

Delivery via email to: Greg.hendrix@legendseniorliving.com

December 20, 2022

License Number: AL1410

Mr. Greg Hendrix, Administrator
Legend At Rivendell
13200 South May Ave
Oklahoma City, OK 73170

RE: Survey Event ID: NEVZ11

Dear Mr. Hendrix:

On **December 2, 2022**, 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.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached. The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance.

However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

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

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

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

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

- Remedy(ies) imposed by the Department,

- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT

Facility: Legends At Rivendell
Address: 13200 South May Ave
City, State, Zip: Oklahoma City, OK, 73170
Provider #: AL1410
Complaint #: OK00059456
Investigation Date(s): 11/21/22 to 11/23/22 and 11/28/22 to 12/02/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were not neglected.	US
2. The center failed to prevent new or worsening pressure ulcers.	S
3. The center failed to notify the responsible party of a change in condition.	S

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

An unannounced on-site investigation was initiated 11/21/2022 at 12:40p.m.

A sample of 6 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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

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

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

Record reviews were completed for residents that needed assistance with meals. Staff were observed assisting residents at meal times. Residents were observed for pocketing of food or food left on their face. No concerns were noted. Resident's teeth and mouth were observed when talking to them. No concerns were noted.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Determination Summary and Follow-Up Action:

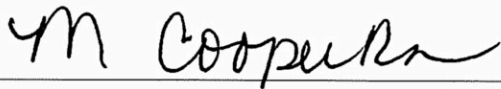
Deficient practice was substantiated for allegation #2 and #3. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

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

Mary Cooper RN/CHFS

Date report completed: 12/08/2022

INVESTIGATIVE REPORT

Facility: Legends At Rivendell
Address: 13200 South May Ave
City, State, Zip: Oklahoma City, OK, 73170
Provider #: AL1410
Complaint #: OK00059795
Investigation Date(s): 11/21/22 to 11/23/22 and 11/28/22 to 12/02/22

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The facility failed to protect the resident from sexual abuse.	S
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☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 11/21/2022 at 12:40p.m.

A sample of 3 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations

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

A 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, C1512 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 survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, reading "M Cooper RN". The signature is written in a cursive style with a horizontal line underneath it.

Mary Cooper RN/CHFS

Date report completed: 12/07/2022

INVESTIGATIVE REPORT

Facility: Legends At Rivendell
Address: 13200 South May Ave
City, State, Zip: Oklahoma City, OK, 73170
Provider #: AL1410
Complaint #: OK00059821
Investigation Date(s): 11/21/22 to 11/23/22 and 11/28/22 to 12/02/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to have and/or implement infection control practices related to laundry services.	US

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

An unannounced on-site investigation was initiated 11/21/2022 at 12:40 p.m.

A sample of 3 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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

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

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

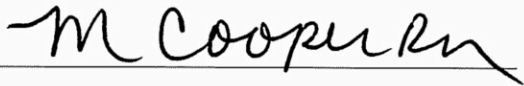
Resident agreements define if the facility staff or residents are responsible for laundry services. Residents were observed to be wearing clean clothes, with no lingering odors. Laundry rooms on both centers were observed and were found to have soap readily available. Two systems of washing was observed one system used chemicals/soap in five gallon jugs, and were commercial grade washers. The other system was residential washers located on each unit in the memory care. The Residents had access to washers and are required to provide their own laundry soap according to contracted services. Laundry staff, maintenance and direct care staff were interviewed regarding laundry services. Residents were interviewed regarding laundry services and had no complaints.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, reading "M Cooper RN", is written over a horizontal line.

Mary Cooper RN/CHFS

Date report completed: 12/08/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/02/2022
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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
N 000	Initial Comments A re-licensure was completed in conjunction with complaint #OK00059795, OK00059456, and OK00059821. Listed below are abbreviations that will be used throughout this document. ADL-Activities of Daily Living AG-Alginate AL-Assisted Living Antibx-antibiotic APAP-acetaminophen APRN-Advanced Practice Registered Nurse BID-two times a day cm-centimeter CMA-Certified Medication Aide CNA-Certified Nursing Assistant Cre-Cream DR/Dr-Doctor drsng-dressing d/t-due to E coli-Escherichia coli (bacteria) ER-emergency room eval-evaluate HCD-Health Care Director HCC-Health Care Coordinator HH-Home Health I and D- Incision and Drainage IND-indicated IV-intravenous L-Left LPN-Licensed Practical Nurse meds-medications MAR-Medication Administration Record MG/mg-milligram ML/ml-Milliliter OSDH-Oklahoma State Department of Health POA-Plan of Accommodation PRN-as needed	N 000		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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N 000	Continued From page 1 PT/Pt-patient Q-every QA-Quality Assurance R/RT-Right R/T-Refer To r/t-related to RD-Resident Director Res-resident RN-Registered Nurse ROM-range of motion SN-Skilled Nurse TABS-tablets TID-three times a day Tx-treat VO-verbal order VA-Veterans Administration VAC-vacuum-assisted wound closure vs-vital signs w/e-weekend wk-week WNL-within normal limits x-times	N 000		
N1105 SS=E	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services.	N1105		

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N1105	Continued From page 2 (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure skill/proficiency evaluations were completed upon hire and annually for eight (#1, 3, 4,5, 6, 7, 8, and #9) of 18 CNAs reviewed for skills/competency evaluations. HCD #1 identified the census to be 61. Findings: CNA #5 was hired on 11/21/16. The employee record contained no skills/competency evaluations. CNA #9 was hired on 12/31/19. The employee record contained no skills/competency evaluations. CNA #7 was hired on 02/19/20. The employee record contained no skills/competency evaluations. CNA #6 was hired on 05/10/22. The employee record contained no skills/competency evaluations. CNA #8 was hired on 07/01/22. The employee	N1105		

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N1105	Continued From page 3 record contained no skills/competency evaluations. CNA #4 was hired on 09/21/22. The employee record contained no skills competency evaluations. CNA #3 was hired on 10/06/22. The employee record contained no skills/competency evaluations. CNA #1 was hired on 10/10/22. The employee record contained no skills/competency evaluations. On 11/30/22 at 2:20 p.m., HCD #1 was asked to provide documentation of the skills/proficiency evaluations. The HCD reported the requested evaluations were not completed. HCD #1 was asked how soon after hire are the skills/proficiency evaluations completed. They stated "We try to get it in the first thirty days." HCD #1 was asked if the facility was completing skills/proficiency evaluations prior to employee assignments to resident care. They stated the facility was not doing skills/proficiency evaluations prior to assigning new employees to resident care.	N1105		
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides'	N1442		

Oklahoma State Department of Health

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N1442	Continued From page 4 skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews, the center failed to ensure: a. skill/proficiency evaluations were completed upon hire and annually b. and ensure CMA's were competent prior to assignment for medication administrations for four (#2, 3, 4 and #5) of ten CMA's reviewed for skills/competency evaluations and observed during medication administration. HCD #1 identified 61 residents resided in the memory care unit and HCD #2 identified 55 residents resided in the AL. Findings: A "Medication Administration" policy, dated 07/01/12, read in part, "...Drugs shall be administered to each resident in accordance with a physician's written order..." A "Handwashing" policy, dated 11/01/12, read in parts, "...expectation for effective hand washing as a first line of defense in infection control... Staff should always thoroughly wash their hands...after removing gloves...after disposing of other personal protective equipment...before handling of any medications and/or treatment ..."	N1442		

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N1442	Continued From page 5 1. A "Physician Order," dated 04/01/22, documented Resident #5 was to be administered one and one-half tablets of Metoprolol 50 mg extended release daily. A "Physician Order," dated 04/01/22, documented Resident #5 was to be administered Pantoprazole 40 mg delayed release once every Monday, Wednesday and Friday. The physician orders for Resident #5 did not contain documentation to crush medications or open capsules. On 11/30/22 at 7:40 a.m., during the medication administration, CMA #4 was observed to prepare medications for Resident #5. Seven medications were identified to be administered and included Metoprolol 50 mg and Pantoprazole 40 mg. CMA #4 opened capsules of medications and crushed all tablets, placed the medication mixture in pudding and administered to Resident #5 2. A "Physician Order," dated 10/05/22, documented Resident #13 was to be administered acetaminophen 650 mg, extended release two times a day. A "Physician Order," dated 10/05/22, documented Resident #13 was to be administered divalproex 250 mg delayed release at 10:00 a.m., and at bedtime. The physician orders for Resident #13 did not contain documentation to crush medications or open capsules. On 11/30/22 at 7:50 a.m., during the medication administration, CMA #4 was observed to prepare medications for Resident #13. Four medications	N1442		

Oklahoma State Department of Health

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N1442	Continued From page 6 were identified to be administered and included acetaminophen 650 mg, extended release and divalproex 250 mg delayed release. CMA #4 opened capsules and crushed all of the tablets, mixed with pudding and administered to Resident #13. On 11/30/22 at 11:30 a.m., CMA #4 was asked if Residents #5 and #13 had physician orders to open capsules and crush medications. CMA #4 stated when they were trained, they were told that all residents on the unit either had a swallowing problem and/or would pocket medications. They stated all medications were to be crushed/opened capsules, and placed in pudding for administration, even if there was no order to crush medications. CMA #4 was asked who provided the instructions to crush all of the medications. They stated they had been trained by another CMA. 3. CMA #3 was hired on 07/28/11. The employee record contained no skills/competency evaluations. CMA #2 was hired on 09/16/22. The employee record contained no skills/competency evaluation. CMA #4 was hired on 10/31/22. The employee record contained no skills/competency evaluations. On 11/30/22 at 2:20 p.m., HCD #1 was asked to provide documentation of the skills/proficiency evaluations not located in the employee records. The HCD reported the requested evaluations were not completed. HCD #1 was asked how soon after hire were the skills/proficiency evaluations completed. They	N1442		

Oklahoma State Department of Health

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N1442	Continued From page 7 stated "We try to get it in the first thirty days." HCD #1 was asked if the facility was completing skills/proficiency evaluations prior to employee assignments to medication administration. They stated no. HCD #1 was asked who had provided orientation/training for CMA #4 upon hire. They stated they would have to look. No further information was provided. 4. On 11/30/22 at 4:13 p.m., CMA #5 was observed to cleanse their hands with sanitizer, open the medication cart, and obtained one oral medication for Resident #14. CMA #5 walked down the hall, administered the medication to Resident #14, and returned to the medication cart. On 11/30/22 at 4:23 p.m., without sanitizing/washing their hands, CMA #5 obtained one oral medication and a tube of topical gel for Resident #15. The CMA walked down the hall and administered the oral medication. CMA #5 reached into a hip pocket and stated, "I thought I had gloves in my pocket but it is only my handkerchief." CMA #5 removed the handkerchief from the hip pocket, wiped their forehead, and replaced the handkerchief to the hip pocket. On 11/30/22 at 4:35 p.m., without washing/sanitizing hands, CMA #5 stooped to their knees, in front of resident #15, placed the tube of topical gel on the floor, donned gloves, and pulled Resident #15's left pant leg up to expose the left knee. CMA #5 picked the tube of	N1442		

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NAME OF PROVIDER OR SUPPLIER LEGEND AT RIVENDELL		STREET ADDRESS, CITY, STATE, ZIP CODE 13200 SOUTH MAY AVE OKLAHOMA CITY, OK 73170		
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N1442	Continued From page 8 medication from the floor, placed gel on a gloved hand, put the tube back on the floor, and rubbed the gel onto Resident #15's left knee. Without changing gloves or sanitizing their hands, CMA #5 lowered the left pant leg and raised the right pant leg to expose the right knee. CMA #5 picked up the tube of gel from the floor, placed a small amount of medication on the gloved hand, placed the tube of medication on the floor, applied the medication to Resident #15's right knee, then pulled the right pant leg down. CMA #5 removed/disposed of the soiled gloves, picked up the tube of topical medication from the floor, returned to the medication cart and placed the tube of topical medication into a bag labeled for Resident #15. Without washing/sanitizing their hands, CMA #5 opened the medication drawer to obtain an oral medication for Resident #12. The CMA walked down the hall and administered the oral medication to Resident #12. On 11/30/21 at 4:40 p.m., CMA #5 was asked when are staff to wash/sanitize their hands. They stated hands are to be washed or sanitized between each resident. CMA #5 was asked if they sanitized before and after each resident. The CMA stated, "I did once." CMA #5 was asked if they recalled placing the tube or topical medication of the floor. The CMA stated, "Yes, I should not have put it on the floor."	N1442		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/02/2022
NAME OF PROVIDER OR SUPPLIER LEGEND AT RIVENDELL		STREET ADDRESS, CITY, STATE, ZIP CODE 13200 SOUTH MAY AVE OKLAHOMA CITY, OK 73170		
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C 000	Continued From page 9	C 000		
C 000	INITIAL COMMENTS A re-licensure was completed in conjunction with complaint #OK00059795, OK00059456, and OK00059821. Listed below are abbreviations that will be used throughout this document. ADL-Activities of Daily Living AG-Alginate AL-Assisted Living Antibx-antibiotic APAP-acetaminophen APRN-Advanced Practice Registered Nurse BID-two times a day cm-centimeter CMA-Certified Medication Aide CNA-Certified Nursing Assistant Cre-Cream DR/Dr-Doctor drsng-dressing d/t-due to E coli-Escherichia coli (bacteria) ER-emergency room eval-evaluate HCD-Health Care Director HCC-Health Care Coordinator HH-Home Health I and D- Incision and Drainage IND-indicated IV-intravenous L-Left LPN-Licensed Practical Nurse meds-medications MAR-Medication Administration Record MG/mg-milligram ML/ml-Milliliter OSDH-Oklahoma State Department of Health	C 000		

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C 000	Continued From page 10 POA-Plan of Accommodation PRN-as needed PT/Pt-patient Q-every QA-Quality Assurance R/RT-Right R/T-Refer To r/t-related to RD-Resident Director Res-resident RN-Registered Nurse ROM-range of motion SN-Skilled Nurse TABS-tablets TID-three times a day Tx-treat VO-verbal order VA-Veterans Administration VAC-vacuum-assisted wound closure vs-vital signs w/e-weekend wk-week WNL-within normal limits x-times	C 000		
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.	C 543		

