
Delivery via email to: admin@meadowlakeretirement.com; survey@stonegatesl.com

September 4, 2024

License Number: AL1411

Ms. Lisa Winter, Administrator
Meadowlakes Retirement Village
963 Sw 107th
Oklahoma City, OK 73170

RE: Survey Event ID: DHH411

Dear Ms. Winter:

On **August 15, 2024**, agents from our office concluded a State Licensure survey along with a complaint investigation 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 **August 15, 2024**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully,



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

Enclosure

INVESTIGATIVE REPORT

Facility: Meadowlakes Retirement Village
Address: 963 SW 107th
City, State, Zip: Oklahoma City, OK, 73170
Provider #: AL1411
Complaint #: OK00065951
Investigation Dates: 08/12/24 through 08/15/24

ALLEGATIONS
1.The center failed to ensure residents' property was not misappropriated.
2.The center failed to have and/or implement an effective pharmacy policy and procedure to ensure medications were administered according to the physicians' orders.
3.The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 08/12/2024 at 12:00 p.m.

A sample of 13 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 of the center were conducted throughout the survey. The center was observed for adequate staff to meet the needs of the residents. Staff were observed for providing assistance to residents according to their contracts and service plans, and medication administration.

Resident records were reviewed including assessments, care plans, contracts, physician orders, nurse progress notes, and medication reports. Center policy and procedures, incident reports, in-services, and personnel files were reviewed.

Residents and staff were interviewed and asked about medications, misappropriation of property, and staffing.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 08/19/2024

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 08/15/2024
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

MEADOWLAKES RETIREMENT VILLAGE **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
D 000	INITIAL COMMENTS A relicensure survey was conducted on 08/12/24 through 08/15/24 Complaint investigation (#OK00065951) was conducted in conjunction with the survey. Facility Census: 51 Listed below are abbreviations that will be used throughout this document. DM - dietary manager	D 000		
D 521 SS=D	317:30-5-763(D)(ii)(I) SANITATION (I) The ALC must maintain the facility, including its individual units, that is clean, safe, sanitary, insect and rodent free, odorless, and in good repair at all times. This Rule is not met as evidenced by: Based on observation and interview, the center failed to ensure the kitchen was maintained in good repair. The administrator identified 16 residents who were Advantage program members. Findings: On 08/12/24 at 12:23 p.m., a tour of the dining room and kitchen was conducted. The following observations were made. a. ceiling lights were burned out and/or not working, b. there were brown water marks on the ceiling tiles. Ceiling tiles were hanging down,	D 521		

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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D 521	Continued From page 1 c. the hot water was shut off at the hand sink due to the knob on the faucet not shutting off the water, d. the metal on the spray nozzle hose was torn and the rubber was exposed. There was water leaking from the hose. The hot water knob was missing on the faucet, e. the gasket on the walk in cooler door was split at the bottom of the door, f. there was ice buildup on the walk in freezer door and the door would not close properly. The gasket on the door was split, and g. one of two gaskets were split on the two door reach in cooler. On 08/12/24 at 2:16 p.m., the DM was asked how staff ensured the kitchen was maintained in good repair. They stated they submitted a form to the maintenance department for repairs. They were shown the above observations.	D 521		
C 000	INITIAL COMMENTS A relicensure survey was conducted on 08/12/24 through 08/15/24 Complaint investigation (#OK00065951) was conducted in conjunction with the survey. Facility Census: 51 Listed below are abbreviations that will be used throughout this document. CHF - congestive heart failure	C 000		

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C 000	Continued From page 2 CMA - certified medication aide CVA - cerebrovascular accident DM - dietary manager DON - director of nursing DR - delayed release ER - extended release GERD - gastroesophageal reflux disease HCL - hydrochloride HTN - hypertension MAR - medication administration record mcg - microgram NSAID - nonsteroidal anti-inflammatory drug OSDH - Oklahoma State Department of Health QA - quality assurance Res - resident RN - registered nurse SOB - shortness of breath tab - tablet	C 000		
C 391 SS=D	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 center failed to ensure the kitchen was maintained in good repair. The administrator identified 51 residents resided in the center. Findings: On 08/12/24 at 12:23 p.m., a tour of the dining	C 391		

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C 391	Continued From page 3 room and kitchen was conducted. The following observations were made. a. ceiling lights were burned out and/or not working, b. there were brown water marks on the ceiling tiles. Ceiling tiles were hanging down, c. the hot water was shut off at the hand sink due to the knob on the faucet not shutting off the water, d. the metal on the spray nozzle hose was torn and the rubber was exposed. There was water leaking from the hose. The hot water knob was missing on the faucet, e. the gasket on the walk in cooler door was split at the bottom of the door, f. there was ice buildup on the walk in freezer door and the door would not close properly. The gasket on the door was split, and g. one of two gaskets were split on the two door reach in cooler. On 08/12/24 at 2:16 p.m., the DM was asked how staff ensured the kitchen was maintained in good repair. They stated they submitted a form to the maintenance department for repairs. They were shown the above observations.	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:	C 522		

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C 522	Continued From page 4 (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 record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for two (#1 and #10) of 10 sampled residents reviewed for comprehensive assessments. The administrator identified 51 residents resided in the center. Findings: 1. Res #1 was admitted to the center on 10/01/17 with diagnoses which included HTN, hyperlipidemia, osteoporosis, hypothyroidism, and CVA with right hemiplegia. It was documented the last comprehensive assessment was completed on 06/30/22. On 08/14/24 at 12:16 p.m., the DON stated there was no documentation a comprehensive assessment was completed for the resident in 2023 or 2024. They stated a comprehensive assessment should be completed annually. 2. Res #10 was admitted to the facility on 06/15/22 with diagnoses which included neuropathy, diabetes mellitus, HTN, and vitamin D deficiency.	C 522		

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C 522	Continued From page 5 It was documented the last comprehensive assessment was completed on 05/24/22. On 08/14/24 at 12:20 p.m., the DON stated they were not able to find a comprehensive assessment completed in 2023 or 2024.	C 522			
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to coordinate an assessment with the signature of a RN or the resident's personal physician for one (#3) of 10 sampled residents reviewed for assessments. The administrator identified 51 residents resided in the center. Findings: Res #3's comprehensive assessment, dated 05/27/24, was not coordinated and signed by a RN or the resident's personal physician. On 08/14/24 at 10:27 a.m., the DON was asked what indicated an assessment was coordinated by the RN or the resident's physician. They stated they were not sure. They were shown where Res #3's assessment was not signed by the RN or resident's physician.	C 542			

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C 952 SS=D	310:663-9-5(b) STAFF QUALIFICATIONS (b) Each assisted living center shall ensure that staff members providing socialization, activity, and exercise services are qualified by training. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure the designated activities staff member was qualified by training to provide activities. The administrator identified 51 residents resided in the center. Findings: An undated staff roster identified the designated activities staff member was hired on 05/29/24. There was no documentation the designated activities staff member had received training to	C 952		

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C 952	Continued From page 7 provide activities. On 08/13/24 at 11:50 a.m., the administrator stated they had no documentation the designated activities staff member had received training to provide activities. They stated they had a resume.	C 952		
C1120 SS=D	310:663-11-2 QUALITY ASSURANCE REPRESENTATIVES The quality assurance committee shall include at least the following: (1) registered nurse or physician if a medical problem is to be monitored or investigated; (2) assisted living center administrator; (3) direct care staff person or a staff person who has responsibility for administration of medications; and (4) pharmacist consultant if a medication problem is to be monitored or investigated. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure the administrator was included in the QA meetings. The administrator identified 51 residents resided in the center. Findings: QA meeting sign in sheets for August 2023, December 2023, March 2024, and June 2024 were reviewed. There was no documentation the administrator was present at the March 2024	C1120		

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C1120	Continued From page 8 meeting. On 08/13/24 at 1:07 p.m., the administrator was shown the QA meeting sign in sheet for March 2024. They were asked to verify there was no signature the administrator at that time was present during the meeting. They stated they did not see where they signed they were present.	C1120		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure medications were administered as ordered for five (#1, 3, 4, 11, and #12) of 10 sampled residents reviewed for medications. The administrator identified 51 residents resided in the center. Findings: A "Medication Ordering and Receipt" policy, dated June 2012, documented refill requests were to be made when a seven day supply remained to allow for timely refill of the prescription. 1. Res #1 had diagnoses which included hypercholesterolemia, diabetes, HTN, and CVA. Physician orders, dated 03/31/16, documented atorvastatin (statin medication) 80 mg daily at noon; and vitamin D3 (vitamin D analog medication) 5,000 unit capsule daily at noon. Physicians orders, dated 12/27/17, documented amlodipine besylate (calcium channel blocker medication) 10 mg tab daily; and hydralazine (vasodilator medication) 25 mg three times daily.	C1505		

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C1505	Continued From page 10 Physicians orders, dated 01/30/18, documented aspirin (salicylate medication) 81 mg tab daily; and clopidogrel (antiplatelet medication) 75 mg daily. A physician order, dated 07/19/21, documented metformin HCL (biguanide medication) 500 mg daily. The July 2024 MAR was reviewed. There were blanks and circled staff initials with documentation they were waiting on the medication. It was documented amlodipine besylate was not administered one out of 31 opportunities; aspirin was not administered one out of 31 opportunities; atorvastatin was not administered three out of 31 opportunities; clopidogrel was not administered two out of 31 opportunities; hydralazine was not administered two out of 93 opportunities; metformin HCL was not administered one out of 31 opportunities; and vitamin D3 was not administered two out of 31 opportunities. On 08/14/24 at 2:50 p.m., the DON was shown the resident's MARs where the resident's medications had not been administered. They stated staff should document when they administer medications. They stated if a medication was not administered there should be a reason documented on the back of the MAR 2. Res #3 had diagnoses which included vitamin deficiency, dry eyes, edema, HTN, and GERD. Physicians orders, dated 05/18/22, documented ascorbic acid (antioxidant medication) 1000 mcg one tab daily; aspirin 81 mg one tab daily; isosorbide mononitrate (nitrate medication) 20 mg tab daily; and omeprazole DR (proton-pump	C1505			

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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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C1505	Continued From page 11 inhibitor medication) 20 mg capsule. A physician order, dated 06/19/22, documented furosemide (diuretic medication) 20 mg tab daily. Physicians orders, dated 08/07/22, documented Refresh Optive gel (ophthalmic lubricant) instill one line of gel in each eye at bedtime; and Refresh Tears (ophthalmic lubricant) instill one drop in each eye three times daily. A physician order, dated 06/14/24, documented metoprolol (beta blocker medication) 50 mg tab twice daily. The July 2024 MAR was reviewed. There were blanks, circled staff initials with no reason the medications were not administered, and/or documentation they were waiting on medications. It was documented ascorbic acid was not administered one out of 31 opportunities; aspirin was not administered 13 out of 31 opportunities; Refresh Optive was not administered two out of 31 opportunities; Refresh Tears was not administered 61 out of 93 opportunities; metoprolol was not administered 57 out of 62 opportunities; furosemide was not administer two out of 31 opportunities; isosorbide mononitrate was not administered 18 out of 31 opportunities; and omeprazole DR was not administered two out of 31 opportunities. On 08/14/24 at 2:45 p.m., the DON was shown the resident's MARs where the resident's medications had not been administered. They stated staff should document when they administer medications. They stated if a medication was not administered there should be a reason documented on the back of the MAR.	C1505		

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 08/15/2024
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
C1505	Continued From page 12 3. Res #4 had diagnoses which included diabetes mellitus, pain, overactive bladder, GERD, allergies, depression, Parkinson's disease, insomnia, anxiety, and hyperlipidemia. Physician orders, dated 02/02/24, documented glipizide (sulfonylurea medication) 5 mg tab daily; naproxen (NSAID medication) 500 mg tab twice a day; oxybutynin chloride ER (anticholinergic medication) 10 mg tab daily; pantoprazole sodium (proton-pump inhibitor medication) 40 mg tab daily; pioglitazone HCL (thiazolidinedione medication) 30 mg tab daily; cetirizine HCL (antihistamine medication) 10 mg tab daily; escitalopram (antidepressant medication) 5 mg tab daily; ropinirole HCL (dopamine receptor agonists medication) 0.25 mg tab at bedtime; venlafaxine HCL ER (antidepressant medication) 150 mg capsule daily; and atorvastatin 20 mg tab every morning. A physician order, dated 03/15/24, documented trazadone (serotonin-antagonist and reuptake-inhibitor medication) 50 mg tab at bedtime. A physician order, dated 03/21/24, documented buspirone HCL (anxiolytic medication) 30 mg tab twice daily. The July 2024 MAR was reviewed. There were blanks, circled staff initials with no reason the medications were not administered, and/or documentation they were waiting on medications. It documented glipizine was not administered six out of 31 opportunities; naproxen was not administered two out of 62 opportunities; oxybutynin chloride ER was not administered 10 out of 31 opportunities; pantoprazole sodium was not administered one out of 31 opportunities;	C1505		

