
Delivery via email to: admin@meadowlakeretirement.com

June 19, 2023

License Number: AL1411

Ms. Brytnea Hollman, Administrator
Meadowlakes Retirement Village
963 Sw 107th
Oklahoma City, OK 73170

RE: Survey Event ID: HERG11

Dear Ms. Hollman:

On **June 6, 2023**, agents from our office concluded a State Licensure survey with complaint investigations at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on June 6, 2023.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT

Facility: Meadowlakes Retirement Village
Address: 963 SW 107th
City, State, Zip: Oklahoma City, OK, 73170
Provider #: AL1411
Complaint #: OK00056066
Investigation Date(s): 06/05/23-06/06/23

ALLEGATION(S)

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| 1. The center failed to provide services according to resident contracts. |
| 2. The center failed to assess residents to determine if their care exceeded the level of care the center could provide. |

An unannounced on-site investigation was initiated 06/05/2023 at 8:15 a.m.

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

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

A Summary of Complaint Investigation:

Tours were conducted upon entry and at random times throughout the survey. Resident rooms were observed for cleanliness and safety. Staff were observed for housekeeping duties. Residents and staff were observed during meals at random times throughout the survey.

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

Residents and staff were interviewed regarding medications, services provided, cleanliness, weight loss, meals, and resident records.

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

Thank you for bringing your concerns to our attention.

Kc Claunch  Digitally signed by Kc Claunch
Date: 2023.06.08 12:28:22 -05'00'

Kc Claunch, LPN CHFS

Date report completed: 06/08/2023

INVESTIGATIVE REPORT

Facility: Meadowlakes Retirement Village
Address: 963 SW 107th
City, State, Zip: Oklahoma City, OK, 73170
Provider #: AL1411
Complaint #: OK00059604
Investigation Dates: 06/05/23 through 06/06/23

ALLEGATIONS

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| 1. The facility failed to meet financial obligations for delivery of care and maintenance of facility. |
| 2. The facility failed to have adequate staffing to meet residents' needs. |
| 3. The facility failed to provide an environment with comfortable temperatures. |

An unannounced on-site investigation was initiated 06/05/2023 at 8:15 a.m.

A sample of eight 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at various times throughout the survey. Residents' rooms were observed for comfortable temperatures and proper care/maintenance. Staff were observed for providing medications to residents, answering call lights in a timely manner, assistance with activities of daily living, and adequate staff to meet residents' needs.

Residents' records were reviewed including physician orders, medication records, nursing notes, service contracts, service plans and resident assessments. Grievance reports, resident council meeting minutes, staffing reports, call light logs, and incident reports were reviewed.

Residents were interviewed related to medication administration, assistance with activities of daily living, staffing, call lights, and maintenance/care of their rooms.

Staff members were interviewed related to the facility policy on medication administration, adequate staff to meet the residents' needs, call lights, and maintenance/care of residents' rooms.

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

Thank you for bringing your concerns to our attention.

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

Melissa Cooper, Health Facility Surveyor

Date report completed: 06/08/2023

INVESTIGATIVE REPORT

Facility: Meadowlakes Retirement Village
Address: 963 SW 107th
City, State, Zip: Oklahoma City, OK, 73170
Provider #: AL1411
Complaint #: OK00059752
Investigation Dates: 06/05/23 through 06/06/23

ALLEGATIONS

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| 1. The facility failed to ensure medications were properly administered. |
| 2. The facility to have adequate staffing to meet residents' needs. |
| 3. The facility failed to have qualified administrator. |
| 4. The facility failed to ensure residents' food preferences were honored. |

An unannounced on-site investigation was initiated 06/05/2023 at 8:15 a.m.

A sample of nine 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 Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at various times throughout the survey. Residents were observed for being properly groomed. Staff were observed for providing medications to residents, assistance with activities of daily living, honoring food preferences during meal service, adequate staff to meet residents' needs, and qualified staff to operate the facility.

Residents' records were reviewed including physician orders, medication records, nursing notes, service contracts, service plans and resident assessments. Grievance reports, resident council meeting minutes, weekly food menus with alternate options, staffing reports, and staff licenses were reviewed.

Residents were interviewed related to medication administration, assistance with activities of daily living, adequate staff to meet their needs, and food preferences.

Staff members were interviewed related to the facility policy on medication administration, adequate staff to meet the residents' needs, staff qualifications, and food preferences.

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

Thank you for bringing your concerns to our attention.

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

Melissa Cooper, Health Facility Surveyor

Date report completed: 06/08/2023

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 C 06/06/2023
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 relicensure survey was conducted from 06/05/23 through 06/06/23. Complaint investigations (#OK00056066, OK00059604, and #OK00059752) were conducted in conjunction with the survey. CHF - chronic heart failure CKD - chronic kidney disease CMA - certified medication aide CVA - cerebrovascular accident DNR - do not resuscitate DON - director of nursing DVT - deep vein thrombosis ER - extended release GERD - gastroesophageal reflux disease HCL - hydrochloride HDL - hyperlipidemia HS - hour of sleep HTN - hypertension MAR - medication administration record meq - miliequivalent mg - milligrams PVD - peripheral vascular disease RD - registered dietitian Res - Resident RN - registered nurse tab - tablet	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure:	C 391		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 391	Continued From page 1 a. the dining room/kitchen and food service equipment were kept clean and maintained in good repair, b. food products were dated, and c. liquid products were labeled. The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 47 residents resided in the facility. Findings: On 06/05/23 at 9:36 a.m., a tour of the dining room and kitchen was conducted. The following observations were made: a. there was an accumulation of black residue on the exterior area of the ice dispenser, b. there was an accumulation of brown residue on the counter under the ice dispenser, c. there was an accumulation of black residue on the floor under the ice dispenser table, d. ceiling lights were burned out and/or not working, e. ceiling lights were not properly shielded, f. brown water marks were on ceiling tiles, g. there was an accumulation of lint on heat/air and return vents, h. there was an accumulation of lint on ceiling tiles and light shields around the heat/air vents,	C 391		

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C 391	Continued From page 2 i. there was an accumulation of black residue on the exterior area of the walk-in cooler door, j. there was an accumulation of lint on the condenser, fan guards, and ceiling in the walk-in cooler, k. there was an accumulation of black residue on the racks in the walk-in cooler, l. there was an accumulation of black and brown residue on the floor in the walk-in cooler, m. there was an opened package of hot dogs in the walk-in cooler. The package was not labeled, n. there was ice buildup on the floor in the walk-in freezer and around the walk-in freezer door, o. there was an accumulation of brown residue on the outside area of bulk food containers of flour and sugar, p. there was brown residue on the stainless steel table and sink in the two compartment sink area, q. there was material peeling off of the wall in the two compartment sink area, r. the gasket on one of two doors located on the Traulsen door reach-in cooler was split and not secure to the door, s. there was an accumulation of black residue, food, and grease on the fryer, fryer baskets, and casters located on the oven, t. there was an accumulation of black residue and food on the microwave table,	C 391		

Oklahoma State Department of Health

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C 391	Continued From page 3 u. there was a spray bottle of a clear liquid on the drain board of the three compartment sink. The bottle was not labeled, v. there was an accumulation of brown and white residue on the three compartment sink and dish machine, and w. there was an accumulation of black residue on the floor under the ice machine. On 06/05/23 at 12:11 p.m., the RD was asked how staff ensured equipment and the physical environment of food service areas were kept clean and maintained in good repair. They stated staff were supposed to clean as they go. They stated maintenance concerns were supposed to be reported to the administrator. They were asked about date marking of food products and labeling of unknown liquids. They stated food products should be dated with the open date and chemicals should be labeled. The RD was made aware of the above findings.	C 391		
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.	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive assessments were completed every 12 months for five (#2, 3, 4, 5, and #7) of eight sampled residents reviewed for annual assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 47 residents resided in the facility. Findings: 1. Res #3 admitted to the facility on 12/28/21 with diagnoses which included CHF, HTN, HLD, and hypothyroidism. An admission assessment was documented as completed on 12/28/21. Record review did not document an annual assessment for 2022. On 06/06/23 at 9:23 a.m. the administrator/DON stated the annual assessment for 2022 could not be located. They stated there was no way to verify it had been completed. 2. Res #5 had a pre-admit assessment documented on 05/31/22. Res #5 admitted to the facility on 06/07/22 with diagnoses which included HTN, diabetes, and vascular dementia. Record review did not document a 14 day comprehensive assessment. On 06/06/23 at 11:39 a.m. the administrator/DON	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 5 stated the 14 day comprehensive assessment could not be located. They stated there was no way to verify it had been completed. 3. Res #7 admitted to the facility on 02/07/22 with diagnoses which included weakness, epilepsy, atrial fibrillation, HTN, hyperlipidemia, and diabetes. An admission/14 day comprehensive assessment was documented on 02/07/23. An annual assessment was documented 05/30/23. On 06/06/23 at 11:59 a.m., the administrator/DON stated the annual was not completed within 12 months. 4. Res #2 was admitted to the facility on 06/18/21 with diagnoses which included diabetes, HTN, acute renal failure, allergies, and stroke. A resident admission assessment, dated 06/18/21, documented an assessment was completed. An annual resident assessment, dated 12/07/22, documented an assessment was completed. There was no documentation an annual resident assessment was completed within 12 months of the admission assessment. On 06/06/23 at 9:44 a.m., the administrator/DON was asked if the resident's annual assessment completed in 2022 was completed within 12 months. They stated the assessment was completed late.	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 6 5. Res #4 was admitted to the facility on 10/17/20 with diagnoses which included weakness, HTN, pain and atrial fibrillation. There was no documentation a resident admission assessment was completed. There was no documentation a resident annual assessment was completed in 2022. On 06/06/23 at 11:43 a.m., the administrator/DON was asked to locate documentation an admission assessment and annual assessment for 2022 had been completed. On 06/06/23 at 11:59 a.m., the administrator/DON stated they could not locate documentation the assessments had been completed. They stated they should have been completed.	C 522		
C 531 SS=D	310:663-5-3(a) ASSESSMENT FORM (a) The admission assessment form shall include but not be limited to the following: (1) resident's identification; (2) disease diagnosis/infections; (3) mental health history, and mental retardation or developmental disability; (4) physical functioning which includes the numbers of persons needed to assist with activities of daily living; (5) incontinence; (6) medications; (7) special treatment and procedures;	C 531		

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C 531	Continued From page 7 (8) cognitive function; and (9) signatures and dates. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure admission assessments contained all required components for one (#6) of eight sampled residents reviewed for admission assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 47 residents resided in the facility. Findings: Res #6 had diagnoses which included HTN, atrial fibrillation, CKD, DVT, CVA, and PVD. A resident admission assessment, dated 05/26/23, documented the components of the assessment including infections, physical functioning, and signature of resident or representative interviewed had not completed. On 06/05/23 at 2:27 p.m., the administrator/DON and corporate nurse consultant #1 were shown the resident's admission assessment. They were asked if all of the components of the assessment were completed. They stated they should have been.	C 531		
C 913 SS=D	310:663-9-1(3) NURSE Each assisted living center shall	C 913		

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C 913	Continued From page 8 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: (3) documenting the resident's living will or "Do Not Resuscitate Order." This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a DNR was documented for one (#3) of nine sampled residents reviewed for code status. The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 47 residents resided in the facility. Findings: Res #3 admitted to the facility on 12/28/21 with diagnoses which included CHF, HTN, HLD, and hypothyroidism. An Oklahoma do-not-resuscitate (DNR) form, dated 09/13/22, documented Res #3's witnessed signature.	C 913		