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C 543	Continued From page 11 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure resident assessments were signed by the resident or resident's representative for four (#7, 8, 1, and #13) of 11 sampled residents reviewed for completed resident assessments. HCD #1 identified 61 residents resided in the memory care unit and HCD #2 identified 55 residents resided in the AL. Findings: A "Resident Assessments," policy effective 07/01/2012, read in parts, "...To set forth guidelines for conducting assessments of the resident to determine appropriateness of residency, to determine the care and services needed and/or desired by the resident, and to determine certain risks the resident might experience in order to plan appropriately to meet the resident needs..." 1. Resident #7 had diagnoses which included, dementia, diabetes mellitus, and high blood pressure. An "Annual Assessment," dated 11/14/22, was conducted for Resident #7. There was no signature of the resident or representative on the assessment. On 11/29/22 at 10:22 a.m., HCD #1 was asked if the annual assessment had been signed by a family member. They stated, "No." 2. Resident #8 had diagnoses which included, Alzheimer's, Dementia and hypertension.	C 543		

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C 543	Continued From page 12 An "Annual Assessment," dated 10/18/22, was conducted for Resident #8. The assessment was not signed by the resident or the resident's representative. On 11/29/22 at 10:11 a.m., HCD #1 was asked if Resident #8's annual assessment should have been signed by the resident or the resident representative. The HCD stated, "Yes." 3. Resident #1 had diagnoses which included atrial fibrillation, aortic valve stenosis, and fractured femur. A "Significant Change," assessment, dated 09/01/22, was conducted for Resident #1. The assessment was not signed by the resident or the resident representative. On 12/02/22 at 11:45 a.m., HCD #1 was asked if the assessment was signed by the resident or resident representative. HCD #1 stated "No." 4. Resident #13 had diagnosis to include dementia, excessive tremors, and Parkinson's disease. A "Resident Assessment Form," dated 07/14/22, documented the assessment was initiated due to a significant change of status. The assessment had not been signed by the resident or a resident representative. On 12/02/22 at 11:25, HCD #1 was asked if the resident assessment, dated 07/14/22, had been signed. They stated the assessment was not signed by the representative and should have	C 543		

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C 543	Continued From page 13 been.	C 543		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure RN supervision to ensure medications were administered according to the physician orders for six (#1, 7, 2, 4, 5, and #13) of 14 sampled residents reviewed for medication administration. HCD #1 identified 61 residents resided in the memory care unit. Findings: 1. Resident #1 had diagnoses which included atrial fibrillation, aortic valve stenosis, and	C 911		

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C 911	Continued From page 14 fractured femur. A "Physician Order," dated 08/31/22, read in parts, "...[Name] Hospice to eval [and] follow Hold all meds except comfort meds..." Resident #1's "September 2022 MAR," read in parts, "...WITHHELD PER DR/RN ORDERS..." for 20/30 p.m. doses for the following medications: a. Buspirone HCL 15 mg take two times a day, b. Divalproex 125 mg take two times a day, c. Docusate Sodium 100 mg take two times a day, d. Donepezil Sodium 100 mg 1 tablet by mouth at bedtime, e. Melatonin 5 mg take two tablets at bedtime, f. Olanzapine 2.5 mg take two times a day, g. Prep H Cre 1% apply to anus two times a day, and h. Temazepam 15 mg at bedtime. Resident #1's "October 2022 MAR," read in parts, "...WITHHELD PER DR/RN ORDERS..." for 20/31 p.m. doses for the following medications: a. Buspirone HCL 15 mg take two times a day, b. Divalproex 125 mg take two times a day, c. Docusate Sodium 100 mg take two times a day, d. Donepezil Sodium 100 mg 1 tablet by mouth at bedtime, e. Melatonin 5 mg take two tablets at bedtime, f. Olanzapine 2.5 mg take two times a day, g. Prep H Cre 1% apply to anus two times a day, and h. Temazepam 15 mg at bedtime. Resident #1's "November 2022 MAR," read in part, "...WITHHELD PER DR/RN ORDERS..." for 7/11 p.m. doses for the following medications:	C 911		

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C 911	Continued From page 15 a. Buspirone HCL 15 mg take two times a day, b. Divalproex 125 mg take two times a day, c. Docusate Sodium 100 mg take two times a day, d. Donepezil Sodium 100 mg 1 tablet by mouth at bedtime, e. Melatonin 5 mg take two tablets at bedtime, f. Olanzapine 2.5 mg take two times a day, g. Prep H Cre 1% apply to anus two times a day, and h. Temazepam 15 mg at bedtime. A "Physician Order", dated 11/04/22, read in parts, "...CEPHALEXIN CAP 500 MG TAKE 1 CAPSULE BY MOUTH TWO TIMES A DAY FOR 10 DAYS (IND:WOUND INFECTION) ..." A "Physician Order", dated 11/05/22, read in parts, "...BACTRIM DS 800-160 MG TABS TAKE ONE TAB BY MOTH [SIC] EVERY 12 HOURS X 10 DAYS FOR WOUND INFECTION..." Resident #1's "November 2022 MAR," documented Cephalexin 500mg mg capsules p.m., dose had not been administered on 11/07/22, 11/08/22, and 11/09/22. the reason for not administering the medications was documented as out of facility or withheld per doctor or RN orders. Residents #1 "November 2022 MAR," documented Bactrim DS 800-160 mg tabs p.m. had not been administered on 11/07/22, 11/08/22, 11/09/22, and 11/11/22. The reason for not administering the medications was documented as out of facility or withheld per doctor or RN orders on 11/07/22, 11/08/22, and 11/11/22. There was no reason documented why the medication had not been administered on 11/09/22.	C 911		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEGEND AT RIVENDELL

**13200 SOUTH MAY AVE
OKLAHOMA CITY, OK 73170**

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C 911	Continued From page 16 On 11/23/22 at 10:46 a.m., HCD #1 was asked why Resident #1 had not been administered the Bactrim and Cephalexin as ordered by the physician. Why did the November MAR document medications were held per physicians orders,. They stated, "Don't know why it says held per physician orders." On 11/23/22 at 3:40 p.m., HCD #1 was asked why had Resident #1's routine medications had been documented withheld per physician orders for the months of September, October and November. They stated, the medication aides were holding the medications, except comfort medications, since the resident was admitted to hospice on 08/31/22. The HCD #1 was asked if [they] had been aware the routine medications had been held. They stated, when they looked at the MAR's yesterday and realized they had been held. On 11/28/22 at 11:33 a.m., HCD #1 was asked if there was an order to discontinue all medications except comfort meds. They stated, there was no order to discontinue all medications. The HCD #1 was asked to review the physician order, dated 08/31/22, that documented to hold all meds except comfort meds. HCD #1 was unaware of the order. The HCD #1 was asked if there was an order to restart the medications since some medications were being administered in the months of September, October and November. HCD #1 stated, "Probably not." There was no clarification of what orders were to be held or administered related to comfort medications. HCD #1 was asked how often they reviewed	C 911		

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C 911	Continued From page 17 MAR's. They stated, they reviewed for new orders daily. HCD #1 was asked why the medications that were not being administered correctly and had not been caught for three months. They stated, "I just do spot checks, but not on every person." HCD #1 was asked if they reconcile the MAR's with the monthly physician orders. They stated, "No." 2. Resident #7 had diagnoses which included, dementia, diabetes mellitus, and high blood pressure. A "Physician Order," dated 11/04/22, read in part, "...Gentamycin 0.3% Ophthalmic Solution Instill 2 drops into each eye every 4 hours for 7 days..." Resident #7's "November 2022 MAR," documented Medication Unavailable, awaiting pharmacy delivery, medication on order and awaiting medication from the pharmacy, for the Gentamycin eye drops, from 11/05/22 through 11/09/22. On 11/29/22 at 11:34 the HCD #1 was asked why the medication was unavailable from 11/05 through 11/09/22. They stated the medication needed prior authorization. On 11/29/22 at 11:34 the HCD #1 was asked why the medication aides initialled they administered the medication. They were asked if the medication was in the center to administer. The HCD #1 stated, "No." On 11/29/22 at 11:34 the HCD #1 stated the Gentamycin eye drops had been started on 11/10/22. The HCD #1 was asked if the initial order was for seven days, why was it given for nine days. The HCD #1 stated, it wasn't	C 911		

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C 911	Continued From page 18 discontinued off the MAR until then. The "November 2022 MAR," documented Resident #7 had been administered the Gentamycin eye drops on 11/05/22 at 4:00 p.m., and 8:00 p.m., and on 11/08/22 at 4:00 p.m. 3. Resident #2 had diagnoses which included Alzheimer's disease. A "Physician Order," dated 09/30/22, read in parts, "...HYDROCO/APAP TAB 5-325 MG TAKE 1 TABLET BY MOUTH EVERY 12 HOURS SCHEDULED..." Resident #2's "October 2022 MAR," documented Resident #2 had not been administered any Hydrocodone 5-325 mg for two doses on October 1, one dose on October 2, two doses on October 3, and two doses on October 4, 2022. Resident #2's "November 2022 MAR," documented Resident #2 had not been administered any Hydrocodone 5-325 mg for two scheduled doses on November 7, 8, 9, and 11. The reason documented for not administering was medication unavailable. On 11/23/22 at 11:45 p.m., HCD #1 was asked if Resident #2 had been administered Hydrocodone 5-325 mg correctly for November. The HCD stated no, the resident was out of medications. On 11/23/22 at 4:15 p.m., HCD #1 was asked if Resident #2 had been administered their medication correctly for October. The HCD stated, "No." 4. Resident #4 had diagnosis which included dementia, and Alzheimer's disease.	C 911		

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C 911	Continued From page 19 A "Physician Order," dated 09/21/22, read in parts, "...Start Doxycycline 100 mg by mouth twice daily for 14 days..." The "September 2022 MAR," had no documentation that the physician order for Doxycycline was administered as ordered. A "Home Health Note," dated 09/23/22, read in parts, "...states facility has not started antibx d/t not being faxed over from the facility and LPN at facility is off today. [Res #4's family member] is upset that antibx were not started..." On 11/28/22 at 12:25 p.m., HCD #1 was asked if the Doxycycline had been started as ordered by the physician. The HCD stated, "It wasn't started due to not being approved by the nurse." 5. Resident #5 had diagnoses to include pain, hypertension, depression, diabetes mellitus and Alzheimers disease. A "Physician order," dated 04/01/22, documented Resident #5 was to be administered: a. Metoprolol 50 mg one and one/half tablets of extended release daily, and b. Pantoprazole 40 mg delayed release daily Monday, Wednesday and Friday. There was no documentation to crush medications or open capsules. On 11/30/22 at 7:40 a.m., during the medication administration, CMA #4 was observed to prepare medications for Resident #5. Seven medications were identified to be administered and included Metoprolol 50 mg and Pantoprazole 40 mg. CMA #4 opened capsules of medications and crushed all tablets, placed the medication mixture in	C 911		

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C 911	Continued From page 20 pudding and administered to Resident #5. 6. Resident #13 had diagnoses which included dementia, Parkinsons, and arthritis. A "Physician Order," dated 10/05/22, documented Resident #13 was to be administered: a. acetaminophen 650 mg, extended release two times a day, and b. divalproex 250 mg delayed release at 10:00 a.m., and at bedtime. There was no documentation to crush medications or open capsules. On 11/30/22 at 7:50 a.m., during the medication administration, CMA #4 was observed to prepare medications for Resident #13. Four medications were identified to be administered and included acetaminophen 650 mg and divalproex 250 mg. CMA #4 opened capsules, crushed all of the tablets, mixed with pudding, and administered to Resident #13. On 11/30/22 at 11:30 a.m., CMA #4 was asked if Residents #5 and #13 had physician orders to open capsules and crush medications. CMA #4 stated they had been trained by another CMA to open capsules and crush all medications no matter what the order indicated. On 11/30/22 at 1:34 p.m., HCD #1 was asked if any type of audit was conducted on medication administration records. They stated only to review if there were new orders from the last review and ensure the new order is placed on the MAR. HCD #1 was asked how the CMAs know what medications can be crushed or capsules opened.	C 911		

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C 911	Continued From page 21 They stated, "We are working on that." HCD #1 was asked if a medication is extended or delayed release should the medication be crushed. They stated, "No." HCD #1 was asked should a resident have a physician order to crush medication/open capsules prior to being done. They stated, "Yes." HCD #1 was asked if the medications are reviewed monthly. They stated, they did the monthly review, but only to ensure current orders have been added to the MAR. HCD #1 was asked if the current review had been enough to ensure that medications are administered as ordered. They stated, "Probably not enough." HCD #1 was asked if in regards to standards of practice, following physician orders, and medications not administered as ordered, did the facility have a system failure. They stated, "Yes." HCD #1 was asked if they were aware of these issues prior to the current survey. They stated, "No."	C 911		
C1110 SS=E	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and	C1110		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/02/2022
NAME OF PROVIDER OR SUPPLIER LEGEND AT RIVENDELL		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1110	Continued From page 22 (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review, observation and interview, the center failed to have a system in place for the following: a. to monitor trends in medication administration for medications error/omissions for six (#1, 2, 4, 5, 7, and #13) of eight sampled residents regarding medications error and/or omissions; and b. to monitor trends related to pressure ulcers for two (#1, and #4) of three sampled residents reviewed for pressure wounds. HCD #1 identified 61 residents resided in memory care. The "Resident Matrix" identified three residents with pressure ulcers. Findings: 1. Resident #5 had diagnoses to include pain, hypertension, depression, diabetes mellitus and Alzheimers disease. A "Physician order," dated 04/01/22, documented Resident #5 was to be administered:	C1110		

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C1110	Continued From page 23 a. Metoprolol 50 mg one and one-half tablets of extended release daily, and b. Pantoprazole 40 mg delayed release daily Monday, Wednesday and Friday. There was no documentation to crush medications or open capsules. On 11/30/22 at 7:40 a.m., during the medication administration, CMA #4 was observed to prepare medications for Resident #5. Seven medications were identified to be administered and included Metoprolol 50 mg and Pantoprazole 40 mg. CMA #4 opened capsules of medications and crushed all tablets, placed the medication mixture in pudding and administered to Resident #5. 2. Resident #13 had diagnoses which included dementia, Parkinsons, and arthritis. A "Physician Order," dated 10/05/22, documented Resident #13 was to be administered: a. acetaminophen 650 mg, extended release two times a day, and b. divalproex 250 mg delayed release at 10:00 a.m., and at bedtime. There was no documentation to crush medications or open capsules. On 11/30/22 at 7:50 a.m., during the medication administration, CMA #4 was observed to prepare medications for Resident #13. Four medications were identified to be administered and included acetaminophen 650 mg and divalproex 250 mg. CMA #4 opened capsules, crushed all of the tablets, mixed with pudding, and administered to Resident #13. On 11/30/22 at 11:30 a.m., CMA #4 was asked if	C1110		

