Oklahoma State Department of Health
Creating a State of Health

December 11, 2019

License Number: AL1413

Ms. Lynne Davis, Administrator
Legend At Rivendell Memory Care
2800 Sw 131st Street
Oklahoma City, OK 73170

Survey Event ID: ZV7U11

Dear Ms. Davis:

On **October 3, 2019**, 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;

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
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Jenny Alexopulos, DO
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(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) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Legend at Rivendell Memory Care**
Address: **2800 SW 131st Street**
City, State, Zip: **Oklahoma City, Oklahoma**
Provider #: **AL1413**
Complaint #: **OK00054365**
Investigation Date(s): **10/01/19 to 10/03/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate staffing to meet the needs of the residents according to their contracts.	S

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

An unannounced on-site investigation was initiated on Tuesday, October 1, 2019 at 12:50 p.m.

A sample of 8 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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:

An investigation specific to staffing, incontinent care, and assistance with activities of daily living (ADL's) was investigated.

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, tag C-0301 and C-1505 for details. However, the supporting details related to adequate hydration, urinary tract infections, and routine checks was unsubstantiated.

The cook was present and prepared the residents meals on the day of the survey. The housekeeping staff assisted when needed as dietary aides.

The center had a hydration station set up on each individual unit. On 10/01/19 at 5:04 p.m., staff was serving residents drinks to include water and lemonade. Long term care aide (LTCA) #4 was asked what time did the staff provided hydration to the residents. She stated at 10:00 a.m., and 2:00 p.m.

The center had no tracking or trending records of urinary tract infections.

A new employee, long term care aide (LTCA) #21 was asked how long she had been employed at the center. She stated she was in training. She was asked if her training consisted of checking on the residents every two hours. She stated yes. Staff was observed checking on residents during survey.

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.

Lisa McAlister, Survey Manager

Mary Cooper RN

Date report completed: 11/26/2019

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Legend at Rivendell Memory Care**
Address: **2800 SW 131ST Street**
City, State, Zip: **Oklahoma City, OK 73170**
Provider #: **AL1413**
Complaint #: **OK00054379**
Investigation Date(s): **10/01/19 through 10/03/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide care according to the resident contract.	S

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

An unannounced on-site investigation was initiated on Tuesday, October 1, 2019 at 12:50 p.m.

A sample of 8 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 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, and Tag C-1505 and C-911for details. However the supporting details related to: the Klonopin (anxiety medication) level, urinary incontinence, activities of daily living (ADLs), meal service, and vital signs were unsubstantiated.

An investigation specific to nutritional consults and weight loss, activities of daily living (ADL), laundry and meal services were conducted.

The resident identified in the complaint was no longer living at the center.

Resident #2's medication administration records (MAR's) for August 2019 was initialed by the staff to indicate Klonopin a Benzodiazepine 0.5 mg was administered to resident #2 (three times daily) and indicated it was discontinued by the physician on September 6, 2019. On 08/26/19 the laboratory test performed outside the

center documented a negative result for Benzodiazepines and the physician elected to discontinue the medication on September 6, 2019. The investigation did not reveal a reason for the negative result.

On 10/01/19 at 4:00 p.m., a new employee, long term care aide (LTCA) #21 was asked how long she had been employed at the center. She stated she was in training. She was asked if her training consisted of checking on the residents every two hours. She stated yes. She stated when she trained yesterday on the other side and she checked on all the incontinent residents every two hours. Staff was observed checking on residents during survey.

Physician's orders for resident #2, documented to perform vital signs on a monthly basis. Resident #2's monthly vital signs were recorded for August and September 2019. No vital signs were documented on the medication administration record (MAR) or nursing note for September 8, 2019. On September 15, 2019, the nurse note documented a blood pressure of 172/93 and a pulse of 76 with a decrease in her level of consciousness and not responding to verbal and soft touch stimuli. Resident was transferred to the hospital on 09/15/19 and discharged on 09/19/19. A hospital record documented resident #2 was admitted to the hospital on 09/15/19 with a documented reason for the stay as acute encephalopathy: dehydration versus physical deconditioning versus infection versus stroke.

At 5:37 p.m., licensed practical nurse (LPN) #1 prepared a hall tray for resident #1's evening meal. Resident's laundry baskets were observed and no soiled linens were found in them. The residents were observed and were not found to be wearing the same clothes each day.

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.

Julie Edmiaston RN, BSN 12/02/2019

Date report completed: 12/02/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1413	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL MEMORY CARE	2800 SW 131ST STREET 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 On 10/01/19 through 10/03/19 an abbreviated survey was conducted to investigate complaint #OK00054379 and #OK00054365. Census was 64.	C 000		
C 301 SS=D	310:663-3-1(a) SERVICE IN ASSISTED LIVING (a) An assisted living center shall not care for any resident needing care in excess of the level that the assisted living center is licensed to provide or capable of providing. This Rule is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to ensure 1 (#8) of 1 sampled resident was not above the level of care the center was able to provide at the time of admission. This deficient practice had the isolated potential for more than minimal harm. Findings: Resident #8 Resident #8 was re-admitted to the center on 09/26/19 with diagnoses to include: dementia with behavioral and psychological symptoms, major neurocognitive disorder, and RBKA (right side below the knee amputation). The licensed practical nurse (LPN) #1 completed the significant change assessment on 09/26/2019. Assessment information documented resident #8 was unable to bear weight with his unaffected leg, was a 2-3 person assist for	C 301		

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C 301	Continued From page 1 transfer and toileting, and incontinent of bowel and bladder. LPN #1 nurse's note for resident #8, dated 09/27/19, documented, "resident was non weight bearing and required a 3-4 person assist for transfer. Family, health care director and resident director made aware. Still waiting on slide board to come." On 10/02/19 at 11:45 a.m., employee #6 was asked about staffing on the hall where resident #8 resided. She stated she did not think they were staffed accordingly. She stated, "It cannot be done. We have to get them changed, and I have to pass medications." She stated we need one more staff member. She stated every morning she called for assistance to help feed residents and no one paid attention. When she asked for help they did not get any help. At 5:20 p.m., LPN #14 reported she assessed the resident at the rehabilitation center for admission, and at that time was wavering on whether to admit resident #8 back to the center. At 5:35 p.m., LPN #1 was asked if resident #8 was above the center's level of care, she replied "yes". On 10/03/19 at 11:05 a.m., resident #8 was asked if the staff had changed him this morning. He stated he had fallen out of bed and they changed him at 3:15 (a.m.) this morning. At 2:40 p.m., the administrator was asked if resident #8 met the center's discharge criteria she stated yes. A plan of accommodation was presented by the administrator but was not dated, or signed. The administrator stated it was created	C 301		

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C 301	Continued From page 2 on 10/01/19. On 10/03/19 at 11:50 a.m., during observation of personal care for resident #8, LTCA's (long term care aides) #4, 17, and #19 transferred the resident from his wheelchair to his bed using a gait belt while the resident held on to his walker. The resident required maximum assistance from all three staff, was unable to bear weight on his unaffected leg, and was only able to provide minimal assist with the transfer. LTCA #9 stated the slide board would not work because the bed was too high compared to the wheelchair and the resident could not get in the shower because the center did not have a shower chair available. Resident #8 received a bed bath on his scheduled day for a shower. LTCA #4 was asked why resident #8 had a bed bath instead of a shower. She replied three of us cannot get him into the shower and resident #8 did not have a shower chair. Policy Admission, Discharge, and Transfer Criteria: Residents of senior living residences with one or more of the following conditions shall not be admitted or retained unless the Negotiated Service agreement includes hospice or family support services which are available 24 hours a day or similar resources: Any ongoing condition requiring a two-person transfer. Personal Care Assessment: The results of the assessment will be communicated to the residence director and the prospective resident or their legal representative. The decision regarding move-in shall be made	C 301		

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C 301	Continued From page 3 based upon the ability of the residence to meet the needs of the resident. Personal and Health Care Service: Resident shall receive assistance with monitoring health care, ordering supplies/supplemental services. Resident services agreement: Admission, retention and discharge criteria: Admission and retention: Prospective resident must be ambulatory, with no more than two person assistance required. Ambulatory means any person who is capable of self-movement; this includes transferring in and out of a wheelchair. An assisted living center shall not care for any resident needing care in excess level that the assisted living center is licensed to provide or capable of providing.	C 301		
C 542 SS=E	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 interview and record review it was determined the center's registered nurse failed to coordinate and sign the significant change assessment for 1(#8) of 1 sampled resident re-admitted to the center. This deficient practice had the isolated potential for more than minimal harm. Findings: Resident #8 was re-admitted to the center on 09/26/19, after rehabilitation for a right side below the knee amputation (RBKA). Resident #8 had a	C 542		

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	AL1413	A. BUILDING _____ B. WING _____	C 10/03/2019

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(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 542	Continued From page 4 diagnoses of major neurocognitive disorder, behavioral and psychological symptoms of dementia, and RBKA. The licensed practical nurse (LPN) #1 completed the significant change assessment on 09/26/19 without coordinating with the center's registered nurse (RN). On 10/03/19 at 12:20 p.m., the registered nurse (RN) #11 was asked to review resident #8's assessment. She stated she recalled signing physician orders, but she did not review or sign the assessment for resident #8. She stated she had briefly looked at him when he was participating in an activity, but had no interaction with him. She also stated she was unaware of his current health status or that he had a RBKA. The significant change assessment was not signed by the RN indicating coordination and review by the RN.	C 542		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following. (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to implement the nursing interventions as outlined in the plan of care to monitor monthly weights and provide quarterly nutritional consults for 1 (#2) of 1 sampled resident with a documented 14.2% weight loss. This resulted in the potential for more than minimal harm at a pattern . Findings:	C 552		

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C 552	Continued From page 5 Resident #2 admitted to the center on 03/01/19 with an initial weight of 148.8 lbs. and discharged from the center on 09/30/19. The plan of care for resident #2, dated 03/01/19, documented the resident required assistance with meal preparation (for example cutting/chopping meats) and opening packets. The plan of care documented the monthly weights were to be performed to monitor for weight changes and nutritional status. The associates were to monitor resident #7 for weight changes and notify the health care coordinator and the assistant health care coordinator immediately of weight changes. Dietary reviews were to be performed quarterly and as needed by dietician. The following weights for resident #2 were recorded: April: 145.4 (lbs.) May: 142.6 June: 142.0 July: Not recorded August: 130.4 September: 127.6 Resident #2 also had a weight of 126.0 pounds recorded on September 24, 2019 indicating continued weight loss. A hospital record for resident #2, documented resident #2 was admitted to the hospital on 09/15/19 with a documented reason for the stay as acute encephalopathy: dehydration versus physical deconditioning versus infection versus stroke. Laboratory results documented a low Albumin level 2.9 (range 3.4-4.8) and a high urine specific gravity of 1.036 (range 1.001-1.034). A low Albumin level can be indicative of malnutrition and has been correlated with the development of pressure ulcers. A high specific gravity can be indicative of dehydration.	C 552		

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C 552	Continued From page 6 A home health document for resident #2, dated 09/19/19, documented resident #2 had developed a right heel wound, size: 1.4 x 1.8 x 0.1, Drainage: scant, Odor: No, Etiology: Pressure Stage: 2. On 10/03/19 at 11:50 a.m., the licensed practical nurse (LPN) #14 was asked when she determined resident #2 had lost weight. She stated in September 2019 when she performed a weight analysis on everyone. At 12:36 p.m., the registered nurse (RN #11) was asked if she was aware resident #2 had a weight loss after she moved from the assisted living unit to the memory care unit. She stated no. She was asked if she was contacted in regards to resident #2's weight loss. She stated no one contacted me. She was asked if she had notified the physician about resident #2's weight loss and she replied "no."	C 552		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by:	C 911		

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C 911	Continued From page 7 Based on interview and record review it was determined the center failed to ensure a registered nurse: 1. Provided supervision and ongoing assessment and developed and implemented nutritional interventions for 1 (#2) of 1 sampled resident with a documented serious weight loss. 2. Staff were provided training for the safe use of a slide board for 1 (#8) of 1 sampled resident who required the use of a slide board for transfer. These deficient practices resulted in the potential for more than minimal harm at a pattern. Findings: Resident #2 Resident #2 admitted to the center on 03/01/19 with an initial weight of 148.8 lbs. and discharged from the center on 09/30/19 with a documented weight of 127.6 lbs. The plan of care for resident #2, dated 03/01/19, documented resident #2 required assistance with meal preparation (for example cutting/chopping meats) and opening packets. The plan of care documented the monthly weights were to be performed to monitor for weight changes and nutrition. The associates (staff) were to monitor resident for changes and notify the health care coordinator and the assistant health care coordinator immediately. Dietary reviews were to be performed quarterly and as needed by dietician. The following monthly weights were recorded for resident #2: March: 148.8 lbs. April: 145.4 lbs. May: 142.6 lbs. June: 142.0 lbs.	C 911		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL MEMORY CARE	2800 SW 131ST STREET 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 911	Continued From page 8 July: No weight recorded August: 130.4 lbs. September: 127.6 lbs. Resident #2 had a 21.2 pound weight loss from admission on March 1st, 2019 to September 1st, 2019. This was a serious unplanned weight loss of 14.2% in 6 months. Resident #2 also had a weight of 126.0 pounds recorded on September 24th, 2019, suggesting continued weight loss of 15.4% in 6 months, 3 weeks. The physician's order for magic cups (nutritional supplement), weekly weights, and mighty shakes (nutritional supplement) was dated on 09/19/19 ten days prior to resident #2 moving out of the center and had not been signed by the physician. On 10/03/19 at 11:50 a.m., licensed practical nurse (LPN) #14 was asked when she determined resident #2 had lost weight. She stated in September 2019 she performed a weight analysis on everyone. At 12:36 p.m., RN #11 was asked if she was aware resident #2 had a weight loss after she moved from the assisted living unit to the memory care unit. She stated no. She was asked if she was contacted in regards to resident #2's weight loss. She stated "no one contacted me." She was asked if she had notified the physician about resident #2's weight loss and she replied "no." Resident #8 A physical therapy evaluation, dated on 10/01/19, for resident #8, documented the resident required maximum assist level with a sliding board for an assistive device. The evaluation also identified muscle weakness/instability, severe balance deficits, decreased activity tolerance, and	C 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1413	A BUILDING _____ B WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL MEMORY CARE	2800 SW 131ST STREET 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 911	Continued From page 9 decreased safety awareness. On 10/02/19 at 5:00 p.m., long term care aides (LTCA's) #8 and #18 were asked if they were trained by the center to use the slide board to transfer resident #8. LTCA's #8 and #18 reported they received no training on how to use the slide board with resident #8. On 10/03/19 at 9:25 a.m., LTCA's #4 and #9 were asked if they received slide board training with resident #8 They stated the nurse provided no training for resident #8's slide board. At 10:50 a.m., the registered nurse (RN) was asked if she trained the staff on the use of the slide board for resident #8. She stated "no." She stated the center did not have a slide board and she just asked the staff if they knew how to use a slide board. She was asked if the staff demonstrated how to use a slide board. She stated the center did not have a slide board to use for demonstration. The RN was asked if she trained her staff on resident #8's slide board. She stated, "No, I did not." She was asked if she thought the staff would need specific training to use the slide board with resident #8. She stated "yes," home health would be out that afternoon to provide a demonstration of how to transfer resident #8 from the bed to the chair utilizing a slide board. Policy The degree of supervision will be determined by the licensed nurse after an assessment of appropriate factors including: The health status and mental and physical stability of the resident, the complexity of the task to be completed.	C 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1413	A BUILDING _____ B WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL MEMORY CARE	2800 SW 131ST STREET 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 911	Continued From page 10 The center's job description for nurse (LPN, RN) dated April 2019, documented, responsible for identifying resident problems, concerns, or issues, and providing appropriate follow-up to ensure resolution.	C 911		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to follow a physician's order for 1 (#2) of 1 sampled resident	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1413	A BUILDING _____ B WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL MEMORY CARE	2800 SW 131ST STREET 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 11 with physician ordered monthly weights to monitor for weight changes and nutritional status. Additionally, the center failed to notify the physician of a documented 14.2% weight loss, failed to perform quarterly nutritional consults by a licensed dietician to prevent or decrease the risk for the development of pressure ulcers. This resulted in the potential for more than minimal harm at a pattern. Findings: Resident #2 was admitted to the center on 03/01/19 with an initial weight of 148.8 lbs. The plan of care for resident #2, dated 03/01/19, documented the resident required assistance with meal preparation (for example cutting/chopping meats) and opening packets. The plan of care documented the monthly weights were to be performed to monitor for weight changes and nutrition. The associates were to monitor resident for weight changes and notify the health care coordinator and the assistant health care coordinator immediately. Dietary reviews were to be performed quarterly and as needed by a licensed dietician. The following weights for resident #2 were recorded: April: 145.4 (lbs.) May: 142.6 June: 142.0 July: Not recorded August: 130.4 September: 127.6 Resident #2 had a 21.2 pound weight loss from admission on March 1st, 2019 to September 1st, 2019. This was a serious unplanned weight loss of 14.2% in 6 months. Resident #2 also had a weight of 126.0 pounds recorded on September 24th, 2019, suggesting continued weight loss of 15.4% in 6 months, 3 weeks.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1413	A BUILDING _____ B WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL MEMORY CARE	2800 SW 131ST STREET 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 On 09/13/19 a home health nurse reported resident #2's family member notified the home health agency of drainage coming from resident #2's heel. The physician was notified and orders were received for wound treatment. Resident #2 was admitted to the hospital on 09/15/19 and returned to the center on 09/19/19. Wound care was initiated by home health on 09/19/19 when resident #2 had returned from a hospital stay. Resident #2 was discharged from the center on 09/30/19. A hospital record for resident #2, documented resident #2 was admitted to the hospital on 09/15/19 with a documented reason for the stay as acute encephalopathy: dehydration versus physical deconditioning versus infection versus stroke. Laboratory results documented a low Albumin level 2.9 (range 3 4-4.8) and a high urine specific gravity of 1.036 (range 1.001-1.034). A low Albumin level can be indicative of malnutrition and has been correlated with the development of pressure ulcers. A high specific gravity can be indicative of dehydration. The physician's order for magic cups (nutritional supplement), weekly weights, and mighty shakes (nutritional supplement) was dated on 09/19/19 ten days prior to resident #2 moving out of the center and had not been signed by the physician. On 10/02/19 at 10:50 a.m., licensed practical nurse (LPN) #14 was asked to submit the nutritional consults performed by the dietician for resident #2. She stated she had not been here to see anyone. On 10/03/19 at 11:50 a.m., LPN #14 was asked when she determined resident #2 had lost weight.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1413	A BUILDING _____ B WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL MEMORY CARE	2800 SW 131ST STREET 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 She stated in September 2019 when she performed a weight analysis on everyone. At 12:36 p.m., the registered nurse (RN) #11 was asked if was aware resident #2 had a weight loss after she moved from the assisted living unit to the memory care unit. She stated no. She was asked if she was notified of resident #2's weight loss. She stated no one contacted me. She was asked if she notified the physician about resident #2's weight loss and she replied "no."	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 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.	C1911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL1413	A. BUILDING _____ B. WING _____	C 10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGEND AT RIVENDELL MEMORY CARE	2800 SW 131ST STREET 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 14 This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to notify the Nurse Aide Registry with a Oklahoma Department of Health (ODH) form 718 within one (1) business day of the reportable incident's discovery for 1 (#7) of 1 sampled resident with an allegation of abuse. This deficient practice resulted in the isolated potential for more than minimal harm. Findings: On 10/03/19 at 9:00 a.m., the regional health care director was asked if she sent the ODH 718 form within one business day to the Nurse Aide Registry. She stated no she did not. The center reported an allegation of staff to resident abuse and completed an investigation; however, failed to notify the nurse aide registry within one business day.	C1911		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL1413	LEGEND AT RIVENDELL MEMORY CARE

Type of Survey (select all that apply)

3								

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30875	10/01/2019	10/03/2019	1.50	0.00	10.00	0.00	4.00	20.00
2. 41872	10/01/2019	10/03/2019	0.50	0.00	10.00	0.00	6.00	7.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

DEC 12 2019

Oklahoma State Department of Health
Creating a State of Health

December 27, 2019

License Number: AL1413

Ms. Lynne Davis, Administrator
Legend At Rivendell Memory Care
2800 SW 131st Street
Oklahoma City, OK 73170

Survey Event ID: ZV7U11

Dear Ms. Davis:

On October 3, 2019, 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 27, 2020**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA *(President)*
Edward A Legako, MD *(Vice-President)*
Becky Payton *(Secretary)*
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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: 12/23/2019** **Facility Name:** Legend at Rivendell Memory Care **License Number:** AL1413 **Survey Event ID:** ZV7U11 **Date Survey Completed: 10/3/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 301	Based on: Based on observation, interview, and record review it was determined the center failed to ensure 1 (#8) of 1 sampled resident was not above the level of care the center was able to provide at the time of admission. This deficient practice had the isolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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 (#8) no longer resides at the community.
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 have the potential to be affected. The Resident Director or Designee will audit all personal care assessments for all residents to ensure 1) the residents are not above the level of care the center is able to provide at the time of admission in accordance with the admission, discharge, retention criteria outlined in the residency agreement.
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 Resident Director or Designee will 1) provide in-service, training and education to the nursing team on the admission, retention and discharge criteria per the residency agreement and SERVICE IN AN ASSISTED LIVING as outlined in 310:663-3-1(a).
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 RD or Designee will conduct random audits to ensure residents are not above the level of care the center is able to provide at the time of admission in accordance with the admission, discharge and retention criteria outlined in the residenty agreement. The RD or Designee will continue audits until such time that the process appears effective. The audits and related documentation will be discussed, reviewed and measured at each QA meeting.

	The audit will be maintained as part of the QA file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Click here to enter a date when corrective action will be completed 1/27/2020
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date 12/23/2019**

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: 12/23/2019** **Facility Name:** Legend at Rivendell Memory Care **License Number:** AL1413 **Survey Event ID:** ZV7U11 **Date Survey Completed: 10/3/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 542	Based on: Based on interview and record review it was determined the center's registered nurse failed to coordinate and sign the significant change assessment for 1(#8) of 1 sampled resident re-admitted to the center. This deficient practice had the isolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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 (#8) no longer resides at the community.
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 have the potential to be affected. The Resident Director or Designee will conduct an audit of all current assessments for compliance with CONDUCT of ASSESSMENT as outlined in 310:663-5-4(b) as indicated by the signature of an RN and will make corrections for compliance immediately.
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 Resident Director or Designee will 1) provide in-service, training and education to the nursing team on the CONDUCT of ASSESSMENT as outlined in 310:663-5-4(b).
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 Resident Director or Designee will conduct random audits to ensure ODH STATE assessments are coordinated and signed by the Registered Nurse. The Resident Director of Designee will make realtime adjustments found during the audit until such time the process appears effective. The audits and related documentation will be discussed, reviewed and measured at each QA meeting. The audit will be maintained as part of the QA file
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	

OSDH Response: Element accepted Yes ☐ No ☐		Click here to enter a date when corrective action will be completed. 1/27/2020	
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Jeanie Riggs RN		**Date 12/23/2019**
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: 12/23/2019** **Facility Name:** Legend at Rivendell Memory Care **License Number:** AL1413 **Survey Event ID:** ZV7U11 **Date Survey Completed: 10/3/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 552	Based on: interview and record review it was determined the center failed to implement the nursing interventions as outlined in the plan of care to monitor monthly weights and provide quarterly nutritional consults for 1 (#2) of 1 sampled resident with a documented 14.2% weight loss. This resulted in the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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 (#2) no longer resides at the community.
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 have the potential to be affected. The Resident Director or Designee will conduct an audit of care plans AND and immediately implement nursing interventions to include nutritional consult and/or nutritional supplements as needed FOR weight loss.
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 Resident Director or Designee will 1) provide in-service, training and education to the nursing team on the USE of ASSESSMENT as outlined in 310:663-5-5(2) and nursing interventions to address weight loss.
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) Resident Director or Designeee will audit care plans, weight logs and dietary consult for consistency. b) The audits and related documents will be discussed, reviewed and measured at each QA meeting. c) The audit will be maintained as part of the QA File.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed? OSDH Response: Element accepted Yes ☐ No ☐		Click here to enter a date when corrective action will be completed. 1/27/2020	
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Tiffanie Robertson		**Date** 12/23/2019
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: 12/23/2019** **Facility Name:** Legend at Rivendell Memory Care **License Number:** AL1413 **Survey Event ID:** ZV7U11 **Date Survey Completed: 10/3/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 911	Based on: Based on interview and record review it was determined the center failed to ensure a registered nurse: 1. Provided supervision and ongoing assessment and developed and implemented nutritional interventions for 1 (#2) of 1 sampled resident witha documented serious weight loss. 2. Staff were provided training for the safe use of a slide board for 1 (#8) of 1 sampled resident who required the use of a slide board for transfer. These deficient practices resulted in the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	Residents (#2) and (#8) no longer reside at the community.
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 have the potential to be affected.
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 Resident Director or Designee will 1) provide in-service, training and education to the RN and nursing team on the staffing requirement of a Registered Nurse as outlined in 310:663-9-1. RN and nursing team will be in-serviced on weight loss interventions as well as the use of a slide board if indicated.
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) A full-time registered nurse is in place and the RD or Designee will audit assessments and interventions for continued compliance. b) The audits and related documentation will be discussed and measured at each QA meeting. c) The audit will be maintained as part of the QA file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Click here to enter a date when corrective action will be completed. 1/27/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required	Date 12/23/2019

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: 12/23/2019** **Facility Name:** Legend at Rivendell Memory Care **License Number:** AL1413 **Survey Event ID:** ZV7U11 **Date Survey Completed: 10/3/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505	Based on: Based on interview and record review it was determined the center failed to follow a physician's order for 1 (#2) of 1 sampled resident with physician ordered monthly weights to monitor for weight changes and nutritional status. Additionally, the center failed to notify the physician of a documented 14.2% weight loss, failed to perform quarterly nutritional consults by a licensed dietician to prevent or decrease the risk for the development of pressure ulcers. This resulted in the potential for more than minimalharm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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 (#2) no longer resides in the community.
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 have the potential to be affected. The Resident Director or Designee will conduct an audit of all physician orders to ensure physician ordered weights are being recorded and immediately implement any nursing interventions to include nutritional consult and/or nutritional supplements as needed.
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 Resident Director or Designee will 1) provide in-service, training and education to the nursing team on RESIDENT RIGHTS as outlined in 310:663-15-1 & 63 OS 1-1918(B)(5) and monitoring and recording of monthly weights per physician order.
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	Enter methods to ensure corrections are sustained: a) The RD or Designee will conduct random audits to ensure weights are being recorded and nutritional interventions implemented if indicated.

c. How monitoring records will be kept to evidence the correction.	b) The audits and related documentation will be discussed, reviewed and measured at each QA meeting. c) The audit will be maintained as part of the QA file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Click here to enter a date when corrective action will be completed. 1/31/2020
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. Tyrone Rogers OAC 310:663-25-4(F)	**Date 12/23/2019**
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	
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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: 12/23/2019** **Facility Name:** Legend at Rivendell Memory Care **License Number:** AL1413 **Survey Event ID:** ZV7U11 **Date Survey Completed: 10/3/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1911	Based on: Based on interview and record review it was determined the center failed to notify the Nurse Aide Registry with a Oklahoma Department of Health (ODH) form 718 within one (1) business day of the reportable incident's discovery for 1(#7) of 1 sampled resident with an allegation of abuse. This deficient practice resulted in the isolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This plan of correction is not to be construed as an admission of our agreement with the findings and conclusions of the statement of deficiencies or the proposed administrative penalty (with the right to correct) on the community. Rather it is submitted as a confirmation of our ongoing efforts to comply with all statuatory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation(s) or finding. We have not presented all contrary factual or legal arguments or have we identified mitigating factors.

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?	Associate was suspended on date of allegation September 30, 2019. Associate reported to Nurse Registry on October 2, 2019.
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 have the potential to be affected.
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 associate was suspended on September 30, 2019 and from ODH 718 submitted on October 2, 2019 to the registry. The Resident Director or Designee will 1) provide in-service, training and education to the nursing team on INCIDENT REPORT TIMELINES as outlined in 310:663-19-1(a).
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) The RD or Designee will audit all nurse registry reportables to ensure timely reporting to the registry. b) The audit and related documentation will be discussed, reviewed and measured at each QA meeting. c) The audit will be maintained as part of the QA file.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	Click here to enter a date when corrective action will be completed. 1/27/2020
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required	**Date 12/23/2019**

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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			
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