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C 913	Continued From page 9 On 06/05/23 at 2:07 p.m., Res #3's chart was reviewed and documented code status as full code. On 06/05/23 at 2:53 p.m., the administrator/DON stated code status was documented on the spine of the chart and the first page of the chart. They were shown the chart for Res #3. They stated the resident was a full code. They were shown the signed DNR form and stated they were unaware Res #3 had elected a DNR. A physician order, dated 06/06/23, documented Res #3's code status as DNR.	C 913		
C 921 SS=D	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication orders were reviewed monthly by a RN for one (#3) of nine sampled residents whose medications were reviewed. The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 47 residents resided in the facility.	C 921		

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 C 06/06/2023
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 921	Continued From page 10 Findings: Res #3 admitted to the facility on 12/28/21 with diagnoses which included CHF, HTN, HLD, and hypothyroidism. An order summary for May 2023 did not document a signature from a RN. On 06/05/23 at 4:00 p.m., the administrator/DON was shown the May 2023 order summary. They stated the signatures on the form were their own and the physician. They stated the RN should review and sign orders monthly. They stated there was not a signature from a RN.	C 921		
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.	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 11 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 record review and interview, the facility failed to ensure medications were administered as ordered for three (#2, 4 and #9) of nine sampled residents reviewed for medications. The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 47 residents resided in the facility. Findings: 1. Res #2 had diagnoses which included allergies, stroke, HTN, diabetes, and hyperlipidemia. Physician orders, dated 06/18/21, documented cetirizine HCL (antihistamine medication) 10 mg tab one tab by mouth daily; clopidogrel bisulfate (antiplatelet medication) 75 mg one tab by mouth daily; and losartan potassium (angiotensin receptor blocker) 100 mg one tab my mouth daily.	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 12 Physician orders, dated 03/15/22, documented metformin HCL (antidiabetic medication) 500 mg one tab by mouth every morning with breakfast; and simvastatin (statin) 5 mg one tab by mouth daily. The September 2022 MAR documented cetirizine HCL, clopidogrel bisulfate, losartan potassium, metformin HCL, and simvastatin were not administered 23 out of 30 opportunities. The administration for the medications were blank. The October 2022 MAR documented cetirizine HCL, clopidogrel bisulfate, losartan potassium, metformin HCL, and simvastatin were not administered 10 out of 10 opportunities. The administration for the medications were blank. On 06/06/23 at 10:58 a.m., the administrator/DON was asked what blanks for medication administration indicated on the MAR. They stated staff did not document they administered the medication. They were shown the resident's MAR where there were blanks. They stated they were not able to verify the medications were administered. 2. Res #4 had diagnoses which included pain. A physician order, dated 03/15/23, documented tramadol HCL (pain medication) 100 mg tab three times a day. The May 2023 MAR and narcotic record documented tramadol was not administered two out of three opportunities on 05/07/23. On 06/06/23 at 2:20 p.m., the administrator/DON was shown the resident's physician order, MAR,	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 13 and narcotic record. They stated the medication was not administered as ordered. 3. An undated "Medication Administration and Management" policy, documented in part "...Medications will be administered to the resident at the time they are ordered within one-hour before or after the time due..." Res #9 had diagnoses which included atrial fibrillation, CHF, GERD, pain, insomnia, and anxiety. A physician order, dated 10/05/21, documented to administer aspirin 81 mg daily at 11:00 a.m. A physician order, dated 10/05/21, documented to administer digoxin 125 mcg daily at 11:00 a.m. Hold if pulse less than 60. A physician order, dated 10/05/21, documented to administer apixaban 2.5 mg two times per day at 11:00 a.m. and 7:00 to 10:00 p.m. A physician order, dated 10/05/21, documented to administer meloxicam 7.5 mg daily at 11:00 a.m. A physician order, dated 10/07/21, documented to administer potassium chloride ER 10 meq daily at 11:00 a.m. A physician order, dated 10/07/21, documented to administer Coreg 1.25 mg two times per day at 11:00 a.m. and 7:00 p.m. to 10:00 p.m. A physician order, dated 10/07/21, documented to administer lisinopril 2.5 mg daily at 11:00 a.m. A physician order, dated 04/14/22, documented