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C1110	Continued From page 24 Residents #5 and #13 had physician orders to open capsules and crush medications. CMA #4 stated they had been trained by another CMA to open capsules and crush all medications no matter what the order indicated. On 11/30/22 at 1:34 p.m., HCD #1 was asked if any type of audit was conducted on medication administration records. They stated only to review if there were new orders from the last review and ensure the new order is placed on the MAR. HCD #1 was asked how the CMAs know what medications can be crushed or capsules opened. They stated, "We are working on that." HCD #1 was asked if a medication is extended or delayed release should the medication be crushed. They stated, "No." HCD #1 was asked should a resident have a physician order to crush medication/open capsules prior to being done. They stated, "Yes." HCD #1 was asked if the medications are reviewed monthly. They stated, they did the monthly review, but only to ensure current orders have been added to the MAR. HCD #1 was asked if the current review had been enough to ensure that medications are administered as ordered. They stated, "Probably not enough." HCD #1 was asked if in regards to standards of practice, following physician orders, and medications not administered as ordered, did the facility have a system failure. They stated, "Yes."	C1110		

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C1110	Continued From page 25 HCD #1 was asked if they were aware of these issues prior to the current survey. They stated, "No." HCD #1 was asked if any issues with medications, narcotic accountability, wound treatment/antibiotics ordered, and administered taken to the QA committee. They stated, "I didn't know I was supposed to." 3. Resident #1 had diagnoses which included atrial fibrillation, aortic valve stenosis, and fractured femur. A "Physician Order," dated 08/31/22, read in parts, "...[Name] Hospice to eval [and] follow Hold all meds except comfort meds..." Resident #1's "September 2022 MAR," read in parts, "...WITHHELD PER DR/RN ORDERS..." for 20/30 p.m. doses for the following medications: a. Buspirone HCL 15 mg take two times a day, b. Divalproex 125 mg take two times a day, c. Docusate Sodium 100 mg take two times a day, d. Donepezil Sodium 100 mg 1 tablet by mouth at bedtime, e. Melatonin 5 mg take two tablets at bedtime, f. Olanzapine 2.5 mg take two times a day, g. Prep H Cre 1% apply to anus two times a day, and h. Temazepam 15 mg at bedtime. Resident #1's "October 2022 MAR," read in parts, "...WITHHELD PER DR/RN ORDERS..." for 20/31 p.m. doses for the following medications: a. Buspirone HCL 15 mg take two times a day, b. Divalproex 125 mg take two times a day, c. Docusate Sodium 100 mg take two times a	C1110		

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C1110	Continued From page 26 day, d. Donepezil Sodium 100 mg 1 tablet by mouth at bedtime, e. Melatonin 5 mg take two tablets at bedtime, f. Olanzapine 2.5 mg take two times a day, g. Prep H Cre 1% apply to anus two times a day, and h. Temazepam 15 mg at bedtime. Resident #1's "November 2022 MAR," read in part, "...WITHHELD PER DR/RN ORDERS..." for 7/11 p.m. doses for the following medications: a. Buspirone HCL 15 mg take two times a day, b. Divalproex 125 mg take two times a day, c. Docusate Sodium 100 mg take two times a day, d. Donepezil Sodium 100 mg 1 tablet by mouth at bedtime, e. Melatonin 5 mg take two tablets at bedtime, f. Olanzapine 2.5 mg take two times a day, g. Prep H Cre 1% apply to anus two times a day, and h. Temazepam 15 mg at bedtime. A "Physician Order," dated 11/04/22, read in parts, "...CEPHALEXIN CAP 500 MG TAKE 1 CAPSULE BY MOUTH TWO TIMES A DAY FOR 10 DAYS (IND:WOUND INFECTION) ..." A "Physician Order," dated 11/05/22, read in parts, "...BACTRIM DS 800-160 MG TABS TAKE ONE TAB BY MOTH [SIC] EVERY 12 HOURS X 10 DAYS FOR WOUND INFECTION..." Resident #1's "November 2022 MAR," documented Cephalexin 500mg mg capsules p.m., dose had not been administered on 11/07/22, 11/08/22, and 11/09/22. the reason for not administering the medications was documented as out of facility or withheld per	C1110		