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 08/15/2024
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
C1505	Continued From page 13 pioglitazine HCL was not administered one out of 31 opportunities; cetirizine HCL was not administered one out of 31 opportunities; escitalopram was not administered nine out of 31 opportunities; ropinirole HCL was not administered one out of 31 opportunities; trazadone was not administered eight out of 31 opportunities; venafaxine HCL was not administered 10 out of 31 opportunities; atorvastatin was not administered two out of 31 opportunities; and buspirone HCL was not administered 16 out of 62 opportunities. On 08/14/24 at 10:32 a.m., the DON was shown the resident's MARs where the resident's medications had not been administered. They stated staff should document when they administer medications. They stated if a medication was not administered there should be a reason documented on the back of the MAR. 4. Res #11 had diagnoses which included CHF, SOB, and eye health. A physician order, dated 03/27/24, documented PreserVision AREDS tab twice daily. A physician order, dated 06/05/24, documented Trelegy Ellipta (respiratory medication) 100-62.5-25 inhale once daily. A physician order, dated 06/20/24, documented torsemide (diuretic) 10 mg 2 tabs every day. On 08/13/24 at 7:10 a.m., CMA #1 was observed administering the resident their morning medications. They were not observed to have administered the resident's PreserVision AREDS, Trelegy Ellipta, or torsemide as scheduled.	C1505		

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 08/15/2024
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
C1505	Continued From page 14 5. Res #12 had diagnoses which included constipation. A physician order, dated 02/28/24, documented Senna Plus (stimulant laxative) 8.6-50 mg tab daily. On 08/13/24 at 7:23 a.m., CMA #1 was observed administering the resident their morning medications. They were not observed to have administered the resident's Senna Plus as scheduled. On 08/14/24 at 8:58 a.m., the DON was asked to review the Res #11's and Res #12's MARs for August 2024. There were circled initials on the MARs with no reason the medications were not administered. The DON stated there should have been a reason documented on the back of the MARs. They were asked to verify the reason the medications were not administered. They were asked what was protocol for reordering medications. They stated they would have to check. On 08/14/24 at 10:15 a.m., the DON stated the medications were overlooked on the medication cart and/or they needed to re-order the medications. They provided the written policy for re-ordering medications.	C1505		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to	C1911		

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 08/15/2024
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
C1911	Continued From page 15 the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure an incident report was submitted to OSDH within one business day for one (#3) of 10 sampled residents reviewed for incidents. The administrator identified 51 residents resided in the center. Findings: Res #3 had diagnoses which included depression, CHF, and insomnia. A combined initial and final incident report, dated	C1911		

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 08/15/2024
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
C1911	Continued From page 16 05/27/24, documented the center received a call from local law enforcement that the resident was seen riding their motor scooter down the street. It was documented the resident and their motor scooter were transported back to the center. It was documented the resident was assessed, placed on one on one, their motor scooter was removed from the resident per the resident's legal representative, and their care plan was updated. It was documented the incident report was submitted to OSDH on 05/29/24. On 08/13/24 at 1:07 p.m., the administrator was asked what was the time frame for submitting initial reports to OSDH. They stated one business day. They were shown where the combined initial and final incident report for the resident was not submitted within one business day.	C1911			

Delivery via email to: admin@meadowlakeretirement.com; survey@stonegatesl.com

September 30, 2024

License Number: AL1411

Lisa Winter, Administrator
Meadowlakes Retirement Village
963 Sw 107th
Oklahoma City, OK 73170

RE: Survey Event DHH411

Dear Ms. Winter:

On **August 15, 2024**, a Licensure inspection with a complaint investigation 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 **October 2, 2024**.

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,



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

Enclosure



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/6/2013

Facility Name: Meadowlakes Retirement Village

License Number: AL1411

Survey Event ID: DHH411

Date Survey Completed: 8/15/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: D 521

Based on: observation and interview, the center failed to ensure the kitchen was maintained in good repair.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The dietary manager and maintenance supervisor have been inserviced on how to communicate kitchen maintenance needs. Ceiling lights and ceiling tiles purchased 9/5/2024. The hand washing sink was fixed on 08/16/2024. The hot water is now turned on and the knob on the faucet is shutting off water. The spray nozzle hose and hot water knob on dish washing sink was replaced on 09/9/2024. The gasket for the walk in cooler and walk in freezer will be replaced. Stainless steel door closers were purchased on 9/5/2024 for the walk in cooler and freezer which will prevent the ice build up on the freezer door. Two gaskets were replaced on the two door reach in cooler on 09/11/2024.

