

**Delivery via email to:** [rmarchbanks@enlivant.com](mailto:rmarchbanks@enlivant.com)

April 25, 2023

License Number: AL5503

Mr. Robert Marchbanks, Administrator  
Southridge Place  
2500 Southwest 89th Street  
Oklahoma City, OK 73159

**RE: Survey Event ID: JVDC11**

Dear Mr. Marchbanks:

On **April 13, 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 **April 13, 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](mailto: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](mailto:LTCEnforcement@health.ok.gov) or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

*Katie Stagner*

Katie Stagner, Enforcement Analyst  
Long Term Care  
Protective Health Services

Enclosure



Oklahoma State Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHRIDGE PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2500 SOUTHWEST 89TH STREET<br/>OKLAHOMA CITY, OK 73159</b> |                                                                                                                          |                                                        |
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| C 000                                                       | <p>INITIAL COMMENTS</p> <p>A relicensure survey was conducted from 04/11/23 through 04/13/23.</p> <p>Listed below are abbreviations that will be used throughout this document.</p> <p>BID - twice a day<br/>cap - capsule<br/>CHF - congestive heart failure<br/>cm - centimeter<br/>CMA - certified medication aide<br/>COPD - chronic obstructive pulmonary disease<br/>CSM - care services manager<br/>ED - executive director<br/>ER - extended release<br/>gm - gram<br/>HFA - hydrofluoroalkane<br/>HTN - hypertension<br/>MAR - medication administration record<br/>mcg - micrograms<br/>mEq - milliequivalent<br/>mg - milligram<br/>ml - milliliter<br/>mid - middle<br/>NSAID - nonsteroidal anti-inflammatory drug<br/>oz - ounce<br/>PRN - as needed<br/>QA - quality assurance<br/>QI - quality improvement<br/>Res - Resident<br/>RN - registered nurse<br/>tab - tablet<br/>UTI - urinary tract infection</p> | C 000                                                                                                  |                                                                                                                          |                                                        |
| C 521<br>SS=D                                               | <p>310:663-5-2(a) ASSESSMENT TIMEFRAMES</p> <p>(a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | C 521                                                                                                  |                                                                                                                          |                                                        |

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Oklahoma State Department of Health

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| C 521                                                       | <p>Continued From page 1</p> <p>This Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to complete an admission assessment within 30 days before or at the time of admission for one (#5) of eight sampled residents reviewed for admission assessments.</p> <p>The "Assisted Living Resident Condition and Care Overview" report, dated 04/11/23, documented 23 residents resided in the facility.</p> <p>Findings:</p> <p>Res #5 was admitted to the facility on 08/10/22 with diagnoses which included diverticulitis, hyperlipidemia, HTN, and hypothyroidism.</p> <p>A resident assessment form, dated 08/11/22, documented a preadmission assessment was completed.</p> <p>There was no documentation an admission assessment was completed 30 days before or at the time of admission.</p> <p>On 04/13/23 at 11:15 a.m., the CSM was asked to verify the resident's admission date. He stated 08/10/22. He was shown the preadmission assessment dated 08/11/22. He stated the assessment should have been a 14 day assessment. He stated there was not an</p> | C 521                                                                                                  |                                                                                                                          |                                                        |

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| C 521                                                       | Continued From page 2<br><br>admission assessment completed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | C 521                                                                                                  |                                                                                                                          |                                                        |
| C 522<br>SS=E                                               | <p>310:663-5-2(b) ASSESSMENT TIMEFRAMES</p> <p>(b) The assisted living center shall complete the comprehensive assessment in accordance with the following:</p> <p>(1) within fourteen (14) days after admission of the resident;</p> <p>(2) once every twelve (12) months thereafter; and</p> <p>(3) promptly after a significant change in the resident's condition.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review and interview, the facility failed to ensure comprehensive assessments were completed:</p> <p>a. 14 days after admission for one (#1) and</p> <p>b. every 12 months for four (#3, 6, 7, and #8) of eight sampled residents reviewed for comprehensive assessments.</p> <p>The "Assisted Living Resident Condition and Care Overview" report, dated 04/11/23, documented 23 residents resided in the facility.</p> <p>Findings:</p> <p>1. A resident assessment, dated 02/13/23, documented a preadmission assessment was completed for Res #1.</p> <p>Res #1 was admitted to the facility on 02/27/23</p> | C 522                                                                                                  |                                                                                                                          |                                                        |

