OKLAHOMA
State Department
of Health

Delivery via email to: alagrange@homesteadofweatherford.com

June 19, 2023

License Number: AL2003

Ms. Ashley LaGrange, Administrator
Homestead Of Weatherford
3601 East Main
Weatherford, OK 73096

RE: Survey Event ID: CINT11

Dear Ms. LaGrange:

On **May 26, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on May 26, 2023.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvn, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2003	A. BUILDING: _____ B. WING _____	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 000	INITIAL COMMENTS A relicensure survey was conducted 05/24/23 through 05/26/23. Listed below are the abbreviations used throughout this document. ADON - Assistant Director of Nurses c/o - complaints of DON - Director of Nurses d/t - due to dx - diagnoses EMS - Emergency Medical Services ER - Emergency Room L - left LPN - Licensed Practical Nurse PRN - as needed R - right r/t - related to SLUMS - Saint Louis University Mental Status Examination s/s - signs and symptoms tv - television	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	C1505		

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C1505	Continued From page 1 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 record review, and interview, the facility failed to complete 72 hour post fall assessments and head injury logs after unwitnessed falls or falls with head injuries for one (#2) of three sampled residents reviewed for falls. Findings: An undated facility "Accidents and Occurrences" policy, read in parts, "...Complete documentation of the occurrence and assessment of the resident in the nurses' notes of the resident's record...Complete a physical assessment to include vital signs every shift for seventy-two (72) hours following the occurrence and document in	C1505		

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C1505	Continued From page 2 the nurses notes..." An undated facility "Head Injury" policy, read in parts, "...the nurse should implement the program's head injury protocol...If the nurse is on-site, a Neurological Assessment will be completed every 15 minutes for the first hour, every 30 minutes for the next two hours, every hour for four hours, and every eight hours for 72 hours...If a nurse is not on-site, the nurse will instruct designated staff to implement the program protocol....If resident was transported for evaluation of the head injury, upon returning...applicable protocol will be initiated upon resident's return depending on whether the nurse is on-site or not..." 1. Resident #2 had diagnoses to include Parkinson's disease; dementia, hypertension, and a history of a fractured right femur. A "Falls Care Plan," dated 12/14/21, read in parts, "...Falls...doesn't want to fall...After a fall and before moving the resident, evaluate the resident for changes in Range of motion and notify the nurse before moving the resident..." A preadmission "Resident Assessment Form," dated 02/18/22, documented Resident #2 was alert and forgetful, judgement was good, mobility fair, was not weight bearing, and required one staff to assist with walker and a gait belt for ambulation. An undated "SLUMS Examination" form, documented Resident #2 had a score of 13 of 30, which indicated Resident #2 had dementia. A "Progress Note," dated 05/29/22, read in parts "...had a fall...with injury to the right side of	C1505		

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C1505	Continued From page 3	C1505		

face...has abrasion to bilateral knees and an abrasion with bruising to the right side of [their] face. Head injury monitoring initiated per protocol..."

The clinical record contained no documentation "Head Injury" monitoring had been completed or Resident #2 had been monitored for the 72 hours per policy.

An "Assisted Living Fall Risk" form, dated 07/05/22, documented the assessment was completed due to "Post Fall." The form did not provide a description of the fall.

The clinical record contained no documentation of a fall on 07/05/22, or that Resident #2 had been assessed for the need to be monitored for 72 hours per the facility policy.

An annual "Resident Assessment Form," dated 08/18/22, documented Resident #2 was alert and forgetful, mobility was fair with a full range of motion, was not weight bearing and required staff assistance and a walker for ambulation.

A "SLUMS Examination" form, dated 08/18/22, documented Resident #2 had a score of 14 of 30 which indicated dementia.

"Progress Notes," dated October 2022, documented unwitnessed falls as follows: one fall on 10/02; and two falls on 10/09/22.

The clinical record contained no documentation that 72 hour monitoring, or head injury logs had been completed per the facility protocol for the falls in October 2022.

An "Assisted Living Fall Risk" assessment, dated

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C1505	Continued From page 4 12/02/22, documented Resident #2 had fallen. The assessment did not provide a description of the event to determine if Resident #2 required 72 hour monitoring or a Head Injury Log to be initiated. The fall was not documented in the progress notes of the clinical record. Progress Notes, dated December 2022, documented unwitnessed falls had occurred on 12/16, 12/26, and 12/29/22. The clinical record contained no documentation Resident #2 had been monitored for 72 hours, or a Head Injury Log had been completed for the three falls in December 2022. The clinical record contained no documentation a post fall assessment had been completed for the fall on 12/26/22. Resident #2's "Assisted Living Lease Agreement," dated 01/01/23, read in parts, "...Residents' Rights...Receive treatment, care and services that are adequate, appropriate and in compliance with relevant state, local and federal laws..." Progress Notes, dated February 2023, documented unwitnessed falls occurred on 02/07, 02/08, 02/09, 02/10, and 02/20/23. The clinical record did not contain documentation of 72 hour monitoring or that Head Injury Logs had been completed for the five unwitnessed falls in February 2023. An annual "Resident Assessment Form," dated 02/18/23, documented Resident #2 was not weight bearing and required staff assistance for oversight and safety, and utilized a walker.	C1505		

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C1505	Continued From page 5 A "Progress Note," dated 03/13/23 at 9:15 a.m., read in parts, "...LATE ENTRY...was lying on [their] back in the floor...lift chair was raised up as far as it would go..." The entry did not indicate the date and time the event occurred. The clinical record contained no documentation Resident #2 had been monitored for 72 hours or a Head Injury Log had been completed after an unwitnessed fall. "Progress Notes," dated April 2023, documented unwitnessed falls on 04/13, 04/19, and 04/26/23. The clinical record did not contain documentation Resident #2 had been monitored for 72 hours or a Head Injury Log had been initiated after three unwitnessed falls in April 2023. "Progress Notes," dated May 2023, documented unwitnessed falls on 05/05, and 05/22/23. The clinical record did not contain documentation Resident #2 had been monitored for 72 hours or a Head Injury Log had been completed after two unwitnessed falls in May 2023. On 05/25/23 at 9:45 a.m., the DON, LPN #1 and Corporate Nurse Consultant #1 were asked if the facility had followed their policy to ensure Resident #2 had been monitored for 72 hours, and Head injury Logs had been completed after each unwitnessed fall. After review of the clinical record and the facility policy, they stated Resident #2 had not been monitored per the facility policy and more documentation should have been completed.	C1505		

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C1951	Continued From page 6	C1951		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain organized and accurate records to reflect the resident's status and monitoring after a fall for two (#2,and #7) of three residents reviewed for falls. Findings: 1. Resident #2 had diagnoses to include Parkinson's disease; dementia, hypertension, and a history of fractured right femur. An "Assisted Living Fall Risk" form, dated 07/05/22, documented Resident #2 had fallen. No clear description was included on the form. The clinical record contained no progress note entry Resident #2 had fallen on 07/05/22. "Assisted Living Fall Risk" forms dated 10/02, and 10/09/22, documented Resident #2 had fallen. "Progress Notes," dated 10/11/22, documented: a. At 2:57 p.m., read in parts, "...10/02/22... [Resident #2] observed sitting on [their] bottom in his bathroom...no obvious signs of injury..." b. At 3:02 p.m., read in parts, "...10/09/22...was laying on [their] floor by [their] walker...fell over	C1951		

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C1951	Continued From page 7	C1951		

and hit [their] head...sent to ER for evaluation..."
c. At 3:04 p.m., read in parts, "...10/09/22...lying on [their] floor in front of [their] recliner, [their] tv tray was flipped over and [their] walker was across the room...was lying on [their] backside and [their] head was leaned up against [their] recliner..."
d. At 3:25 p.m., read in parts, "...10/09/22...c/o of pain...gave tylenol...[at 3:14 a.m.] effective [at 4:14 a.m.]..."
e. At 3:27 p.m., read in parts, "...10/08/22...c/o pain...Tylenol...[at 2:53 a.m.] effective [at 4:16 a.m.]..."

The progress notes, dated 10/11/22, included five entries that spanned from 10/02/22 through 10/09/22, and were not identified as late entries.

"Assisted Living Fall Risk" forms, dated 12/02, and 12/29/22, documented Resident #2 had fallen.

The clinical record contained no progress note or documentation Resident #2 had fallen on 12/02/22.

A "Progress Note," dated 12/22/22 at 3:46 p.m., read in parts, "...12/20/22...[Resident #2] laying on the floor on [their] left side, next to the dining room door..."

A "Progress Note," dated 01/06/23, documented:
a. At 3:45 p.m., read in parts, "...12/26/22...heard a crashing noise from [Resident #2's] apartment...was lying on [their] right side and on [their] right shoulder in front of [their] recliner...fell over...shoulder hurt just a little bit..."
b. At 3:52 p.m., read in parts, "...12/29/22...fallen on the ground in [their] apartment...lying in front of [their] fridge on the floor holding [their] right

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C1951	Continued From page 8	C1951		

arm and the left side of [their] neck..."

The progress notes, dated 12/26/22 and 12/29/22, had not been documented until 01/06/23.

"Assisted Living Fall Risk" forms, dated 02/08, 02/19, and 02/22/23, documented Resident #2 had fallen.

A "Progress Note," dated 02/13/23 at 2:42 p.m., read in parts, "...02/10/23...was on both knees and [their] right leg looked to be tangled up in is [sic] walker...blood was observed on the floor...cut on the upper left side of [their] head...stated that [their] right arm and head hurts...Called EMS..."

An "Assisted Living Fall Risk," form had not been completed for the fall on 02/10/23.

"Progress Notes," dated 02/16/23, read in parts:
a. At 8:53 a.m., "...02/11/23...stitches in tact...No s/s of adverse effects r/t fall at this time..."
b. At 8:54 a.m., "...02/12/23...Stitches remain in tact...r/t fall..."
c. At 10:46 a.m., "...02/13/23...without c/o pain or adverse effects r/t fall..."
d. At 10:47 a.m., "...02/09/23...no acute s/s of distress or pain r/t fall..."

The progress notes, dated 02/09, 02/11, 02/12, and 02/13/23, had not been documented until 02/16/23. The entries were not clearly identified as late entries to identify the specific fall that was monitored.

"Progress Notes," dated 02/22/23, read in parts:
a. At 11:04 a.m., "...02/20/23...was lying on the floor in [their] apartment by [their] TV and [their]

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C1951	Continued From page 9 walker was close by...was looking for earthworms..." b. At 11:24 a.m., "...02/20/23...fall on 2 - 10 shift this day...skin tear to L arm..." The progress notes, dated 02/20/23, had not been documented until 02/22/23 or clearly identified as late entries. An "Assisted Living Fall Risk" form, dated 03/13/23, documented Resident #2 had fallen. A "Progress Note," dated 03/13/23 at 9:15 a.m., read in parts, "...LATE ENTRY...was lying on [their] back in the floor...lift chair was raised up as far as it would go..." The "Progress Note" did not indicate the date and time the late entry event had occurred. "Assisted Living Fall Risk" forms, dated 04/09, 04/19, and 04/26/23, documented Resident #2 had fallen. The clinical record did not contain a Progress Note on 04/09/23 to indicate Resident #2 had fallen. "Progress Notes," dated 04/13/23, read in parts: a. At 10:50 a.m., "...on the floor laying in front of [their] recliner...couldn't state what had happened or how...small skin tear notes to R pinky finger..." b. At 10:54 a.m., "...04/10/23...Xray ordered d/t pain with movement of pinky..." The event, dated 04/10/23 at 10:54 a.m., had not been documented until 04/13/23 or clearly identified as a late entry. 2. Resident #7 had diagnoses to include arthritis,	C1951		

