Oklahoma State Department of Health
Creating a State of Health

February 18, 2020

License Number: AL2502

Ms. Dana Vandever, Administrator
The Willows
301 Melville Drive
Pauls Valley, OK 73075

RE: Survey Event ID: 7ZR811

Dear Ms. Vandever:

On **February 3, 2020**, 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 February 3, 2020.

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) 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,

Katie Stagner

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

SD/kgs

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL2502	A. BUILDING _____ B. WING _____	02/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	301 MELVILLE DRIVE PAULS VALLEY, OK 73075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 01/30/20, 01/31/20, and 02/03/20. Current census was 32. The following deficiencies were cited.	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regards to warewashing sanitation. This failed practice had the wide spread potential for more than minimal harm for all 32 residents who received meals from the kitchen. Findings: 310:257-7-77. Warewashing equipment, determine chemical sanitizer concentration Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. On 01/30/20 at 3:29 p.m., the warewashing machine data plate documented the minimum wash temperature to be 120 degrees Fahrenheit and chlorine concentration to be 50 parts per million. The dietary manager stated the dish machine was a low temperature dish machine with a minimum temperature of 120 degrees Fahrenheit. The dietary manager stated she did not usually test the chemical concentration in the sanitizer solution, did not know if the machine	C 391		

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C 391	Continued From page 1 sanitized correctly, and did not know where the test kit/strips were located.	C 391		
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This Rule is not met as evidenced by: Based on on interview and record review, it was determined the center failed to ensure the residents' medications were reviewed quarterly by a pharmacist. This failed practice had the widespread potential for more than minimal harm for all 32 residents. Findings: On 02/03/20 at 9:56 a.m., no quarterly pharmacy reviews could be found in the documentation submitted. The administrator stated the quarterly pharmacy reviews had not been completed.	C 921		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on interview and record review, it was	C 954		

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C 954	Continued From page 2 determined the center failed to ensure 3 (#4, 5, and #6) of 4 direct care employees who were hired since the previous re-licensure survey were trained in first aid. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 01/31/20 at 1:25 p.m., a review of employees' records revealed the following direct care employees had not been provided first aid training: Long term care aide (LTCA)/employee #4- hired 07/11/19; LTCA/employee #5 - hired 01/03/20; and Certified medication aide/employee #6 - hired 01/13/20. The administrator stated employees #4, 5, and #6 had not received first aid training.	C 954		
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	C1505		

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C1505	Continued From page 3 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 ensure: a) Laboratory tests were completed as ordered for 2 (#4 and #5) of 3 sampled residents who had orders for physician ordered blood tests; and b) Medications were administered as ordered by the physician for 1 (#7) of 8 sampled residents who were received employee administered medications. These failed practices resulted in the potential for more than minimal harm at a pattern. Findings: LABORATORY TESTS RESIDENT #4 Resident # 4 had diagnosis which included long term anticoagulation therapy and was on Coumadin (used to thin blood and prevent blood clots) daily with monthly prothrombin time/International Normalized Ratio (PT/INR) (laboratory test to indicate blood clotting time). No PT/INR results were located in the resident's chart for March, April, May, July, August, October	C1505		

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C1505	Continued From page 4 2019, and January 2020. On 02/03/20 at 9:16 a.m., the administrator/licensed practical nurse (LPN) #1 stated resident #4 did not have his PT/INR drawn in January because he was not taken over to the clinic to get it completed. She stated the other PT/INR results were not found in the resident's chart. RESIDENT #5 Resident #5 had a physician's order for a comprehensive metabolic panel (CMP)(blood test to measure glucose, electrolyte and fluid balance, kidney and liver functions) to be obtained by home health on or around 08/21/19. No CMP results were located in the resident's chart. The third party home health communication forms did not contain documentation the home health had drawn the CMP on resident #5. On 02/03/20 at 8:39 a.m., the administrator/LPN #1 stated the CMP results were not in the chart and she was not sure if it was drawn by home health. MEDICATIONS RESIDENT #7 A physician's order, dated February 2018, documented to administer Felodipine 5 milligrams (mg) (medication used to treat high blood pressure) one time a day at 1:30 p.m., and to administer Felodipine 5 milligrams as needed for blood pressure 150/90 one time daily. A medication administration record for resident #7, dated 12/2019, documented to administer	C1505		

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C1505	Continued From page 5 Felodipine 5 mg one tablet daily at 1:30 p.m., hold if the blood pressure was less than 130/60, and to administer Felodipine 5 mg at 8:00 p.m., hold if blood pressure was less than 130/60. Resident #7's MAR also documented the Felodipine 5 mg dose scheduled at 8 p.m., was administered 7 times with a blood pressure reading less than 150/90 and 3 times without a blood pressure documented. The MAR documentation did not match the physician's order on the blood pressure parameter. On 02/03/20 at 11:25 a.m., resident #7's family member stated the Felodipine was supposed to be given in the afternoon and then again in the evening if resident #7's blood pressure was elevated. At 12:10 p.m., the administrator/LPN #1 stated the evening dose of Felodipine was supposed to be ordered as needed for a blood pressure greater than 150/90 per the physician.	C1505		
C1920 SS=E	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to implement their policy for medication administration. This failed practice had the potential for more than minimal harm at a pattern. Findings:	C1920		

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C1920	Continued From page 6 On 01/30/20 at 11:53 a.m., fifteen white paper souffle medication cups with medications in them were unsecured on top of a medication cart located just inside the main entrance and the dining room, where residents were seated. No employees were in eye-sight of the medication cart or the medications unsecured on top of the medication cart. At 11:59 a.m., certified medication aide (CMA)/employee #2 stated, "She did not usually pull the meds like this." She stated the center was "short-handed" that day. At 5:25 p.m., the administrator/licensed practical nurse (LPN) #1 agreed the medications should not have been left unsecured on top of the medication cart. POLICY A procedure for medication administration, not dated, documented, "...Cart must always be visible to person administering medications..." Administration of medication policy, not dated, documented, "...Medication cart is to be kept locked at all times unless in use and within sight...Medications are administered at the time they are prepared. Medications are not pre-poured..."	C1920		
C1922 SS=E	310:663-19-2(a)(2) MEDICATION ADMINISTRATION (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and	C1922		

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C1922	Continued From page 7 record the medication. Medications shall be prepared within one hour prior to administration. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center's employees failed to: a) Observe the swallowing of medications for 3 (#1, 2, and #3) of 3 sampled residents who received employee administered medications; and b) Record the medications administered for 3 (#2, 9, and #10) of 3 sampled residents. These failed practices had the potential for more than minimal harm at a pattern. Findings: OBSERVE SWALLOWING On 01/30/20 at 12:15 p.m., certified medication aide (CMA)/employee #2 stated she left the residents' medications on the dining room tables. She stated the residents do not like the employees to watch while they take their medications. At 12:17 p.m., CMA/employee #2 put medication in front of resident #1 and walked away to administer medication to another resident. At 12:21 p.m., resident #2 and #3 had medication cups with pills/capsules in them on the dining room table. Resident #3 stated she took her medication after she ate. At 5:25 p.m., the administrator/licensed practical nurse (LPN) #1 stated it was the center's policy	C1922		

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C1922	Continued From page 8 for the employee who administered medication to observe the resident swallow the medication. On 01/31/20 at 9:27 a.m., resident #2 stated the employees left her medications on the dining room table for her to take when she was ready. At 10:01 a.m., resident #8 stated the staff usually left her medication on the dining room table for her to take. On 02/03/20 at 11:25 a.m., resident #7's family member stated she visited often and ate lunch with the residents and noticed the employees left medications on the dining room tables for the residents. She also stated the employees had left medications in resident #7's apartment. The family member further stated the employees needed to make sure resident #7 took her medication because she had dementia. MEDICATION RECORD On 01/30/20 at 4:45 p.m., the medication administration records were reviewed with CMA/employee #2, who had administered medications that day. She stated she had administered medications, and not signed the medications out to resident #2, 9, and #10. She was asked how someone would know if the medications were administered if they were not signed out. She stated all of the residents were pretty alert and could tell you if they got their medications.	C1922		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly	C1951		

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C1951	Continued From page 9 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 interview and record review, it was determined the center failed to ensure organized and accurate written records were maintained for 4 (#1, 2, 7, and #13) of 8 sampled residents who received employee administered medications. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #1 Resident #1's January 2020 medication administration record (MAR) documented the resident was to be administered Levothyroxine (used to treat hypothyroidism) daily and Lactaid (used to treat lactose intolerance) before meals and dairy snacks. The resident's record did not contain a physician's order for the medications. On 01/30/20 at 12:17 p.m., certified medication aide (CMA)/employee #2 placed the Lactaid at the dining table in front of resident #1. RESIDENT#2 Resident #2's January 2020 MAR documented the resident was to be administered Prednisone (used to decrease inflammation in lung diseases) daily at 12:00 p.m., starting on 01/25/20. The resident's record did not contain a physician's order for the Prednisone medication.	C1951		

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C1951	Continued From page 10 RESIDENT #7 The physician's order in resident #7's record, dated 02/2018, documented to administer Felodipine 5 milligrams daily at 1:30 p.m., and to administer Felodipine 5 milligrams as needed one time a day for blood pressure of 150/90. Resident #7's MAR for 12/2019 and 01/2020 documented the resident was to be administered Felodipine 5 milligrams two times a day, and to hold the medication if the blood pressure was less than 130/60. The MAR did not match the physician's orders in the resident's record. RESIDENT #13 On 01/30/20 at 4:15 p.m., resident #13 was administered Lactaid 3000 unit one capsule. No physician's order was found in the resident's record for the Lactaid. At 5:25 p.m., the administrator/licensed practical nurse stated the residents went to the doctors office and they would send the new prescriptions to the pharmacy electronically. She stated the orders in the resident's records should be updated when the physician made changes.	C1951		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL2502	THE WILLOWS

Type of Survey (select all that apply)

2				

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				

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. 36191	01/30/2020	02/03/2020	0.75	0.00	17.00	0.00	6.50	13.00
2.								
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**

FEB 19 2020

OKLAHOMA
State Department
of Health

Delivery Via Email: lpn_583@yahoo.com

October 2, 2020

License Number: AL2502

Ms. Dana Vandever, Administrator
The Willows
301 Melville Drive
Pauls Valley, OK 73075

RE: Survey Event 7ZR811

Dear Ms. Vandever:

On **February 3, 2020**, 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 **March 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,

Katie Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State Department of Health, ou=Long Term Care, email=katies@health.ok.gov, c=US
Date: 2020.10.02 13:35:09 -05'00'

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/28/2020** **Facility Name:** The Willows Assisted Living Residence **License Number:** AL2502 **Survey Event ID:** 7ZR811 **Date Survey Completed: 2/3/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391	Based on: Based on observation and interview, it was determind the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regard to ware washing sanitation. The failed practice had the wide spread potential for more than minimal harm for all 32 residents who received meals from the kitchen.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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 log sheet has been implemented to document the proper sanitation range for warewashing equipment. Dietary workers will ensure the proper sanitation level is being met by utilizing chlorine test strips and recording the reading three times a day; breakfast, lunch and dinner. Proper testing strips have been provided to the dietary staff and each dietary worker has been properly trained on the use of the testing strips. The test strips have a color coated range of acceptable chlorine level which is determined to be 50ppm-100ppm. This range ensures that all dishes are properly sanitized.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident who is receiving meals from the kitchen will be provided properly sanitized dishes at all times.
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?	A log sheet has been implemented to document the proper sanitation range for warewashing equipment. Dietary workers will ensure the proper sanitation level is being met by utilizing chlorine test strips and recording the reading three times a day; breakfast, lunch and dinner. Proper testing strips have been provided to the dietary staff and all dietary workers have been educated on the correct use of the testing strips. Testing strips will be kept within reach of the warewashing machine so they can be easily located and used.
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	a)The daily tempature and chemical sanitition log sheet will be signed and/or initialed by any dietary worker who is operating warewashing equipment. b)Tempature and sanitation log sheets will be monitored weekly by the dietary supervisor and will be provided to the facility administrator at the end of each month for

c. How monitoring records will be kept to evidence the correction.	record keeping purposes. The completed log sheets will be reviewed and discussed at each quarterly Quality Assuranace meeting. b) The dietary supervisor or the facility administrator will be responsible for reporting dietary needs or concerns during each QA meeting. The completed tempature and chemical santatizer log sheets will be reviewed and discussed during each quartlerly meeting. c) A three ring binder will be used to organize and store each completed log sheet. This three ring binder will be kept on the book shelf located inside the administrators office. The binder will be properly marked and recognizable for easy location.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/3/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Dana D. Vandever OAC 310:663-25-4(F)	**Date 3/2/2020**

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

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/2/2020** **Facility Name:** The Willows Assisted Living Residence **License Number:** AL2502 **Survey Event ID:** 7ZR811 **Date Survey Completed: 2/3/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C921	Based on: Based on interview and record review, it was determined the center failed to ensure the residents medications were reviewed quarterly by a pharmacist. This failed practive had the widespread potential for more than minimal harm for all 32 residents

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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 licensed pharmacist will conduct quarterly medication reviews on all residents residing at The Willows Assisted Living as required by LTC rules and regulations. This service will provided by Reavis Super Drug and Health Care Pharmacy located in Pauls Valley, Oklahoma. As soon as the missed quarterly reviews were brought to the attention of the consulting pharmacist, he arranged for the quarterly review to be conducted.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident residing at The Willows Assisted Living Residence, who receives medication administration services provided by our staff, will be provided proper medication review monthly by an RN and quarterly by a licensed pharmacist.
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?	An updated pharmaceutical consultant agreement has been signed between The Willows Assited Living Residence and Reavis Super Drug and Health Care Pharmacy. It is agreed that a licensed pharmacist will conduct quarterly medication reviews on all residents residing at The Willows Assisted Living Residence.
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.	a)Reavis Super Drug and Health Care Pharmacy has agreed to provide a printed quarterly report on each resident receiving medication administration services. The signed agreement between the consulting pharmacy and The Willows Assisted Living Residence states that each quarterly review will be completed and all reports will be provided to our facility in a timely manner. a)Once the quarterly report is received, each printed report will be reviewed by the administrator and the RN consultant. Any recommendations or concerns listed by

	the pharmacist will be addressed. b)The pharmaceutical consultant will be present at the quarterly QA meeting and will report on findings of his/her quarterly report. c)All Pharmaceutical Quarterly reports will be filed together in a designated folder and kept in the filing cabinet located inside the administrators office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/21/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Dana D. Vandever** OAC 310:663-25-4(F)	**Date 3/2/2020**

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/3/2020** **Facility Name:** The Willows Assisted Living Residence **License Number:** AL2502 **Survey Event ID:** 7ZR811 **Date Survey Completed: 2/3/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954	Based on: All resident care staff will be trained in first aid training during new employee orientation. This will ensure that al resident care staff are properly trained in first aid prior to caring for the residents at The Willows Assisted Living Residence.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All resident care staff will be trained in first aid training during new employee orientation. This will ensure that all resident care staff are properly trained in first aid prior to caring for the residents at The Willows Assisted Living.
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 resident care staff will be required to have completed first aid training prior to caring for the residents who reside at The Willows Assisted Living Residence
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 person providing new employee orientation will ensure that first aid training is provided to any and all newly hired resident care employee. This required training will be documented on the employee training check sheet by a licensed nurse or RN consultant
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.	a) Orientation check sheets including first aid training and CPR training will be placed in each employee file. Each employee will complete a test at the end of training to evaluate understanding of the material. This completed test will be made part of the employee file. The Administration Assistant will conduct monthly file checks to ensure complete compliance. b)Each quarterly QA meeting will now include a time to discuss all newly employeed personel. Completed orientation check list and proof of all mandatory training will be provided. c) The Quality Assurance minutes will include the orientation and first aid training reports. Any suggestions or concerns given by committee members shall be included in the final minutes of each meeting. Enter methods to keep monitoring records:

OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/14/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Dana D Vandever** OAC 310:663-25-4(F)	**Date 3/3/2020**

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/3/2020** **Facility Name:** The Willow Assisted Living Residence **License Number:** AL2502 **Survey Event ID:** 7ZR811 **Date Survey Completed: 2/3/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Based on interview and record review, laboratory tests were completed as ordered for 2 (#4 and #5) of 3 sampled residents who had orders for physician ordered blood test and medications were administered as ordered by the physician for 1 (#7) of sampled residents who were receiving employee administered medications. These failed practices resulted n the potential for more than minimal harm

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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 # 4 received a PT/INR on 2/3/20; the same day the surveyor brought the missed lab draw to our attention. Those results are in residents chart. Resident # 5 had received the CMP that was sited in prefix tag C1505 on the date required 8/21/19. Home Health agency provided proof of lab testing while surveyor was still on site. In regard to Resident #7, residents PCP has provided a clear and concise order for the administration of Felodipine. This order was updated on the MAR. A vital sign flow sheet has been placed along with the MAR for proper documentation of the resident's blood pressure. All staff members who are certified to administer medications have been educated on the importance of blood pressure monitoring prior to the administration of this medication. The night time dose of this medication has been changed to a PRN per doctors order.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident who has physician ordered lab testing will be identified as a potential risk for untimely lab testing. Any resident who has physician ordered medications can be considered at possible risk for the improper dosing of a medication or the skipped monitoring of vital signs. In an effort to ensure that this does not happen, all physician orders will be noted on the MAR as written by the physician. All medication orders will be obtained by the ordering physician or by the pharmacy that has filled the prescribed medication.
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?	A duel calendar system will be used to schedule all upcoming physician ordered lab testing. All routine and specifically ordered lab testing will be noted on both calendars as orders are received.

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.	a) All physician ordered lab testing will be documented on each calendar at the time the order is received. Once the testing has been completed, the results will be obtained and placed in residents chart. Monthly chart reviews will be conducted to cross check the scheduled lab testing that has been noted on the monthly calendar to ensure that coordinating test results have been received and placed in chart. a) all medication orders will be updated on the MAR as written by the physician. Physician orders based on the printed monthly MAR, will be provided to the physician for review and for approval. Newly signed monthly physician orders will be placed in each resident chart. b) Lab testing results will be reported to the QA committee at each quarterly meeting. The RN consultant will provide an update on the efficiency of the system to the QA committee quarterly. Recently signed physician orders will be verified by the QA committee to ensure current orders are always on file. c)The RN consultant will address lab testing results in her monthly consultant report that is provided to the administrator. All consultant reports will be kept in an appropriately named binder and will kept in the filing cabinet inside the administrators office. All recently signed physician orders will be kept in each resident chart. These orders will be received as soon as possible once a new order is given. Printed physician orders that coordinate with the MAR will be provided to each PCP each month for approval. Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/7/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Dana D Vandever OAC 310:663-25-4(F)	**Date 3/3/2020**

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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: 3/3/2020** **Facility Name:** The Willows Assisted Living Residence **License Number:** AL2502 **Survey Event ID:** 7ZR811 **Date Survey Completed: 2/3/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1922	Based on: Based on observation, interview and record review, it was determined the center's employees failed to a) observe the swallowing of medications and b) record the medications administered for 3 sampled residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Each CMA and MAT administering medications within our center will ask that each resident take all administered medications when given. Each resident will be observed swallowing all medications by the CMA or MAT. All administered medication will be properly documented at the time of administration.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident who is receiving medication assistance within our facility will have only qualified personel administering medications. All newly employeed medication staff will be educated on the centers policy and procedure relating to proper medication administration. All residents will be observed swallowing all medications and proper documentation will be completed at the time medication is administered. Residents will also be educated on the policy so they will understand the reason why they should allow staff to observe the swallowing of all medications.
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?	Each medication assistant will be provided a copy of the facilities policy regarding proper medication administration. Each employee will be asked to sign a confirmation indicating they are aware of the centers policies. Each employee will be inserviced at least quarterly regarding proper medication administration techniques. All employees who are certified to administer medications will be properly trained and evaluated by a licensed nurse to ensure the centers policy and procedures are being met. Inservice training will focus on the importance of observing the swallowing of all medications and the proper documentation of medications once medication is given.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained?	a) All CMAs and MATs will be shadowed by a licensed nurse to ensure all medication administration policies and

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.	procedures are being observed. Focus will be given on the actual observation of the swallowing of medications and the proper documentation of medications once they are given. Enter methods to evaluate for effectiveness: b) The signed policy and procedures will be reviewed at each quarterly QA meeting. The administrator will report on all newly employeed medication administration staff member and provide proof of proper training for each employee. c) All signed policy and procedure confirmations will be placed in each employees file. Skills check sheets will be completed during shadowing and will be signed, dated, and placed in each employee file. Proof of relevant inservice training relating to medication administration will be kept in the Employee Inservice binder that is located in the administrators office. The skills check will include the observation of swallowing of medications and the proper documentation of medications once they are given.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/20/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Dana D Vandever** OAC 310:663-25-4(F)	**Date 3/3/2020**

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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: 3/3/2020** **Facility Name:** The Willows Assisted Living Residence **License Number:** AL2502 **Survey Event ID:** 7ZR811 **Date Survey Completed: 2/3/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1922	Based on: Based on observation, interview and record review, it was determined the center's employees failed to a) observe the swallowing of medications and b) record the medications administered for 3 sampled residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Each CMA and MAT administering medications within our center will ask that each resident take all administered medications when given. Each resident will be observed swallowing all medications by the CMA or MAT. All administered medication will be properly documented at the time of administration.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident who is receiving medication assistance within our facility will have only qualified personel administering medications. All newly employeed medication staff will be educated on the centers policy and procedure relating to proper medication administration. All residents will be observed swallowing all medications and proper documentation will be completed at the time medication is administered. Residents will also be educated on the policy so they will understand the reason why they should allow staff to observe the swallowing of all medications.
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?	Each medication assistant will be provided a copy of the facilities policy regarding proper medication administration. Each employee will be asked to sign a confirmation indicating they are aware of the centers policies. Each employee will be inserviced at least quarterly regarding proper medication administration techniques. All employees who are certified to administer medications will be properly trained and evaluated by a licensed nurse to ensure the centers policy and procedures are being met. Inservice training will focus on the importance of observing the swallowing of all medications and the proper documentation of medications once medication is given.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained?	a) All CMAs and MATs will be shadowed by a licensed nurse to ensure all medication administration policies and

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.	procedures are being observed. Focus will be given on the actual observation of the swallowing of medications and the proper documentation of medications once they are given. Enter methods to evaluate for effectiveness: b) The signed policy and procedures will be reviewed at each quarterly QA meeting. The administrator will report on all newly employeed medication administration staff member and provide proof of proper training for each employee. c) All signed policy and procedure confirmations will be placed in each employees file. Skills check sheets will be completed during shadowing and will be signed, dated, and placed in each employee file. Proof of relevant inservice training relating to medication administration will be kept in the Employee Inservice binder that is located in the administrators office. The skills check will include the observation of swallowing of medications and the proper documentation of medications once they are given.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/20/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Dana D Vandever** OAC 310:663-25-4(F)	**Date 3/3/2020**

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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: 3/3/2020** **Facility Name:** The Willows Assisted Living Residence **License Number:** AL2502 **Survey Event ID:** 7ZR811 **Date Survey Completed: 2/3/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1951	Based on: Based on observation, interview and record review, it was determined the center failed to ensure organized and accurate written records were maintained for 4 of 8 sampled residents who received employee administered medications.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Current medication orders have been received and placed in each residents chart. All physician signed orders have been verified as matching each of the residents MAR.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Any resident who is receiving medication assistance within our facility will have updated and verified physician orders on file at all times.
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?	Signed physician orders will be obtained from each residents PCP each month. If medication changes are made throughout the month, these changes will be verified by the licensed nurse on duty. The LPN or RN consultant will obtain a hand written prescription and/or an electronic RX confirming the medication change. All medication orders will be placed in the residens chart.
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) Each resident chart will be checked once every month to ensure current physician orders are on file for all medications that are administered. The licensed nurse will document on the back of each residens MAR at the end of each month stating current orders are on file. b) The RN consultant will provide information regarding physician orders and/or any other medication concern in her monthly consultant report. Those reports will be submitted for review at each quarterly QA meeting. c) Each Monthly MAR will be kept in a specific storage box for easy access. Each MAR will be signed and dated verifying that it has been

	matched with current physician orders prior to storage. All physician orders will be filed in each resident's chart as soon as they are received.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/27/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Dana D Vandever** OAC 310:663-25-4(F)	**Date 3/3/2020**

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