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| C 522                                                       | <p>Continued From page 3</p> <p>with diagnoses which included CHF, HTN, atrial fibrillation, glaucoma, and cognitive impairment.</p> <p>A resident assessment, dated 04/05/23, documented a 14 day assessment was completed.</p> <p>There was no documentation a comprehensive assessment was completed 14 days after admission.</p> <p>On 04/13/23 at 10:55 a.m., the CSM was asked about the 14 day assessment completed for the resident. He stated the assessment was not completed within 14 days of the residents' admission.</p> <p>2. Res #3 was admitted to the facility on 07/14/21 with diagnoses which included COPD, major depressive disorder, heartburn, polyneuropathy, and unspecified asthma.</p> <p>There was no documentation a comprehensive assessment was completed in 2022.</p> <p>On 04/12/23 at 2:20 p.m., the CSM was asked to provide a comprehensive assessment for the resident completed in 2022.</p> <p>On 04/12/23 at 2:28 p.m., the CSM stated he was not sure where the assessment could be. He stated it should have been completed.</p> <p>3. Res #6 was admitted to the facility on 01/14/22.</p> <p>An admission assessment was completed on 01/14/22.</p> <p>There was no comprehensive assessment completed for 2023.</p> | C 522                                                                                                  |                                                                                                                          |                                                        |



Oklahoma State Department of Health

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| C 522                                                       | Continued From page 4<br><br>On 04/13/23 at 10:57 a.m., the CSM stated a comprehensive assessment for Res #6 had not been completed for 2023. He stated the assessments should be completed annually.<br><br>4. Res #7 was admitted to the facility on 05/03/18.<br><br>An admission assessment was completed on 05/03/18.<br><br>There was no comprehensive assessment completed for 2022.<br><br>On 04/13/23 at 1:44 p.m., the CSM stated he could not locate a comprehensive assessment for Res #7 for 2022. He stated he was unsure if it was completed.<br><br>5. Res #8 was admitted to the facility on 03/24/23.<br><br>An admission assessment was completed on 03/24/23.<br><br>There was no comprehensive assessment completed for 2022.<br><br>On 04/13/23 at 1:44 p.m., the CSM stated he could not locate a comprehensive assessment for Res #8 for 2022. He stated he was unsure if it was completed. | C 522                                                                                                  |                                                                                                                          |                                                        |
| C 531<br>SS=D                                               | 310:663-5-3(a) ASSESSMENT FORM<br><br>(a) The admission assessment form shall include but not be limited to the following:<br>(1) resident's identification;<br>(2) disease diagnosis/infections;                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | C 531                                                                                                  |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| C 531                                                       | <p>Continued From page 5</p> <p>(3) mental health history, and<br/>mental retardation or<br/>developmental disability;</p> <p>(4) physical functioning which<br/>includes the numbers of persons<br/>needed to assist with<br/>activities of daily living;</p> <p>(5) incontinence;</p> <p>(6) medications;</p> <p>(7) special treatment and<br/>procedures;</p> <p>(8) cognitive function; and</p> <p>(9) signatures and dates.</p> <p>This Rule is not met as evidenced by:<br/>Based on record review and interview, the facility<br/>failed to ensure admission assessments<br/>contained all required components for two (#1<br/>and #3) of eight sampled residents reviewed for<br/>admission assessments.</p> <p>The "Assisted Living Resident Condition and<br/>Care Overview" report, dated 04/11/23,<br/>documented 23 residents resided in the facility.</p> <p>Findings:</p> <p>1. A resident assessment, dated 02/13/23,<br/>documented a preadmission assessment was<br/>completed for Res #1. There was no signature<br/>for the resident or representative interviewed.</p> <p>On 04/12/23 at 10:26 a.m., the CSM was shown<br/>the resident's preadmission assessment. They<br/>stated there should have been a resident or<br/>representative signature.</p> | C 531                                                                                                  |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| C 531                                                       | Continued From page 6<br><br>2. Res #3 was admitted to the facility on 07/14/21 with diagnoses which included COPD, major depressive disorder, heartburn, polyneuropathy, and unspecified asthma.<br><br>A resident assessment, dated 07/14/21, documented a 14 day assessment was completed. There was no signature for the resident or representative interviewed and participating healthcare professional. There was no documentation a preadmission assessment was completed.<br><br>On 04/12/23 at 3:19 p.m., the CSM was shown the 14 day assessment dated 07/14/21. They stated the assessment should have been a preadmission assessment. They stated there was no signature for the resident or representative interviewed and participating healthcare professional. | C 531                                                                                                  |                                                                                                                          |                                                        |
| C 543<br>SS=D                                               | 310:663-5-4(c) CONDUCT OF ASSESSMENT<br><br>(c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure a comprehensive assessment                                                                                                                                                                                                                                   | C 543                                                                                                  |                                                                                                                          |                                                        |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHRIDGE PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2500 SOUTHWEST 89TH STREET<br/>OKLAHOMA CITY, OK 73159</b> |                                                                                                                          |                                                        |
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| C 543                                                       | Continued From page 7<br><br>included a personal interview between the resident or the resident's representative and the person completing the form for one (#3) of eight sampled residents reviewed for comprehensive assessments.<br><br>The "Assisted Living Resident Condition and Care Overview" report, dated 04/11/23, documented 23 residents resided in the facility.<br><br>Findings:<br><br>An resident assessment, dated 02/16/23 documented an annual assessment was completed for Res #3. It documented they were alert and oriented times three and confused at times. There was no documentation a personal interview between the resident or their representative and the person completing the form was conducted.<br><br>On 04/12/23 at 2:28 p.m., the CSM was shown the assessment where there was no documentation a personal interview between the resident or their representative and the person completing the form was conducted. He stated the resident or their representative should have been interviewed. He stated they should have signed the form.<br><br>On 04/13/23 at 12:07 p.m., Res #3 was shown their annual assessment completed. They were asked if they or their representative were interviewed regarding their assessment. They stated, "No." | C 543                                                                                                  |                                                                                                                          |                                                        |
| C1110<br>SS=E                                               | 310:663-11-1 QUALITY ASSURANCE<br>COMMITTEE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | C1110                                                                                                  |                                                                                                                          |                                                        |

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| C1110                                                       | <p>Continued From page 8</p> <p>(1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall:</p> <ul style="list-style-type: none"> <li>(1) monitor trends and incidents;</li> <li>(2) monitor customer satisfaction measures;</li> </ul> <p>and</p> <ul style="list-style-type: none"> <li>(3) document quality assurance efforts and outcomes.</li> </ul> <p>This Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to ensure QA meetings were held on a quarterly basis.</p> <p>The "Assisted Living Resident Condition and Care Overview" report, dated 04/11/23, documented 23 residents resided in the facility.</p> <p>Findings:</p> <p>The monthly 2022 QI committee meeting agenda and minute reports were reviewed. There was no documentation the QA committee met April through June and July through September.</p> <p>On 04/13/23 at 1:44 p.m., the ED was asked if the QA committee met during the months of April through June and July through September. He stated if the reports were not in the QA book they</p> | C1110                                                                                                  |                                                                                                                          |                                                        |



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| C1110                                                       | Continued From page 9<br><br>did not meet.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | C1110                                                                                                  |                                                                                                                          |                                                        |
| C1327<br>SS=E                                               | <p>310:663-13-2(7) CONTENTS OF CONTRACT</p> <p>Each resident service contract shall contain a clear statement of the following:</p> <p>(7) a provision that the written contract constitutes the entire agreement between the resident and the assisted living center not excluding the marketing materials and the requirements of this Chapter;</p> <p>This Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to ensure each residents service contract contained a clear statement the contract constituted the entire agreement between the resident and the facility for eight (#1, 2, 3, 4, 5, 6, 7, and #8) of eight sampled residents reviewed for service agreements.</p> <p>The "Assisted Living Resident Condition and Care Overview" report, dated 04/11/23, documented 23 residents resided in the center.</p> <p>Findings:</p> <p>Service contracts were reviewed for Res #1, #2, #3, #4, #5, #6, #7, and #8. There was no documentation a provision that the written contract constituted the entire agreement between the resident the the facility.</p> <p>On 04/12/23 at 2:45 p.m., the ED was asked to review the service contract for the provision. He</p> | C1327                                                                                                  |                                                                                                                          |                                                        |

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| C1327                                                       | Continued From page 10<br><br>stated he could not find it and would have to<br>contact corporate.<br><br>On 04/13/23 at 12:15 p.m., the ED stated he had<br>not received any information from corporate or<br>legal regarding the required provision in the<br>service contract. He stated he had reviewed the<br>contract again and it did not contain the required<br>provision.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | C1327                                                                                                  |                                                                                                                          |                                                        |
| C1505<br>SS=D                                               | 310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT<br>RIGHTS - Medical Care<br><br>Each assisted living center and its staff shall be<br>familiar with and shall observe all resident rights<br>and responsibilities enumerated under Title 63<br>O.S. Supp. 1997, Section 1-1918.B<br><br>63 O.S. 1-1918.(B)(5)<br>(5) Every resident shall have the right to receive<br>adequate and appropriate medical care<br>consistent with established and recognized<br>medical practice standards within the community.<br>Every resident, unless adjudged to be mentally<br>incapacitated, shall be fully informed by the<br>resident's attending physician of the resident's<br>medical condition and advised in advance of<br>proposed treatment or changes in treatment in<br>terms and language that the resident can<br>understand, unless medically contraindicated,<br>and to participate in the planning of care and<br>treatment or changes in care and treatment.<br>Every resident shall have the right to refuse<br>medication and treatment after being fully<br>informed of and understanding the consequences<br>of such actions unless adjudged to be mentally<br>incapacitated. | C1505                                                                                                  |                                                                                                                          |                                                        |