to administer tramadol HCL 50 mg two times per	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 14 day at 11:00 a.m. and 7:00 p.m. to 10:00 p.m. A physician order, dated 04/14/22, documented to administer docusate 100 mg two times per day at 11:00 a.m. and 7:00 to 10:00 p.m. A physician order, dated 12/05/22, documented to administer citalopram 10 mg daily at 11:00 a.m. A physician order, dated 03/28/23, documented to administer furosemide 40 mg daily at 11:00 a.m. On 06/05/23 at 12:30 p.m. CMA #1 was observed during medication pass. CMA #1 was observed collecting the following medications for Res #9: a) one aspirin 81 mg b) one citalopram 10 mg c) one digoxin 0.125 d) one docusate 100 mg e) one eliquis 2.5 mg f) two furosemide 20 mg g) one lisinopril 2.5 mg h) one meloxicam 7.5 mg i) one potassium 10 meq On 06/05/23 at 12:43 p.m. CMA #1 was observed removing the lisinopril 2.5 mg from the cup. CMA #1 was not observed to circle the held medication on the MAR or documenting a reason the medication was held. The CMA administered the remaining medications to Res #9. On 06/06/23 at 12:19 p.m. CMA #1 was observed during medication pass. CMA #1 was observed collecting and administering the following medications to Res #9: a) one aspirin 81 mg b) one citalopram 10 mg	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 15 c) one digoxin 0.125 mg d) one docusate 100 mg e) one eliquis 2.5 mg f) two furosemide 20 mg g) one lisinopril 2.5 mg h) one meloxicam 7.5 mg i) one potassium 10 meq j) one coreg 3.125 mg k) one tramadol 50 mg On 06/06/23 at 12:35 p.m., CMA #1 was asked when Res #9's medication were due, they stated at 11:00 a.m. They were asked if the medications were administered on time on 06/05/23 and 06/06/23, they stated no they were not. The CMA was asked what the hold parameters for the lisinopril 2.5 mg were for the resident, they observed the MAR and stated there were none. The CMA was asked if they should have held the medication on 06/05/23, they stated no.	C1505		
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	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 16 prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure: a. medications were administered within one hour before or after the scheduled time for one (#4 and #9), and b. medications were accurately documented as administered for four (#2, 4, and #6) of nine sampled residents reviewed for medications. The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 47 residents resided in the facility. Findings: 1. Res #2 had diagnoses which included stroke, HTN, and diabetes. Physician orders, dated 06/18/21, documented clopidogrel bisulfate (antiplatelet medication) 75 mg one tab by mouth daily; and losartan potassium (angiotensin receptor blocker) 100 mg one tab my mouth daily. A physician order, dated 03/15/22, documented metformin HCL (antidiabetic medication) 500 mg one tab by mouth every morning with breakfast. The September 2022 MAR documented clopidogrel bisulfate, losartan potassium, and	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 17 metformin HCL were not administered on 09/17/22, 09/19/22, and 09/23/22. There were circled staff initials and no documented reason the medications were not administered. On 06/06/23 at 10:58 a.m., the administrator/DON was asked what circled staff initials indicated on the MAR. They stated it indicated the medication was not in the building or the resident was out of the facility. They stated there should be documentation on the back of the MAR for the reason the medication was not administered. They were shown the resident's MAR. They stated staff should have documented the reason the medications were not administered. 2. Res #4 had diagnoses which included pain. A physician order, dated 05/02/22, documented Norco (pain medication) 5-325 mg one tab by mouth every four hours as needed. A physician order, dated 03/15/23, documented tramadol HCL (pain medication) 100 mg one tab by mouth three times a day. The MAR documented the frequency of the medication administration was 7:00 a.m. - 10:00 a.m., 12:00 p.m., and 7:00 p.m. - 10:00 p.m. The April 2023 MAR and narcotic record were reviewed and documented Norco was administered on the narcotic record, but not on the MAR 15 out of 27 opportunities. The May 2023 MAR and narcotic records were reviewed and documented the following: a. Norco was administered on the narcotic record, but not on the MAR two out of three	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 18 opportunities, and b. tramadol was administered more than one hour before or one hour after the scheduled frequency 24 out of 93 opportunities. The June 2023 MAR and narcotic records were reviewed and documented tramadol was administered more than one hour before or one hour after the scheduled frequency three out of 17 opportunities. On 06/06/23 at 2:20 p.m., the administrator/DON was asked what was the protocol for medication administration. They stated medications could be administered one hour before or one hour after the scheduled time. They stated medications should be documented on both the MAR and narcotic record if applicable. They were shown the resident's MAR and narcotic records where the documentation was not accurate for medication administration and where medications were not administered at the scheduled frequency. 3. Res #6 had diagnoses which included CVA, HLD, and vitamin B-1 deficiency. Physician orders, dated 05/20/23, documented aspirin (nonsteroidal anti-inflammatory medication) 81 mg one tab by mouth daily; atorvastatin calcium (statin) 20 mg one tab by mouth at HS; folic acid (vitamin) 1 mg tab by mouth daily; and thiamine vitamin B-1 (vitamin) 100 mg one tab by mouth daily. The June 2023 MAR documented circled staff initials and no reason the following medications were not administered for aspirin, folic acid, and thiamine vitamin B-1 06/01/23 through 06/02/23,	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 19 and atorvastatin 06/01/23 through 06/02/23. On 06/05/23 at 2:51 p.m., the administrator/DON was asked what circled staff initials indicated on the MAR. They stated it indicated the medication was not in the building or the resident was out of the facility. They stated there should be documentation on the back of the MAR the reason the medication was not administered. They were shown the resident's MAR. They stated staff should have documented the reason the medications were not administered. 4. An undated "Medication Administration and Management" policy, documented in part "...Medications will be administered to the resident at the time they are ordered within one-hour before or after the time due..." Res #9 had diagnoses which included atrial fibrillation, CHF, GERD, pain, insomnia, and anxiety. A physician order, dated 10/05/21, documented to administer aspirin 81 mg daily at 11:00 a.m. A physician order, dated 10/05/21, documented to administer digoxin 125 mcg daily at 11:00 a.m. Hold if pulse less than 60. A physician order, dated 10/05/21, documented to administer apixaban 2.5 mg two times per day at 11:00 a.m. and 7:00 to 10:00 p.m. A physician order, dated 10/05/21, documented to administer meloxicam 7.5 mg daily at 11:00 a.m. A physician order, dated 10/07/21, documented to administer potassium chloride ER 10 meq daily at 11:00 a.m.	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 20 A physician order, dated 10/07/21, documented to administer Coreg 1.25 mg two times per day at 11:00 a.m. and 7:00 p.m. to 10:00 p.m. A physician order, dated 10/07/21, documented to administer lisinopril 2.5 mg daily at 11:00 a.m. A physician order, dated 04/14/22, documented to administer tramadol HCL 50 mg two times per day at 11:00 a.m. and 7:00 p.m. to 10:00 p.m. A physician order, dated 04/14/22, documented to administer docusate 100 mg two times per day at 11:00 a.m. and 7:00 to 10:00 p.m. A physician order, dated 12/05/22, documented to administer citalopam 10 mg daily at 11:00 a.m. A physician order, dated 03/28/23, documented to administer furosemide 40 mg daily at 11:00 a.m. On 06/05/23 at 12:30 p.m. CMA #1 was observed during medication pass. CMA #1 was observed collecting the following medications for Res #9: a) one aspirin 81 mg b) one citalopram 10 mg c) one digoxin 0.125 d) one docusate 100 mg e) one eliquis 2.5 mg f) two furosemide 20 mg g) one lisinopril 2.5 mg h) one meloxicam 7.5 mg i) one potassium 10 meq On 06/05/23 at 12:43 p.m. CMA #1 was observed removing the lisinopril 2.5 mg from the cup. CMA #1 was not observed to circle the held medication on the MAR or documenting a reason the medication was held. The CMA administered the	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 21 remaining medications to Res #9. On 06/06/23 at 12:19 p.m. CMA #1 was observed during medication pass. CMA #1 was observed collecting and administering the following medications to Res #9: a) one aspirin 81 mg b) one citalopram 10 mg c) one digoxin 0.125 mg d) one docusate 100 mg e) one eliquis 2.5 mg f) two furosemide 20 mg g) one lisinopril 2.5 mg h) one meloxicam 7.5 mg i) one potassium 10 meq j) one coreg 3.125 mg k) one tramadol 50 mg On 06/06/23 at 12:35 p.m., CMA #1 was asked when Res #9's medication were due, they stated at 11:00 a.m. They were asked if the medications were administered on time on 06/05/23 and 06/06/23, they stated no they were not. The CMA was asked what the hold parameters for the lisinopril 2.5 mg were for the resident, they observed the MAR and stated there were none. The CMA was asked if they should have held the medication on 06/05/23, they stated no.	C1923		
C1952 SS=D	310:663-19-3(b) MAINTENANCE OF RECORDS (b) Each resident's records shall be retained for at least five (5) years after the resident's transfer, discharge or death. Destruction of records shall be done in a manner to preserve resident confidentiality.	C1952		

Oklahoma State Department of Health

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C1952	Continued From page 22 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain resident records for at least five years for one (#1) of nine sampled residents whose records were reviewed. Findings: The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 47 residents resided in the facility. On 06/05/23 at 11:18 a.m., the administrator/DON was notified of need for Res #1's records. On 06/05/23 at 2:45 p.m., the administrator/DON provided a manilla envelope labeled with Res #1's name, physician, room number, and admission date. The administrator/DON stated the envelope contained the only records for Res #1 that could be located. The envelope contained five pages of physician orders and nine pages of physician visit notes. On 06/06/23 at 09:48 the administrator/DON was asked to check the records for any additional information for Res #1 including incident reports. On 06/06/23 at 10:38 a.m., the administrator/DON stated no additional records could be located.	C1952		

Delivery via email to: admin@meadowlakeretirement.com

August 7, 2023

License Number: AL1411

Ms. Brytnea Hollman, Administrator
Meadowlakes Retirement Village
963 SW 107th
Oklahoma City, OK 73170

Survey Event ID: HERG11

Dear Ms. Hollman:

On **June 6, 2023**, a Relicensure survey and a complaint investigation were 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 have been corrected and you were in substantial compliance by **July 19, 2023**.

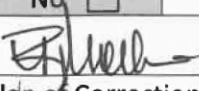
We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

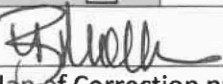
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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 7/3/2023		
	Facility Name: Meadowlake Retirement Village		
	License Number: AL1411		
	Survey Event ID: HERG11		
			Date Survey Completed: 6/6/2023
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C391		Based on: observation and interview, the facility failed to ensure: the diningroom/kitchen and food service equipment were kept clean and maintained in good repair, food products were dated, and liquid products were labeled.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Preparation and/or execution of this Plan of Correction is not an admission or agreement by the provider of the truth of the allegations set forth on the statement of deficiencies. This Plan of Correction is prepared and executed solely as it is required by State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance.			
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?		The Dietary Manager will audit food storage for appropriate labels and dates and cleanliness immediately and correct any issues identified.	
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 that reside in the facility have the potential to be affected by the same deficient practice.	
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?		RD will educate the dietary manager and the manager will educate the dietary department. The dietary department will be educated on requirements for food storage and cleaning requirements.	
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.		Enter methods to ensure corrections are sustained: The Dietary Manager will audit food storage areas daily until all areas are clean and addressed and then will audit weekly for 90 days. QAPI now and quarterly Schedules will be made for cleaning and auditing for proper labeling of food. Copies of the audit will be submitted and kept in the QAPI committee binder.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/19/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Brytna Hollman 			Date 7/3/2023
OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	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.

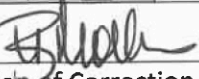
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	Facility Name: Meadowlake Retirement Village		
	License Number: AL1411		
	Survey Event ID: HERG11		
Date Survey Completed: 6/6/2023			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C522	Based on: record review and interview, the facility failed to ensure comprehensive assessments were completed every 12 months for five (#2, 3, 4, 5, and 7) of eight sampled residents reviewed for annual assessments.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
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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?		DON/designee will audit charts for identified residents #2,3,4,5, and 7 to ensure assessments are completed and placed in the residents record.	
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 who reside in the facility have the potential to be affected by this alleged deficient practice.	
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?		RN consultant will educate DON and ADON on assessment schedule and on what's needed for annual assessments.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Enter methods to ensure corrections are sustained:	
a. How the correction will be evaluated for effectiveness;		DON/designee will complete random audits of medical records for appropriate clinical assessments weekly for 90 days, and will complete all assessment due and place them into the residents' records according to the assessment schedule.	
b. How the correction will be incorporated into the center's quality assurance system; and		QAPI now and then quarterly.	
c. How monitoring records will be kept to evidence the correction.		All assessments will be retained in the resident's designated file, and copies of the audits will be submitted and kept in the QAPI committee binder.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/19/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Brytnea Hollman  OAC 310:663-25-4(F)			Date 7/3/2023
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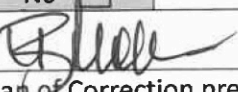
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	Survey Event ID: HERG11		
			Date Survey Completed: 6/6/2023
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C531		Based on: record review and interview, the facility failed to ensure admission assessments contained all required components for one (#6) of eight sampled residents reviewed for admission assessments.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
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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?		DON/designee will complete all components of the assessment; including signatures for the identified resident.	
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 residing in the facility have the potential to be affected by the same deficient practice be identified.	
OSDH Response: Element accepted Yes ☐ No ☐			
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		The Regional Nurse will educate the DON and ADON on admission assessment requirements.	
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.		Enter methods to ensure corrections are sustained: DON/designee will review all new assessments, annual, and significant changes as needed. QAPI findings now and quarterly All records will be kept in a designated area in the facility for review, and copies of the audit will be submitted and kept in the QAPI committee binder.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/19/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Brytna Hollman 			Date 7/3/2023
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SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C913		Based on: record review and interview, the facility failed to ensure a DNR was documented for one (#3) of nine sampled residents reviewed for code status.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
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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?		All residents' records will be reviewed for appropriate code status, appropriate paperwork, and that correct orders are documented in the residents' records.	
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 residing in the facility have the potential to be affected by the same deficient practice.	
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?		Regional nurse will educate DON and ADON for appropriate paperwork and code status orders needs.	
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.		Enter methods to ensure corrections are sustained: DON/designee will audit random records weekly for appropriate code status and orders and paperwork for 90 days. QAPI now and quarterly. Copies of the audit will be submitted and kept in the QAPI committee binder.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/19/2023	
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