



Delivery Via Email: adm@meadowlakeretirement.com

August 12, 2020

License Number: AL1411

Ms. Cara Northcutt, Administrator
Meadowlakes Retirement Village
963 SW 107th
Oklahoma City, OK 73170

RE: Survey Event ID: 2BMX11

Dear Ms. Northcutt:

On **March 12, 2020**, 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 March 12, 2020.

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) 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,

Katie Stagner
Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State
Department of Health, ou=Long Term
Care, email=katies@health.ok.gov, c=US
Date: 2020.08.12 09:36:59 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1411	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/12/2020
NAME OF PROVIDER OR SUPPLIER MEADOWLAKES RETIREMENT VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 963 SW 107TH OKLAHOMA CITY, OK 73170		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 03/10/2020 through 03/12/2020. Current census was 58. The following deficient practice was cited.	C 000		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure an annual comprehensive assessment was completed for 3 (#6, 9, and #10) of 3 sampled residents. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 03/12/2020 at 11:56 a.m., a review of resident #6's chart revealed an annual comprehensive assessment, dated 03/16/18. The chart did not contain an annual comprehensive assessment for 2019. At 12:38 p.m., a review of resident #9's chart revealed an annual comprehensive assessment dated, 05/31/18. The chart did not contain an annual comprehensive assessment for 2019. At 12:56 p.m., a review of resident #10's chart revealed an admission comprehensive	C 522		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 522	Continued From page 1 assessment dated, 05/25/17. The chart did not contain an annual comprehensive assessment for 2018 or 2019. At 2:49 p.m., the licensed practical nurse stated they could not find any comprehensive assessments for residents #6, 9, or #10 except what was in their charts. He further stated he did not know if they had ever been completed or not.	C 522		



Delivery Via Email: admin@meadowlakeretirement.com

August 20, 2020

License Number: AL1411

Ms. Cara Northcutt, Administrator
Meadowlakes Retirement Village
963 SW 107th
Oklahoma City, OK 73170

RE: Survey Event 2BMX11

Dear Ms. Northcutt:

On March 12, 2020, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **September 9, 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,

Katie
Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma
State Department of Health,
ou=Long Term Care,
email=katies@health.ok.gov, c=US
Date: 2020.08.20 15:31:02 -05'00'

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER MEADOWLAKES RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 963 SW 107TH OKLAHOMA CITY, OK 73170
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Oklahoma State Department of Health
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TITLE

(X6) DATE

Oklahoma State Department of Health

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Delivery via email to: admin@meadowlakeretirement.com

January 13, 2021

License Number: AL1411

Ms. Cara Northcutt, Administrator
Meadowlakes Retirement Village
963 Sw 107th
Oklahoma City, OK 73170

RE: Survey Event 2BMX12

Dear Ms. Northcutt:

On **January 7, 2021**, an offsite/paper revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 12, 2020**, have now been corrected effective **September 9, 2020**.

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

Sincerely,

Users, Lisa
D Calvin

Digitally signed by
Users, Lisa D Calvin
Date: 2021.01.13
15:21:40 -06'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL1411	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/07/2021
NAME OF PROVIDER OR SUPPLIER MEADOWLAKES RETIREMENT VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 963 SW 107TH OKLAHOMA CITY, OK 73170		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was completed on 01/07/21. Credible evidence of correction was submitted for all deficiencies from the 03/12/20 survey.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE