staff identified above.	C 953		
C1321 SS=F	310:663-13-2(1) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (1) assisted living center's name and address; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Resident Service Contract contained the assisted living center's address for ten (#1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) of ten sampled residents. The Administrator identified 60 residents resided at the facility. Findings: The Resident Service Contract for residents #1, 2, 3, 4, 5, 6, 7, 8, 9, and #10 did not contain the facility address as part of the contract.	C1321	It is the policy of this facility for the service contract to contain a clear statement of the assisted living center's name and address. This alleged deficiency had the potential to affect all residents. The Business Office Manager/Designee will audit all resident service contracts and ensure name and address are clearly stated. The Administrator will report findings weekly monthly for 3 months and randomly thereafter and report to the QAPI committee for action as appropriate. The facility will be in substantial compliance by 8/21/24.	8/21/2024

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C1321	Continued From page 13 On 06/27/24 at 1:40 p.m., the Administrator was asked to identify where the facility address was listed in the Resident Service Contract for the residents listed above. They reviewed the contracts and acknowledged they did not contain the facility address.	C1321		
C1325 SS=F	310.663-13-2(5) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (5) dispute resolution and grievance procedures; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Resident Service Contract contained the assisted living center's grievance procedures for ten (#1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) of ten sampled residents. The Administrator identified 60 residents resided at the facility. Findings: The Resident Service Contract for residents #1, 2, 3, 4, 5, 6, 7, 8, 9, and #10 did not contain the facility grievance procedures as part of the contract. On 06/27/24 at 1:40 p.m., the Administrator was asked to identify where the facility grievance procedures was listed in the Resident Service	C1325	It is the policy of this facility that each resident contract shall contain a clear statement of the dispute resolution and grievance procedures. This alleged deficiency had the potential to affect all residents. The Business Office Manager/Designee will audit all resident service contracts and ensure dispute resolution and grievance procedures are clearly outlined. The Administrator will report findings weekly monthly for 3 months and randomly thereafter and report to the QAPI committee for action as appropriate. The facility will be in substantial compliance by 8/21/2024.	

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C1325	Continued From page 14 Contract for the residents listed above. They reviewed the contracts and acknowledged they did not contain the facility grievance procedures.	C1325		
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. This Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure residents were provided medication as ordered by the physician for one (#5) of 4 sampled residents observed during medication administration. The Administrator identified 60 residents resided in the facility.	C1923	The facility will ensure medications are administered following physician's orders. This alleged deficiency had the potential to put 1 resident at risk. DON/Designee will audit scaled medication orders for each new resident, as well as all pre-existing orders with scaled medications for current residents for 6 weeks. The DON/Designee will complete random audits, thereafter. Any deficiencies will be corrected on the spot, and the findings of the quality assurance checks will be documented and submitted to the monthly quality assurance team meetings for further review or corrective action. The facility will be in substantial compliance by 8/21/2024.	8/21/2024

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C1923	Continued From page 15 Findings: Resident #5 had diagnoses which included HTN and atrial flutter. A physician's order, written 06/27/24, read, "Medrol Tablet Therapy Pack 4 MG (MethylPREDNISolone) Give 2 tablet by mouth two times a day for cellulitis/ skin infection until 06/27/2024 23:59 AND Give 1 tablet by mouth one time only for cellulitis/skin infection until 06/27/2024 23:59 AND Give 1 tablet by mouth one time only for cellulitis/ skin infection until 06/27/2024 23:59 AND Give 1 tablet by mouth three times a day for cellulitis/ skin infection until 06/28/2024 23:59 AND Give 2 tablet by mouth one time only for cellulitis/ skin infection until 06/28/2024 23:59 AND Give 1 tablet by mouth four times a day for cellulitis/ skin infection until 06/29/2024 23:59 AND Give 1 tablet by mouth three times a day for cellulitis/ skin infection until 06/30/2024 23:59 AND Give 1 tablet by mouth two times a day for cellulitis/ skin infection until 07/01/2024 23:59 AND Give 1 tablet by mouth one time only for cellulitis/ skin infection until 07/02/2024 23:59." June MAR documented Resident #5 was to receive Methylprednisolone 4mg pack give 1 tablet by mouth one time only for cellulitis/skin infection on 06/27/24 with hours of administration set to 'One Time'. On 06/27/24 at 8:32 a.m., CMA #6 was observed administering Medrol Tablet 4mg pack- 2 tablets by mouth at 8:32 a.m. to Resident #5. On 06/27/24 at 9:10 a.m., CMA #6 was asked if they had administered the correct dosage of Medrol to Resident #5 and stated the order was	C1923		

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C1923	Continued From page 16 very confusing the way it was written. On 06/27/24 at 10:10 a.m., CNO was informed of observation during medication pass and asked if the correct dosage had been given per the physician's order. After reviewing the MD order and the MAR they stated the order is very confusing, it should have been clarified when it was received.	C1923		
C6000 SS=D	63 OS 1-1947(F) Criminal History Background Check (F) Except as otherwise provided in subsection L of this section, an employer shall not employ, independently contract with, or grant privileges to, an individual who regularly has direct patient access to service recipients of the employer until the employer conducts a registry screening and criminal history record check in compliance with subsection I of this section. This subsection and subsection D of this section shall not apply to the following: 1. An individual who is employed by, under independent contract to, or granted clinical privileges with, an employer on or before November 1, 2012. An individual who is exempt under this subsection is not limited to working within the employer with which he or she is employed, under independent contract to, or granted clinical privileges. That individual may transfer to another employer that is under the same ownership with which he or she was employed, under contract, or granted privileges. If that individual wishes to transfer to another employer that is not under the same ownership, he or she may do so provided that a registry screening and criminal history record check are	C6000	It is the policy of this facility to complete criminal history background checks prior to employment. The background check for Employee #5 was completed 5/31/24. This alleged deficiency had the potential to put all residents at risk. The Director of Culture & Engagement/Designee will audit all employee files and ensure background checks are current and in good standing. The Administrator will report findings weekly monthly for 3 months and randomly thereafter and report to the QAPI committee for action as appropriate. The facility will be in substantial compliance by 8/21/24.	8/21/2024