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 are served from the kitchen could be affected by this alleged area of non-compliance.

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 dietary manager will be inserviced on monitoring items for maintenance and requesting replacements or repair PRN.

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

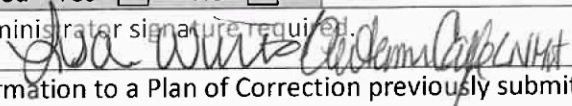
- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

The kitchen checklist will be utilized to audit the kitchen weekly X4 weeks (for improvement needs) then monthly and prn per normal kitchen procedures. Any issues identified in need of maintenance repair will be placed in the maintenance request book.

The Administrator will review the kitchen audit weekly x 4 weeks, then monthly to ensure requests are placed and take care of timely.

		The Administrator will review the maintenance request book weekly x4 weeks then monthly to ensure requests are placed and taken care of timely.	
		QAPI now and Quarterly	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/2/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)		Administrator signature required <i>Ava White</i>	Date 9/18/2024
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 9/6/2013	
	Facility Name: Meadowlakes Retirement Village	
	License Number: AL1411	
	Survey Event ID: DHH411	
		Date Survey Completed: 8/15/2024
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 391	Based on: observation and interview, the center failed to ensure the kitchen was maintained in good repair.	
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 and maintenance supervisor have been inserviced on how to communicate kitchen maintenance needs. Ceiling lights and ceiling tiles purchased 9/5/2024. The hand washing sink was fixed on 08/16/2024. The hot water is now turned on and the knob on the faucet is shutting off water. The spray nozzle hose and hot water knob on dish washing sink was replaced on 09/9/2024. The gasket for the walk in cooler and walk in freezer will be replaced. Stainless steel door closers were purchased on 9/5/2024 for the walk in cooler and freezer which will prevent the ice build up on the freezer door. Two gaskets were replaced on the two door reach in cooler on 09/11/2024.
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 are served from the kitchen could be affected by this alleged area of non-compliance.
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 dietary manager will be inserviced on monitoring items for maintenance and requesting replacements or repair PRN.
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.		The kitchen checklist will be utilized to audit the kitchen weekly X4 weeks (for improvement needs) then monthly and prn per normal kitchen procedures. Any issues identified in need of maintenance repair will be placed in the maintenance request book. The Administrator will review the kitchen audit weekly x 4 weeks, then monthly to ensure requests are placed and take care of timely.

		The Administrator will review the maintenance request book weekly x4 weeks then monthly to ensure requests are placed and taken care of timely.	
		QAPI now and Quaterly	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/2/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)		Administrator signature required: 	Date 9/18/2024
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.
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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 9/6/2024		
	Facility Name: Meadowlake Retirement Village		
	License Number: AL1411		
	Survey Event ID: DHH411		
			Date Survey Completed: 8/15/2024
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 522		Based on: record review and interview, the center failed to ensure comprehensive assessments were completed every 12 months for two (#1 and #10) of 10 sampled residents reviewed for comprehensive assessments.	
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?		DON/designee will audit charts for identified residents #1 and #10 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 this community have the potential to be affected by this alleged are of non-compliance	
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 Consultant will inservice the DON and Administrator on the required assessments for each resident residing in the assisted living center.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		An audit of all current residents will be completed to determine that appropriate assessments are completed for each current resident.	
a. How the correction will be evaluated for effectiveness;		The monthly schedule will be made, with all current residents included, for assessment completion.	
b. How the correction will be incorporated into the center's quality assurance system; and		QAPI now and Quarterly	
c. How monitoring records will be kept to evidence the correction.		The Administrator or designee will review the schedule and assessments to ensure they are completed monthly x 3 months.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/2/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required OAC 310:663-25-4(F)		Date 9/18/2024	
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.

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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: [Surveyor](#)

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Facility in Compliance by: [Click here to enter a date.](#)



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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/6/2024

Facility Name: Meadowlake Retirement Village

License Number: AL1411

Survey Event ID: DHH411

Date Survey Completed: 8/15/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 542

Based on: record review and interview, the center failed to coordinate an assessment with the signature of a RN or the resident's personal physician for one (#3) of 10 sampled residents reviewed for assessments.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having 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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required

[Handwritten Signature]

Date 9/18/2024

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.
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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

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Facility in Compliance by: Click here to enter a date.



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/6/2024

Facility Name: Meadowlake Retirement Village

License Number: AL1411

Survey Event ID: DHH411

Date Survey Completed: 8/15/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 952

Based on: record review and interview, the center failed to ensure the designated activities staff member was qualified by training to provide activities.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having 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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.

Date 9/18/2024

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

Addendum Date

Enter a date of addendum.

Submitted by

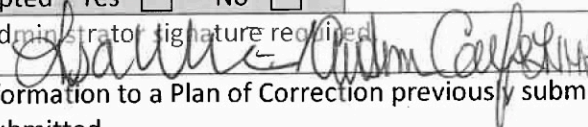
Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: [Surveyor](#)

If Plan of Correction is unacceptable, the reasons are as follows: [Click here to enter text.](#)

Facility in Compliance by: [Click here to enter a date.](#)

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 9/6/2024		
	Facility Name: Meadowlake Retirement Village		
	License Number: AL1411		
	Survey Event ID: DHH411		
			Date Survey Completed: 8/15/2024
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C 1120		Based on: record review and interview, the center failed to ensure the administrator was included in the QA meetings.	
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 facility QAPI committee meetings are current. They will continue QAPI meetings quarterly as required.	
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 this community have the potential to be affected by this alleged are of non-compliance	
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 Director of Operations will inservice the DON and administrator in the required QAPI committee participants.	
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.		The facility will hold an immediate QAPI committee meeting to discuss current deficiencies, then monthly QAPI meetings for 3 months and then resume quarterly meetings and prn thereafter. The RDO or RNC will review QAPI meeting completion and participation monthly for 3 months then quarterly for 1 month. Any identified deficiencies will be corrected immediately with additional training given.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		10/2/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required OAC 310:663-25-4(F) 		Date 9/18/2024	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: [Click here to enter text.](#)

Facility in Compliance by: [Click here to enter a date.](#)



Oklahoma State
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/6/2024

Facility Name: Meadowlake Retirement Village

License Number: AL1411

Survey Event ID: DHH411

Date Survey Completed: 8/15/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1505

Based on: observation, record review, and interview, the center failed to ensure medications were administered as ordered for five (#1, 3, 4, 11, and #12) of 10 sampled residents reviewed for medications.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having 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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The DON will review residents medication administration records for the 5 residents affected and notify residents and physicians of medication administration errors within 7 days.

All residents who reside in this community have the potential to be affected by this alleged area of non-compliance

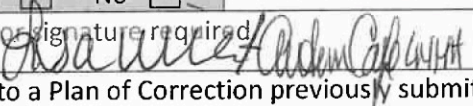
The facility has inserviced the staff who administer medication on the 5 rights of medication administration and on the administration policies and procedures. The medication aids will be inserviced on re-ordering medication timely
The medication aids will be educated to notify the DON and or Administrator if they are unable to administer medication as ordered at the time of the occurrence.

The Facility DON or designee will audit medication administration records weekly.

Any alternate findings related to medication not being administered as ordered will require physician notification within 24 hours of identifying the error.

Medication reorder books will be audited to ensure medications are arriving as ordered. 2 times a week for 2 weeks then weekly for 4 weeks, then monthly for 2 months and prn.

QAPI now and Quarterly

5. On what date will corrective action be completed?		10/2/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required OAC 310:663-25-4(F)		 Date 9/18/2024	
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.
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Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
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Facility in Compliance by: Click here to enter a date.			



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/6/2024

Facility Name: Meadowlake Retirement Village

License Number: AL1411

Survey Event ID: DHH411

Date Survey Completed: 8/15/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1911

Based on: record review and interview, the facility failed to ensure an incident report was submitted OSDH within one business day for the one (#3) of 10 sampled residents reviewed for incidents.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having 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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained?
Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.

Date 9/18/2024

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.

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Facility in Compliance by: [Click here to enter a date.](#)

Delivery via email to: admin@meadowlakeretirement.com; survey@stonegatesl.com

October 11, 2024

License Number: AL1411

Ms. Lisa Winter, Administrator
Meadowlakes Retirement Village
963 Sw 107th
Oklahoma City, OK 73170

RE: Survey Event DHH412

Dear Ms. Winter:

On **October 9, 2024**, an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey with complaint investigations on **August 15, 2024**, have now been corrected effective **October 2, 2024**.

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

Respectfully,



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

Enclosure