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| C1505                                                       | <p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on record review, observation, and interview, the facility failed to ensure wound care was completed for one (#2) of eight sampled residents reviewed for adequate and appropriate medical care.</p> <p>The "Assisted Living Resident Condition and Care Overview" report, dated 04/11/23, documented 23 residents resided in the center.</p> <p>Findings:</p> <p>Res #2 had diagnoses which included hypertension, neuropathy, and edema.</p> <p>A physician order, dated 03/15/23, documented to perform dressing changes daily to a right leg wound.</p> <p>The March 2023 MARs and TARs were reviewed and did not document an order to provide daily dressing changes.</p> <p>A home health RN visit note, dated 03/22/23, documented a skin tear to the right mid calf. It was documented the onset date was 03/17/23. It was documented wound care was provided during the visit.</p> | C1505                                                                                                  |                                                                                                                          |                                                        |

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| C1505                                                       | Continued From page 12<br><br>A home health RN visit note, dated 04/03/23,<br>documented the wound was assessed. There<br>was no documentation wound care was provided.<br><br>On 04/12/23 at 1:10 p.m., the CSM stated there<br>should have been documentation from the home<br>health agency for the daily treatments. He stated<br>the two visit notes were the only documentation<br>provided from the home health agency.<br><br>On 04/12/23 at 2:24 p.m., Res #2 was observed<br>in their bed. A one cm scabbed area behind their<br>knee was observed. This area was identified by<br>the CSM as the wound the order was to treat.<br><br>On 04/12/23 at 3:15 p.m., the CSM stated the<br>order was missed. He stated he had performed<br>the dressing change "a couple of times", but not<br>daily. He stated it should have been<br>communicated to the home health agency, but<br>was not. | C1505                                                                                                  |                                                                                                                          |                                                        |
| C1923<br>SS=E                                               | 310:663-19-2(a)(3) MEDICATION<br>ADMINISTRATION<br><br>(3) An accurate written record of medications<br>administered shall be maintained. The<br>medication record shall include:<br>(A) The identity and signature of the person<br>administering the medication.<br>(B) The medication administered within one<br>hour of the scheduled time.<br>(C) Medications administered as the resident's<br>condition may require (p.r.n.) are recorded<br>immediately, including the date, time, dose,<br>medication, and administration method.<br>(D) Adverse reactions or results.<br>(E) Injection sites.                                                                                                                                                                                                                                                                                              | C1923                                                                                                  |                                                                                                                          |                                                        |

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| C1923                                                       | <p>Continued From page 13</p> <p>(F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident.</p> <p>(G) Medication error incident reports.</p> <p>This Rule is not met as evidenced by:<br/>Based on record review, observation, and interview, the facility failed to ensure:</p> <p>a. PRN medication administration records included indication and/or effectiveness for the use of the medication for two (#3 and #5), and</p> <p>b. an individual inventory record was maintained for schedule II medications prescribed for one (#4) of eight sampled residents reviewed for medications.</p> <p>The "Assisted Living Resident Condition and Care Overview" report, dated 04/11/23, documented 23 residents resided in the facility.</p> <p>Findings:</p> <p>1. Res #4 had diagnoses which included lupus, fibromyalgia, and rheumatoid arthritis.</p> <p>A physician order, dated 08/31/22, documented Res #4 could self administer medications.</p> <p>A physician order, dated 02/01/23, documented hydromorphone (a schedule II opioid pain reliever) 4 mg tablet, one tablet at bedtime.</p> <p>There was narcotic inventory sheets for February 2023 through April 2023.</p> | C1923                                                                                                  |                                                                                                                          |                                                        |

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| C1923                                                       | <p>Continued From page 14</p> <p>On 04/12/23 at 4:11 p.m., CMA #1 stated the staff do not keep a record of Res #4's medications. She stated the resident ordered her own medications and kept them in a lock box in their room.</p> <p>On 04/13/23 at 9:11 a.m., Res #4 was observed in their room seated in an arm chair. They stated they handled their own medication administration and their family ordered them when they ran out. They stated they did not provide any documentation to the facility when they received refills on their medications. They stated their family did not provide any documentation to the facility when they received a refill.</p> <p>On 04/13/23 at 9:47 a.m., the CSM stated the staff do not document a count or record of Res #4's narcotics. He stated Res #4 was cognitively intact and did not require staff to administer or monitor their medications. He stated if the resident had an issue with their medications they would tell the staff. He stated he was unaware the facility was required to keep a record of schedule II medications.</p> <p>On 04/13/23 at 10:23 a.m., the CSM stated he had counted Res #4's hydromorphone. He stated the resident had 132 tablets of the medication in the lock box.</p> <p>2. Res #3 had diagnoses which included chronic pain.</p> <p>A physician order, dated 02/16/23, documented Norco (pain medication) 5/325 mg one tab by mouth one time a day in the morning as needed.</p> <p>The March 2023 MAR documented 12 out of 15 opportunities there was no reason provided for</p> | C1923                                                                                                  |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHRIDGE PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2500 SOUTHWEST 89TH STREET<br/>OKLAHOMA CITY, OK 73159</b> |                                                                                                                          |                                                        |
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| C1923                                                       | Continued From page 15<br><br>the administration of the Norco and three out of 15 opportunities there were no documented effectiveness.<br><br>On 04/12/23 at 2:20 p.m., the CSM was asked what was the protocol for administering PRN medications. He stated the date, time, staff initials, results, and the reason the medication was administered should be documented. He was shown the resident's MAR where there was no documentation for the reason the medication was administered and no documented effectiveness.<br><br>3. Res #5 had diagnoses which included pain.<br><br>A physician order, dated 12/30/22, documented Advil (NSAID) 200 mg one tab by mouth every six hours as needed.<br><br>The March 2023 MAR documented one out of one opportunity there was no reason provided or the documented effectiveness for the administration of the Advil.<br><br>On 04/13/23 at 10:55 a.m., the CSM was asked what was the protocol for administering PRN medications. He stated the date, time, staff initials, results, and the reason the medication was administered should be documented. He was shown the resident's MAR where there was no documentation for the reason the medication was administered and no documented effectiveness. | C1923                                                                                                  |                                                                                                                          |                                                        |
| C1951<br>SS=E                                               | 310:663-19-3(a) MAINTENANCE OF RECORDS<br><br>(a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | C1951                                                                                                  |                                                                                                                          |                                                        |



Oklahoma State Department of Health

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| C1951                                                       | <p>Continued From page 16</p> <p>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.</p> <p>This Rule is not met as evidenced by:<br/>Based on record review and interview, the facility failed to ensure medication administration records were complete and accurate for five (#1, 2, 3, 5, and #6) of eight sampled residents reviewed for medications.</p> <p>The "Assisted Living Resident Condition and Care Overview" report, dated 04/11/23, documented 23 residents resided in the facility.</p> <p>Findings:</p> <p>1. Res #2 had diagnoses which included neuropathy.</p> <p>A physician order, dated 09/27/22, documented to administer Flonase nasal spray (an allergy medication), two sprays in each nostril one time per day.</p> <p>A physician order, dated 09/27/22, documented to administer gabapentin (an anticonvulsant) 300 mg, one capsule by mouth three times per day.</p> <p>A physician order, dated 09/27/22, documented to administer Miralax (a laxative) 17 gm in 8 oz of water two times per day.</p> <p>A physician order, dated 02/03/23, documented to administer Norco (a pain medication) 5/325 mg, one tab by mouth every four hours routinely.</p> | C1951                                                                                                  |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| C1951                                                       | <p>Continued From page 17</p> <p>The March 2023 MAR documented the following.</p> <p>a. on 03/11/23 at 4 a.m., the administration of Norco was blank,</p> <p>b. on 03/11/23 at 8 a.m., the administration of Norco had circled initials. There was no indication on back of MAR,</p> <p>c. on 03/12/23 at 8 a.m., the administration of Flonase was blank,</p> <p>d. on 03/18/23 at 12 p.m., 4 p.m., and 8 p.m., the administration of Norco was blank,</p> <p>e. on 03/18/23 at 2 p.m. and 8 p.m., the administration of gabapentin was blank,</p> <p>f. on 03/18/23 at 8 p.m., administration of Miralax was blank</p> <p>g. on 03/23/23 at 8 a.m., 2 p.m., and 8 p.m., the administration of gabapentin was blank, and</p> <p>h. on 03/26/23 at 12 p.m., the administration of Norco had circled initials. There was no indication on back of MAR,</p> <p>On 04/12/23 at 11:29 a.m., the CSM stated all circled initials on the MAR should have an indication as to why the medication was not given on the back of the MAR. They stated they were never notified Res #2 did not receive medications on 03/11/23, 03/12/23 or 03/18/23. They stated blanks indicated the medication was not documented.</p> <p>2. Res #6 had diagnoses which included dysuria.</p> <p>A physician order, dated 03/06/23, documented to</p> | C1951                                                                                                  |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| C1951                                                       | <p>Continued From page 18</p> <p>administer cephalexin (an antibiotic) 500 mg one time per day, three days per week on Monday, Wednesday, and Friday.</p> <p>A physician order, dated 04/04/23, documented to administer ciprofloxacin (an antibiotic) 500 mg, give one tab by mouth every 12 hours for seven days.</p> <p>The April 2023 MAR documented the following:</p> <p>a. cephalexin was administered on Saturday 04/01/23, Sunday 04/02/23, Tuesday 04/04/23, and Thursday 04/13/23, and</p> <p>b. ciprofloxacin administered on 04/05/23 at 8 p.m. was blank.</p> <p>On 04/13/23 at 11:51 a.m., CMA # 1 stated the medications for Res #6 were dispensed from the pharmacy daily. She stated the medications were pre-packaged according to each administration time. The CMA showed the packaging verifying each medication was individually wrapped and labeled with the administration time. They stated the resident did not miss any doses of their antibiotic and the charting was incorrect. They stated the MAR for the cephalexin was documented incorrectly and there was no way for the resident to receive the medication unless it was ordered and pre-packaged by the pharmacy. They stated the documentation was incorrect.</p> <p>3. Res #1 had diagnoses which included UTI.</p> <p>A physician order, dated 03/10/23, documented cephalexin (an antibiotic) 500 mg one cap BID for 10 days.</p> <p>The March 2023 MAR documented circled staff initials for the 8:00 p.m. dose of cephalexin on</p> | C1951                                                                                                  |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| C1951                                                       | <p>Continued From page 19</p> <p>03/11/23. There was no documentation for the reason the medication was not administered.</p> <p>On 04/12/23 at 11:29 a.m., the CSM was asked what circled staff initials indicated on the MAR. They stated there should be documentation on the back of the MAR for the reason the medication was not administered. They were shown the resident's MAR where there was no documentation for the reason the medication was not administered.</p> <p>4. Res #3 had diagnoses which included chronic pain, COPD, major depressive disorder, polyneuropathy, and constipation.</p> <p>Physician orders, dated 11/02/22, documented Zyrtec (an antihistamine) 10 mg one tab by mouth one time a day; Lexapro (an antidepressant) 20 mg one tab by mouth one time a day; gabapentin (an anticonvulsant) 60 mg one tab by mouth two times a day; Macrobid (an antibiotic) 10 mg one cap by mouth one time a day; pantoprazole (a proton-pump inhibitor) 40 mg tab by mouth one time a day; and rosuvastatin (a statin) 5 mg one tab by mouth one time a day.</p> <p>A physician order, dated 01/03/23, documented Albuterol HFA inhaler (a bronchodilator) two puffs by mouth every six hours.</p> <p>A physician order, dated 01/10/23, documented Cymbalta (an antidepressant) one cap by mouth two times a day.</p> <p>Physician orders, dated 01/11/23, documented lactulose solution (a laxative) 10 mg/15 ml one tablespoon by mouth two times a day, and potassium chloride ER (an electrolyte supplement) 10 mEq one tab by mouth one time</p> | C1951                                                                                                  |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| C1951                                                       | <p>Continued From page 20</p> <p>a day.</p> <p>A physician order, dated 03/01/23, documented morphine ER (an opioid) 15 mg one tab by mouth one time a day at bedtime.</p> <p>A physician order, dated 03/07/23, documented Anoro Ellipta (an anticholinergic) 62.5/25 mcg inhale one puff by mouth one time a day.</p> <p>The March 2023 MAR documented blanks for the following medication administrations:</p> <p>a. one out of 31 opportunities for Zyrtec, Lexapro, Macrobid, pantoprazole, morphine, Anoro Ellipta, potassium chloride, and rosuvastatin,</p> <p>b. 20 out of 124 opportunities for Albuterol,</p> <p>c. one out of 62 opportunities for Cymbalta and gabapentin, and</p> <p>d. three out of 62 opportunities for lactulose solution.</p> <p>On 04/12/23 at 2:20 p.m., the CSM was asked what the blanks on the MAR indicated. They stated it meant staff did not initial or the medication was not administered. They were shown the blanks on the resident's MAR.</p> <p>5. Res #5 had diagnoses of heart failure and HTN.</p> <p>A physician order, dated 12/30/22, documented digoxin (a cardiac glycoside) 0.125 mg one tab every day.</p> <p>A physician order, dated 02/01/23, documented check blood pressure one time a day in the</p> | C1951                                                                                                  |                                                                                                                          |                                                        |

Oklahoma State Department of Health

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| C1951                                                       | <p>Continued From page 21</p> <p>morning.</p> <p>The March 2023 MAR documented blanks for one out of 62 opportunities for the administration of digoxin and three out of 31 opportunities for blood pressure checks.</p> <p>On 04/13/23 at 10:55 a.m., the CSM was asked what the blanks on the MAR indicated. They stated it meant staff did not initial or the administration was not conducted. He was shown the blanks on the resident's MAR.</p> | C1951                                                                                                  |                                                                                                                          |                                                        |

Delivery via email to: [RMarchbanks@enlivant.com](mailto:RMarchbanks@enlivant.com)

June 2, 2023

License Number: AL5503

Mr. Robert Marchbanks, Executive Director  
Southridge Place  
2500 Southwest 89th Street  
Oklahoma City, OK 73159

**RE: Survey Event JVDC11**

Dear Mr. Marchbanks:

On **April 13, 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 **June 9, 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

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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:** 5/8/2023

**Facility Name:** Southridge Place

**License Number:** AL5503

**Survey Event ID:** JVDC11

**Date Survey Completed:** 4/13/2023

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C521

Based on: record review and interview, the facility failed to complete an admission assessment within 30 days before or at the time of admission for one (#5) of eight sampled residents reviewed for admission assessments.

### ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

#### REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.

*[Signature]* ED

Date 5/8/2023

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 5/03/23, Care Service Manager (CSM) completed resident #5's admission assessment.

By 6/09/23, CSM and or designee will audit current resident charts to assess for completion of admission state assessment, CSM to address findings as necessary.

On 5/03/23 Regional Director of Care Services (RDSCS) provided education to Executive Director (ED) and CSM on requirement for completing an admission assessment within 30 days before or at the time of admission.

Beginning 5/08/23, ED and/or designee will review new resident files to ensure the admission state assessment has been completed weekly for 4 weeks, bi-weekly for 4 weeks, then monthly for 1 month. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:



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.



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## OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/8/2023

Facility Name: Southridge Place

License Number: AL5503

Survey Event ID: JVDC11

Date Survey Completed: 4/13/2023

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522

Based on: record review and interview, the facility failed to ensure comprehensive assessments were completed.

### ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

#### REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature *[Signature]*

Date 5/8/2023

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 5/06/23, CSM completed resident #1, 3, 6, 7 and 8's comprehensive state assessments.

By 6/09/23, CSM and or designee will audit current charts to assess for compliance with Preadmission, 14 day and Annual comprehensive state assessments, CSM to address findings as necessary.

On 5/06/23, RDCS educated ED and CSM on requirement for comprehensive assessments to be completed within 14 days after admission and annually.

Beginning 5/08/23, ED and or designee will review current resident files to ensure the comprehensive state assessment has been completed according to required timelines weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

|                                                                                                                                                       |                           |                     |                                           |
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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. |                           |                     |                                           |
| <b>Addendum Date</b>                                                                                                                                  | Enter a date of addendum. | <b>Submitted by</b> | Enter name of person submitting addendum. |
| <b>Items Below Are For OSDH Use Only</b>                                                                                                              |                           |                     |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> 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.                                                                                                |                           |                     |                                           |



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## OPTIONAL PLAN OF CORRECTION TEMPLATE

**Current Date:** 5/8/2023

**Facility Name:** Southridge Place

**License Number:** AL5503

**Survey Event ID:** JVDC11

**Date Survey Completed:** 4/13/2023

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C531

Based on: review and interview, the facility failed to ensure admission assessments contained all required components for two (#1 and #3) of eight sampled residents reviewed for admission assessments.

### ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

#### REQUIRED ELEMENTS OF A PLAN

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

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 5/06/23, CSM reviewed preadmission state assessment with resident #1 and obtained resident #1's signature for preadmission state assessment dated 2/13/23.

On 5/06/23, CSM reviewed 14 day state assessment with resident #3 and obtained resident #3's signature for 14 day state assessment dated 7/14/21, and CSM completed new comprehensive state assessment on resident #3, resident #3 signed the assessment and CSM signed as the participating healthcare professional.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

On 5/03/23, RDCS educated CSM on requirement for admission assessments and required components including signatures and dates.

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?