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C1951	Continued From page 10 ataxic gait, and weakness. A "Progress Note," dated 04/06/23 at 11:05 a.m., read in parts, "...LATE ENTRY...found [Resident #7] sitting on her bottom between [their] bed and recliner...tripped over [their] shoe and fell down...large skin tear to R arm from wrist to elbow. AL ankle bruised and swollen...reported pain rating 6/10...assisted resident up...was unable to bear weight on AL ankle...transported to...ER...returned to the facility with report of broken right wrist and small fracture to left ankle...appointment with orthopedic surgeon..." "Progress Notes," dated 04/13/23, read in parts, a. At 9:44 a.m., "...04/07/23...returned to facility with d/t of fractured R wrist and L ankle...requiring assistance with transfers and ambulation d/t immobility of these extremities...." b. At 9:44 a.m., read in parts, "...04/08/23...pain medication PRN r/t fracture...requiring 2x assist with all transfers..." c. At 9:46 a.m., read in parts, "...04/09/23...Requiring assistance with all transfers and ambulation..." A "Progress note dated 04/14/23 at 10:01 a.m., read in parts, "...returned to community the evening of 04/13/23 after surgery to repair fracture to R wrist...has weight bearing orders..." An event occurred on 04/06/23 which resulted in a fracture, the progress notes did not contain follow up to monitor the status of the resident until 04/13/23. On 05/25/23 at 9:45 a.m., the DON, ADON, and Corporate Nurse #1 were asked what the facility policy was regarding charting in the clinical records in a timely manner. They stated they did	C1951		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2003	A. BUILDING: _____ B. WING _____	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF WEATHERFORD	3601 EAST MAIN WEATHERFORD, OK 73096

(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
C1951	Continued From page 11 not have a policy. They were asked if the clinical records were maintained to be accurate and complete at all times to reflect the resident status and needs, if progress notes were entered up to a week after an incident occurred. They stated, "Not at the time, we each document in our book." They stated they record items in a book that each nurse keeps and they document in the clinical record later when they have more time. They were asked if the books were part of the clinical record. They stated, "No, that documentation is only the nurse personal notes."	C1951		

OKLAHOMA
State Department
of Health

Delivery via email to: mmilliron@homesteadofweatherford.com

July 3, 2023

License Number: AL2003

Morgan Milliron, Administrator
Homestead Of Weatherford
3601 East Main
Weatherford, OK 73096

RE: Survey Event CINT11

Dear Morgan Milliron:

On **May 26, 2023**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **July 27, 2023**.

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

Respectfully,

Tempal Killman

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

enc

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 6/26/2023
	Facility Name: Homestead of Weatherford
	License Number: AL2003
	Survey Event ID: CINT11
	Date Survey Completed: 5/26/2023

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: 1505	Based on: record review, and interview, the facility failed to complete 72hr post fall assessments and head injury logs after unwitnessed falls or falls with head injuries for on (#2) of three sampled residents reviewed for falls.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

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?	a. A fall risk assessment will be completed for each fall unless one has already been completed for that day or there is no change in the resident's condition or status from previous fall risk assessment. A progress note will be completed for each fall and for 72hrs per current policy, until the updated fall policy is made available. Protocol would then be implemented from the new policy. Implemented 6/26/23. b. Current fall and accident/occurrences policy and procedure is under review for further clarification and distinction between level of care being addressed in the policy. The policy currently contains company protocols for AL, MC, SNF, LTC and independent living residents in one document. c. A head injury log will be initiated and completed for all unwitnessed falls or falls with head injury. Implemented 6/26/23. d. Staff will be educated on 6/27, on initiating and completing the head injury log. Audit of compliance will be conducted by the regional RN and/or the float LPN by 7/26/23 and will continue on a monthly basis.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Every fall will be addressed in the same manner as stated above. Audit of compliance will be conducted by the regional RN and/or the float LPN by 7/26/23 and will continue on a monthly basis.
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 care coordinator will ensure that the monitoring of fall reporting, initiation and completion of the head injury log and progress noting is done for every fall. Staff will be educated on 6/27, on the importance of reporting to the nurse in a timely manner.

