OKLAHOMA
State Department
of Health

Delivery via email to: kproctor@cardinalbay.org

January 3, 2023

License Number: AL1412

Ms. Karen Proctor, Administrator
Village On the Park - Oklahoma City
1515 Kingsridge Drive
Oklahoma City, OK 73170

Survey Event ID: 416111

Dear Ms. Proctor:

On **December 21, 2022,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

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

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

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

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

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Village On The Park**
Address: **1515 Kingsridge Drive**
City, State, Zip: **Oklahoma City, OK, 73170**
Provider #: **AL1412**
Complaint #: **OK00059901**
Investigation Date(s): **12/21/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were not neglected	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 12/21/2022 at 9:25 a.m.

A sample of three residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.

Alisha Conley

Clinical Health Facility Surveyor

Date report completed: 12/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1412	A. BUILDING: _____ B. WING _____	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE PARK - OKLAHOMA CITY	1515 KINGSRIDGE DRIVE 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 Complaint investigation #OK00059901 was conducted on 12/21/22. Listed below are abbreviations that will be used throughout this document: ADLs - activities of daily living DON - director of nursing Res - resident	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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	AL1412	A. BUILDING: _____ B. WING _____	12/21/2022

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C1505	Continued From page 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and interview, the center failed to provide safety checks every two hours per the service plan for three (#1, #2, and #3) of three residents reviewed for neglect.

The "Daily Census" documented 20 residents resided in the Memory Care Unit.

Findings:

1. Res #1 was admitted with diagnoses which included dementia, osteoarthritis, atherosclerosis, and chronic gout.

A "Resident Annual Assessment," dated 07/23/22, documented the resident was oriented to self, confused at times, forgetful, and had fair mobility, strength, and gait. The resident required stand by assistance in ambulation with a walker and one person assistance with most ADLs.

A "Service Plan," dated 09/23/22, documented the resident required stand by assistance when transferring and safety checks by staff every two hours.

A "Morse Fall Risk Assessment," dated 09/23/22,

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	AL1412	A. BUILDING: _____ B. WING _____	12/21/2022

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VILLAGE ON THE PARK - OKLAHOMA CITY	1515 KINGSRIDGE DRIVE OKLAHOMA CITY, OK 73170

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C1505	Continued From page 2 documented the resident was at high risk for falls. The December 2022 electronic health record had no documentation of the required "two-hour safety checks" for 151 of the 243 opportunities. On 12/21/22 at 12:00 p.m., Res #1 was observed sitting in a recliner in his room with a caregiver call button alert necklace around his neck. Res #1 was unable to verbalize the purpose of the necklace or demonstrate how to activate the button for assistance from staff. The resident was asked how he would call for assistance from the staff if needed. The resident stated he would call one of his six children on the telephone if he needed help. The resident stated the staff have not checked on him for hours at a time during the night and that he has been left sitting on the toilet without assistance for several hours in the past. 2. Res #2 was admitted with diagnoses which included dementia, rheumatoid arthritis, osteoarthrits, and displaced fracture of lateral malleolus of left fibula, subsequent encounter for closed fracture without routine healing. A "Morse Fall Assessment," dated 06/16/22, documented the resident was at high risk for falls. A "Service Plan", dated 08/04/22, documented the resident required assistance when transferring, bathing, dressing, and safety checks by staff every two hours. The December 2022 Flowsheet documented safety checks were not performed on 12/04, 12/05, 12/11, 12/17, 12/18, and 12/19. 3. Res #3 had diagnoses which included Alzheimer's disease, hypertension, and irritable bowel syndrome.	C1505		

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	AL1412	A. BUILDING: _____ B. WING _____	12/21/2022

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C1505	Continued From page 3 A comprehensive assessment and service plan, dated 03/22/22, documented Res #3 required assistance/supervision with ADLs. Task documentation for the last 30 days documented staff were to provide wellness checks every two hours. The task was not documented as completed 217 out of 320 opportunities. On 12/21/22 at 11:30 a.m., the DON was asked how the center ensured residents in the Memory Care Unit were monitored for safety. She stated all residents who resided in the Memory Care Unit should be observed for safety by the staff every two hours per their service plan. She stated the staff were required to document the two-hour checks in the electronic health record. On 12/21/22 at 12:30 p.m., the DON stated the resident had no documentation in the electronic health record for all of the required "'every two-hour" safety check opportunities in December 2022 but there should have been.	C1505		

OKLAHOMA
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Delivery via email to: kproctor@cardinalbay.org

January 17, 2023

License Number: AL1412

Ms. Karen Proctor, Administrator
Village On the Park - Oklahoma City
1515 Kingsridge Drive
Oklahoma City, OK 73170

Survey Event ID: 416111

Dear Ms. Proctor:

On **December 21, 2022,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 30, 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

Digitally signed by Tempal Killman
Date: 2023.01.17 13:33:02 -06'00'

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: 1/11/2023** **Facility Name:** Village on the Park-Oklahoma City **License Number:** AL1412 **Survey Event ID:** 416111 **Date Survey Completed: 12/21/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: Enter ID Prefix Tag from Column X4 on STATE FORM.	Based on: record review, observation, and interview, the center failed to provide safety checks every two hours per the service plan for three (#1, #2, and #3) of three residents reviewed for neglect.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Village on the Park OKC strives to meet the needs of all residnets and meet compliance with all documentation

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?	Resident #1: *Assessment and service plan will be reviewed and updated to be completed by DRC/designee on or before 1/13/2023 *Staff will be in-serviced on resident #1's updated service plan including required tasks and documentation, to be completed by DRC/designee on or before 1/13/2023. *Updated service plan will be reviewed with Resident #1 and their responsible party to be completed by DRC/designee on or before 1/13/2023. *Safety Checks are to be performed and documented per the resident's service plan by staff, initiated immediately, and are being reviewed for completion and accuracy three times a week by DRC/designee. Resident #2: *Assessment and service plan will be reviewed and updated to be completed by DRC/designee on or before 1/13/2023 *Staff will be in-serviced on resident #2's updated service plan including required tasks and documentation, to be completed by DRC/designee on or before 1/13/2023. *Updated service plan will be reviewed with Resident #2 and their responsible party to be completed by DRC/designee on or before 1/13/2023. *Safety Checks are to be performed and documented per the resident's service plan by staff, initiated immediately, and are being reviewed for completion and accuracy three times a week by DRC/designee. Resident #3: *Assessment and service plan will be reviewed and updated to be completed by DRC/designee on or before 1/13/2023

	*Staff will be in-serviced on resident #3's updated service plan including required tasks and documentation, to be completed by DRC/designee on or before 1/13/2023. *Updated service plan will be reviewed with Resident #3 and their responsible party to be completed by DRC/designee on or before 1/13/2023. *Safety Checks are to be performed and documented per the resident's service plan by staff, initiated immediately, and are being reviewed for completion and accuracy three times a week by DRC/designee.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	*Review of all other resident service plans for accuracy to be completed by DRC/designee on or before January 30, 2023. *Review of all resident ADL and safety check documentation to be completed by DRC/designee on or before January 30, 2023. *Continued education of staff related to safety and care of residents to be completed monthly and as needed per Quality Assurance Team findings.
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?	*Documentation of all resident ADL's and Safety Checks will be reviewed for completion and accuracy three times a week by DRC/designee. *Resident service plans will be reviewed and updated every 6 months and upon change of condition to be completed by the DRC/designee. *Care confereneces will be offered to review service plans with residents and/or their responsible party every 6 months and upon significant change, completed by the DRC/designee and ED. *Staff inservice regarding Abuse/Neglect, Safety Checks and Restraints was completed on 12/22/22 by DRC. *Staff Education regarding Abuse/Neglect, Legalities of Neglect, Documentation, Legalities of Documentation, Service Plans, Resident Care, Reporting, Job Descriptions, State Board of Nursing Legalities of certifications, and Resident Rights was done on 12/27/22, 12/28/22, 12/29/22, and 12/30/22 by DRC & RN Consultant. *Point of Care refresher training with DRC/designee is scheduled to be completed by 1/30/23.

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: a. Quality Assurance Team meetings to held monthly and adhoc for the months of February, March, and April to review findings and clinical audits. QA team will determine if meetings will continue monthly after April or return to quarterly depending on monitoring outcomes and findings. b. Any findings not in compliance will be documented and the employee not in compliance will be educated. Continued staff education to be completed monthly as scheduled and as needed per monitoring outcomes and findings. c. Resident ADL and safety check documentation will be reviewed three times a week by DRC/designee by use of clinical audit tool and kept in DRC office. QA meeting minutes will be recorded and kept in the ED's office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/30/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 11/1/23

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

Delivery via email to: kproctor@cardinalbay.org

February 21, 2023

License Number: AL1412

Ms. Karen Proctor, Administrator
Village On the Park - Oklahoma City
1515 Kingsridge Drive
Oklahoma City, OK 73170

Survey Event ID: 416112

Dear Ms. Proctor:

On **February 13, 2023,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 21, 2022,** have now been corrected effective **January 30, 2023.**

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1412	A. BUILDING: _____ B. WING _____	R 02/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE PARK - OKLAHOMA CITY	1515 KINGSRIDGE DRIVE OKLAHOMA CITY, OK 73170

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{C 000}	INITIAL COMMENTS A follow-up survey was completed on 02/13/23. The deficient practice was cleared.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE