Oklahoma State Department of Health
Creating a State of Health

February 24, 2020

License Number: AL1410

Ms. Nancy Klepac, Administrator
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

Survey Event ID: I4V211

Dear Ms. Klepac:

On **February 14, 2020**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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. 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 will be completed for each violation; and
(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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,

Kari Stagner

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Legend at Rivendell**
Address: **13200 S. May Ave.**
City, State, Zip: **Oklahoma City Ok 73170**
Provider #: **AL1410**
Complaint #: **OK00055037**
Investigation Date(s): **02/13/20 through 02/14/20**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were administered as ordered by the physician and failed to ensure medications were properly obtained and stored.	S

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Thursday, February 13, 2020 at 1:18 p.m.

A sample of 3 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 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-1505, C-1912, and C-1923 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Billie Seeman, RN, Clinical Health Facility Surveyor

Date report completed: 02/14/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1410	A BUILDING _____ B WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL	13200 SOUTH MAY AVE OKLAHOMA CITY, OK 73170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An abbreviated survey was conducted on 02/13/20 and 02/14/20 to investigate complaint #OK00055037. Current census was 62. The following deficiencies were cited.	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure medications were available for administration for	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1410	A. BUILDING _____ B. WING _____	02/14/2020

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C1505	Continued From page 1 3 (#1, 2, and #3) of 3 sampled residents who received physician ordered employee administered medications. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #1 Resident #1 had an order for folic acid (supplement), Pramipexole for Parkinson's disease, and Seroquel for anxiety. A November 2019 medication administration record (MAR) documented 4 doses of the folic acid were not administered due to "Medication not available," which was documented on the MAR A December 2019 MAR documented 3 doses of the Pramipexole were not administered, and 2 doses of the Seroquel were not administered due to "Medication not available." A care plan for resident #1, dated 12/20/19, documented the resident required/requested assistance with managing, supervising, and administering medication. On 02/13/20 at 3:26 p.m., resident #1 stated she had almost run out of her Clonazepam on a Friday, and the center stated the medication would not be available until Monday. She stated her daughter had to call the physician to get the medication refilled so she would not run out. At 3:42 p.m., the registered nurse (RN) stated she was not sure why the medications had not been ordered and administered. She stated it may have been a medication the daughter needed to bring, or the center may not have received a refill from the physician. On 02/14/20 at 8:33 a.m., resident #1's daughter	C1505		

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C1505	Continued From page 2 stated the center had run out of the resident's Pramipexole in December of 2019. She stated the center had contacted her on a Friday, for her to get resident #1's Clonazepam refilled from her neurologist. RESIDENT #2 Resident #2 had a diagnosis of hyperlipidemia (elevated lipid levels) and had an order for Rosuvastatin (Crestor) (used to treat hyperlipidemia). Resident #2's January 2020 MAR documented Rosuvastatin was not administered on 01/19/20 through 01/29/20, due to medication not available. The resident had missed 11 doses of the Rosuvastatin medication. On 02/13/20 at 3:48 p.m., the RN stated resident #2's son brought a ninety-day supply of Rosuvastatin to the center around 12/03/19, but it was not signed in and nobody could find the medication. On 02/14/20 at 10:50 a.m., resident #2's son stated he brought a ninety-day supply of Rosuvastatin to the center and gave it to an employee who assured him she knew how to check the medication in. He stated he then received a telephone call from the pharmacy notifying him the center had requested another refill for the Rosuvastatin. The son then stated he notified the center he had already delivered the Rosuvastatin to the center. RESIDENT #3 Resident #3 had an order for Lisinopril for hypertension. A December 2019 MAR documented 3 doses of the Lisinopril were not administered due to "Medication not Available,"	C1505		

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C1505	Continued From page 3 which was documented on the MAR. A care plan for resident #3, dated 12/12/19, documented the resident required/requested assistance with managing, supervising, and administering medication. On 02/13/20 at 3:40 p.m., the RN stated she did not know why resident #3 ran out of her Lisinopril. She stated the employees who worked during the day shift were responsible for re-ordering the medication refills.	C1505		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require	C1912		