	The regional RN and float LPN will monitor compliance with random audits. Implemented on 6/26 and ongoing. Audit of compliance will be conducted by the regional RN and/or the float LPN by 7/26/23 and will continue on a monthly basis.
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 regional RN and float LPN will monitor compliance with random audits. Implemented on 6/26 and ongoing. Audit of compliance will be conducted by the regional RN and/or the float LPN by 7/26/23 and will continue on a monthly basis. a. The resident care coordinator, regional RN and float LPN will monitor occurrences and initiation and completion of head injury log, progress notes and fall risk assessments as per stated above. b. The random audit findings will be trended for improvement. c. Record of trending will be maintained in the QA binder. Implemented 6/26/23. Audit of compliance will be conducted by the regional RN and/or the float LPN by 7/26/23 and will continue on a monthly basis.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/27/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 6/26/2023

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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 6/26/2023
	Facility Name: Homestead of Weatherford
	License Number: AL2003
	Survey Event ID: CINT11
	Date Survey Completed: 5/26/2023

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: 1951	Based on: Observation, record review, and interview the facility failed to maintain organized and accurate records to reflect the resident's status and monitoring after a fall for two (#2, and #7) of three resident reviewd for falls.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the intent of this center to be in compliance with all state rules and regulations. This center will implement actions to correct deficiency.

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?	a. Clear, concise and timely documentation will occur with each occurrence. Implemented 6/26/2023. b.A fall risk assessment will be completed for each fall unless one has already been completed for that day or there is no change in the resident's condition or status from previous fall risk assessment. c. A progress note will be completed for each fall and for 72hrs per current policy, until the updated fall policy is made available. Protocol would then be implemented from the new policy. Implemented 6/26/23. d. Current fall and accident/occurrence policy and procedure is under review for further clarification and distinction between level of care being addressed in the policy. The policy currently contains company protocols for AL, MC, SNF, LTC and independent living residents in one document. Date of completion of review is unknown at this time. e. A head injury log will be initiated and completed for all unwitnessed falls or falls with head injury. Implemented 6/26/23. f. Staff will be educated on 6/27, on initiating and completing the head injury log. g. Audit of compliance will be conducted by the regional RN and/or the float LPN by 7/26/23 and will continue on a monthly basis.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Every fall will be addressed in the same manner as stated above. Audit of compliance will be conducted by the regional RN and/or the float LPN by 7/26/23 and will continue on a monthly basis.
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 care coordinator will ensure that the monitoring of fall reporting, initiation and completion of the head injury log and progress noting is done for every fall in a timely manner. Staff will be educated on 6/27, on the importance of reporting to the nurse in a timely manner. The regional RN and float LPN will monitor compliance with random audits. Implemented on 6/26 and ongoing. Audit of compliance will be conducted by the regional RN and/or the float LPN by 7/26/23 and will continue on a monthly basis.
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 regional RN and float LPN will monitor compliance with random audits. Implemented on 6/26 and ongoing. Audit of compliance will be conducted by the regional RN and/or the float LPN by 7/26/23 and will continue on a monthly basis. a.The resident care coordinator, regional RN and float LPN will monitor occurrences and initiation and completion of head injury log, progress notes and fall risk assessments as per stated above. b.The random audit findings will be trended for improvement. c.Record of trending will be maintained in the QA binder. Implemented 6/26/23. Audit of compliance will be conducted by the regional RN and/or the float LPN by 7/26/23 and will continue on a monthly basis.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/27/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	Morgan Miller	**Date** Enter a date of signature.	12/26/2023

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: mmilliron@homesteadofweatherford.com

August 31, 2023

License Number: AL2003

Ms. Morgan Milliron, Administrator
Homestead Of Weatherford
3601 East Main
Weatherford, OK 73096

RE: Survey Event CINT12

Dear Ms. Milliron:

On **August 30, 2023,** anoffsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **May 26, 2023,** have now been corrected effective **July 26, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2003	A. BUILDING: _____ B. WING _____	R 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF WEATHERFORD	3601 EAST MAIN WEATHERFORD, OK 73096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 08/30/29. The facility was in substantial compliance	{C 000}		

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