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C1110	Continued From page 27 doctor or RN orders. Residents #1 "November 2022 MAR," documented Bactrim DS 800-160 mg tabs p.m. had not been administered on 11/07/22, 11/08/22, 11/09/22, and 11/11/22. The reason for not administering the medications was documented as out of facility or withheld per doctor or RN orders on 11/07/22, 11/08/22, and 11/11/22. There was no reason documented why the medication had not been administered on 11/09/22. On 11/23/22 at 10:46 a.m., HCD #1 was asked why Resident #1 had not been administered the Bactrim and Cephalexin as ordered by the physician. Why did the November MAR document medications were held per physicians orders,. They stated, "Don't know why it says held per physician orders." On 11/23/22 at 3:40 p.m., HCD #1 was asked why had Resident #1's routine medications had been documented withheld per physician orders for the months of September, October and November. They stated, the medication aides were holding the medications, except comfort medications, since the resident was admitted to hospice on 08/31/22. The HCD #1 was asked if [they] had been aware the routine medications had been held. They stated, when they looked at the MAR's yesterday and realized they had been held. On 11/28/22 at 11:33 a.m., HCD #1 was asked if there was an order to discontinue all medications except comfort meds. They stated, there was no order to discontinue all medications. The HCD #1 was asked to review the physician order, dated 08/31/22, that documented to hold all meds	C1110		

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C1110	Continued From page 28 except comfort meds. HCD #1 was unaware of the order. The HCD #1 was asked if there was an order to restart the medications since some medications were being administered in the months of September, October and November. HCD #1 stated, "Probably not." There was no clarification of what orders were to be held or administered related to comfort medications. HCD #1 was asked how often they reviewed MAR's. They stated, they reviewed for new orders daily. HCD #1 was asked why the medications that were not being administered correctly and had not been caught for three months. They stated, "I just do spot checks, but not on every person." HCD #1 was asked if they reconcile the MAR's with the monthly physician orders. They stated, "No." 4. Resident #7 had diagnoses which included, dementia, diabetes mellitus, and high blood pressure. A "Physician Order", dated 11/04/22, read in parts, "...Gentamycin 0.3% Ophthalmic Solution Instill 2 drops into each eye every 4 hours for 7 days..." Resident #7's MAR, dated November 2022, documented Medication Unavailable, awaiting pharmacy delivery, medication on order and awaiting medication from the pharmacy, for the Gentamycin eye drops, from 11/05/22 through 11/09/22. HCD #1 was asked why the medication was unavailable from 11/5 through 11/9. They stated, the medication needed prior authorization. The	C1110		

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C1110	Continued From page 29 HCD was asked why did the medication aides initial the MAR they administered the medication. Was the medication in the center to administer. The HCD stated, no. The HCD stated it was started on 11/10/22. The HCD was asked if the initial order was for seven days why was it given for nine days until 11/19/22. The HCD stated, it wasn't discontinued off the MAR until then. 5. Resident #2 had diagnoses which included Alzheimer's disease. A "Physician Order," dated 09/30/22, read in parts, "...HYDROCO/APAP TAB 5-325 MG TAKE 1 TABLET BY MOUTH EVERY 12 HOURS SCHEDULED..." Resident #2's "October 2022 MAR," documented Resident #2 had not been administered any Hydrocodone 5-325 mg for two doses on October 1, one dose on October 2, two doses on October 3, and two doses on October 4, 2022. Resident #2's "November 2022 MAR," documented Resident #2 had not been administered any Hydrocodone 5-325 mg for two scheduled doses on November 7, 8, 9, and 11. The reason documented for not administering was medication unavailable. On 11/23/22 at 11:45 p.m., HCD #1 was asked if Resident #2 had been administered Hydrocodone 5-325 mg correctly for November. The HCD stated no, the resident was out of medications. On 11/23/22 at 4:15 p.m., HCD #1 was asked if Resident #2 had been administered their medication correctly for October. The HCD stated, "No."	C1110		

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C1110	Continued From page 30 6. Resident #4 had diagnosis which included dementia, and Alzheimer's disease. A "Care Plan," dated 11/14/22, read in parts, '...Coordination of third Party Services Independent in coordination and communication with third party service providers. Direct Care Staff ...8/10/22-wound care..." There were no interventions documented on the care plan for prevention and worsening of pressure ulcers for Resident #4. A "Nurse Progress Note," dated 08/10/22, read in parts, "...Resident has an app 5 x 2 open wound on [their] right hip incision. We placed mepilex border and [HCD] was in room as well. There is a raised area and [HCD] seems to think it is part of the hardware. Sent request to [name] APRN to see about new orders ..." A "Physician Order," dated 09/21/22, read in parts, "...Start Doxycycline 100 mg by mouth twice daily for 14 days..." The "September 2022 MAR," had no documentation that the physician order, on 09/21/22, for Doxycycline was administered as ordered. A "Home Health Note," dated 09/23/22, read in parts, "...states facility has not started antibx d/t not being faxed over from the facility and LPN at facility is off today. [Res #4's family member] is upset that antibx were not started..." On 11/28/22 at 12:25 p.m., HCD #1 was asked if the Doxycycline had been started as ordered by the physician on 09/21/22. The HCD stated, "It wasn't started due to not being approved by the	C1110		