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C1912	Continued From page 4 treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure an allegation of misappropriation was reported to the Oklahoma State Department of Health (OSDH) for 1 (#2) of 1 sampled resident who had missing medications. This failed practice had the isolated potential for more than minimal harm. Findings: Resident #2 had a diagnosis of hyperlipidemia (elevated lipid levels) and had an order for Rosuvastatin (Crestor) (Medication for hyperlipidemia). Resident #2's medication administration record, dated 01/2020, documented Rosuvastatin was not administered on 01/19/20 through 01/29/20 due to medication not available. On 02/13/20 at 3:48 p.m., the registered nurse (RN) stated resident #2's son brought a ninety-day supply of Rosuvastatin to the center, but it was not signed in and nobody could find the medication. She stated she did not submit a state reportable incident for the missing medication. On 02/14/20 at 10:50 a.m., resident #2's son	C1912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1912	Continued From page 5 stated he brought a ninety-day supply of Rosuvastatin to the center and gave it to an employee who assured him she knew how to check the medication in. He stated he then received a telephone call from the pharmacy notifying him the center had requested another refill for the Rosuvastatin. The son then stated he notified the center he had already delivered the Rosuvastatin to the center. No OSDH incident report was available for the allegation of misappropriation of resident #2's medication.	C1912		
C1923 SS=E	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:	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1923	Continued From page 6 Based on interview and record review, it was determined the center failed to ensure medication error incident reports were completed for medications not administered as ordered by the physician for 3 (#1, 2, and #3) of 3 sampled residents who missed doses of medications. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #1 Resident #1 had an order for folic acid (supplement), Pramipexole for Parkinson's disease, and Seroquel for anxiety. A November 2019 medication administration record (MAR) documented 4 doses of the folic acid were not administered. A December 2019 MAR documented 3 doses of the Pramipexole were not administered, and 2 doses of the Seroquel were not administered. RESIDENT #2 Resident #2 had an order for Rosuvastatin for hyperlipidemia. A January 2020 MAR documented 11 doses of the Rosuvastatin were not administered. RESIDENT #3 Resident #3 had an order for Lisinopril for hypertension. A December 2019 MAR documented 3 doses of the Lisinopril were not administered. No medication error incident reports were provided for the medications that were not administered. On 02/14/20 at 10:38 a.m., the registered nurse	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1923	Continued From page 7 (RN) stated she had not completed medication error incident reports for the missed doses of medication.	C1923		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL1410	LEGEND AT RIVENDELL

Type of Survey (select all that apply)

[3][ ][ ][ ][ ]

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

[ ][ ][ ][ ][ ]

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 36191	02/13/2020	02/14/2020	1.00	0.00	5.75	0.00	3.50	7.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

FEB 2 5 2020

Oklahoma State Department of Health
Creating a State of Health

March 11, 2020

License Number: AL1410

Ms.. Nancy Klepac, Administrator
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

Survey Event ID: I4V211

Dear Ms.. Klepac:

On February 14, 2020, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **April 6, 2020**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Sue Davis
Long Term Care Enforcement Coordinator
Oklahoma State Department of Health

SD/tk

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/4/2020** **Facility Name:** Legend at Rivendell **License Number:** AL1410 **Survey Event ID:** I4V211 **Date Survey Completed: 2/14/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: interview and record review, it was determined the center failed to ensure medications were available for administration for 3 (#1, 2, and #3) of 3 sampled residents who received physician ordered employee administered medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Physician orders were verified and medications ordered and made available for 3 (#1, 2, and #3) residents who receive physician ordered employee administered medications.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The Resident Director or Designee will 1) provide in-service, training and education to the nursing team on RESIDENT RIGHTS as outlined in 310:663-15-1 & 63 OS 1-1918(B)(5) and the availability and administration of medications per physician order.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	a) The Resident Director or Designee will conduct random audits to ensure medications are available and are being administered per physician order. b) The audits and related documentation will be discussed, reviewed and measured at each QA meeting. c) The audit will be maintained as part of the QA file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	April 6, 2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Nancy Klepac, RN	**Date:** 03/06/2020

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 3/4/2020
	Facility Name: Legend at Rivendell
	License Number: AL1410
	Survey Event ID: I4V211
	Date Survey Completed: 2/14/2020

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1912	Based on: interview and record review, it was determined the center failed to ensure an allegation of misappropriation was reported to the Oklahoma State Department of Health (OSDH) for 1 (#2) of 1 sampled resident who had missing medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	An allegation of misappropriation was reported to the Oklahoma State Department of Health (OSDH) for resident (#2) who had missing medications.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The Resident Director or Designee will 1) provide in-service, training and education to the nursing team and team members responsible for administering medications on INCIDENTS REQUIRING REPORT as outlined in 310:663-19-1(b).
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	a) The Resident Director or Designee will conduct random audits to ensure that any allegation of misappropriation of a resident's property is reported to the OSDH (Oklahoma State Department of Health) in a timely manner. b) The audits and related documentation will be discussed, reviewed and measured at each QA meeting. c) The audit will be maintained as part of the QA file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/6/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Nancy Kelsay, RD	**Date 3/6/2020**

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/4/2020** **Facility Name:** Legend at Rivendell **License Number:** AL1410 **Survey Event ID:** I4V211 **Date Survey Completed: 2/14/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1923	Based on: interview and record review, it was determined the center failed to ensure medication error incident reports were completed for medications not administered as ordered by the physician for 3 (#1, 2, and #3) of 3 sampled residents who missed doses of medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Medication error incident reports were completed for medications not administered as ordered by physician for 3 residents (#1, 2, and 3) who missed doses of medication.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have the potential to be affected.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The Resident Director or Designee will 1) provide in-service, training and education to the nursing team and staff on MEDICATION ADMINISTRATION as outlined in 310:663-19-2(a)(3) and the completion of incident reports for medications not administered per physician order.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	a) The Resident Director or Designee will conduct random audits to ensure medication error incident reports are completed for medications not administered per physician order. b) The audits and related documentation will be discussed, reviewed and measured at each QA meeting. c) The audit will be maintained as part of the QA file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Click here to enter a date when corrective action will be completed. 4-6-2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Nancy Poore-C, RD	**Date:**	3-6-2020

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

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum

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