By 6/09/23, ED and or designee will audit current resident files to ensure comprehensive state assessments have required components including resident, representative and participating healthcare professional signatures.

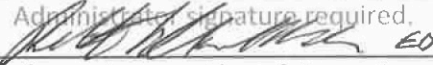
OSDH Response: Element accepted Yes ☐ No ☐

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

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

Beginning 5/08/23, ED and or designee will review current resident files to ensure the comprehensive state assessment have required components including signatures weekly for 4 weeks, bi-weekly for 4 weeks, then monthly for 1 month. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Enter methods to evaluate for effectiveness:

|                                                                                                                                                                                                           |                           |                                              |                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------|-------------------------------------------|
|                                                                                                                                                                                                           |                           | Enter methods to incorporate into QA system: |                                           |
|                                                                                                                                                                                                           |                           | Enter methods to keep monitoring records:    |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                  |                           |                                              |                                           |
| 5. On what date will corrective action be completed?                                                                                                                                                      |                           | 6/9/2023                                     |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                  |                           |                                              |                                           |
| <b>Administrator's Signature</b> <small>Administrator signature required.</small><br><small>OAC 310:663-25-4(F)</small>  |                           | <b>Date 5/8/2023</b>                         |                                           |
| 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.                                                     |                           |                                              |                                           |
| <b>Addendum Date</b>                                                                                                                                                                                      | Enter a date of addendum. | <b>Submitted by</b>                          | Enter name of person submitting addendum. |
| <b>Items Below Are For OSDH Use Only</b>                                                                                                                                                                  |                           |                                              |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> 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.                                                                                                                                                    |                           |                                              |                                           |





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## OPTIONAL PLAN OF CORRECTION TEMPLATE

**Current Date:** 5/8/2023

**Facility Name:** Southridge Place

**License Number:** AL5503

**Survey Event ID:** JVDC11

**Date Survey Completed:** 4/13/2023

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C543

Based on: review and interview, the facility failed to ensure a comprehensive assessment included a personal interview between the resident or the resident's representative and the person completing the form for one (#3) of eight sampled residents reviewed for comprehensive assessments.

### ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

#### REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

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

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 5/06/23, CSM interviewed and completed a comprehensive state assessment for resident #3.

By 6/09/23, CSM and or designee will complete audit of current resident files to ensure comprehensive state assessment interviews are conducted between community healthcare professional and residents and or their representatives and are documented accordingly. CSM to address findings as necessary.

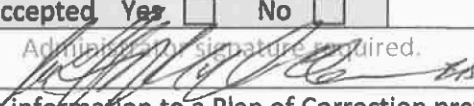
On 5/03/23, RDSCS educated ED and CSM on requirement for comprehensive assessments to include a personal interview between the resident or the resident's representative and the person completing the form.

Beginning 5/08/23, ED and or designee will review current resident comprehensive state assessment to ensure healthcare professional, resident and or representative interviews are conducted weekly for 4 weeks, bi-weekly for 4 weeks, then monthly for 1 month. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

|                                                                                                                                                                                                    |                           |                      |                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------|-------------------------------------------|
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                           |                           |                      |                                           |
| 5. On what date will corrective action be completed?                                                                                                                                               |                           | 6/9/2023             |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                           |                           |                      |                                           |
| <b>Administrator's Signature</b> <i>Administrative signature required.</i><br><small>OAC 310:663-25-4(F)</small>  |                           | <b>Date 5/8/2023</b> |                                           |
| 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.                                              |                           |                      |                                           |
| <b>Addendum Date</b>                                                                                                                                                                               | Enter a date of addendum. | <b>Submitted by</b>  | Enter name of person submitting addendum. |
| <b>Items Below Are For OSDH Use Only</b>                                                                                                                                                           |                           |                      |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> 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.                                                                                                                                             |                           |                      |                                           |



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## OPTIONAL PLAN OF CORRECTION TEMPLATE

**Current Date:** 5/8/2023

**Facility Name:** Southridge Place

**License Number:** AL5503

**Survey Event ID:** JVDC11

**Date Survey Completed:** 4/13/2023

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1110

Based on: review and interview, the facility failed to ensure QA meetings were held on a quarterly basis.

### ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

#### REQUIRED ELEMENTS OF A PLAN

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

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 5/05/23, ED met with QI committee and meeting minutes completed for May 2023. Meeting included monitoring of trends and incidents, monitoring of customer satisfaction measures and documentation of quality assurance efforts and outcomes.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

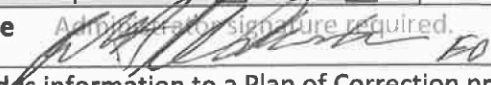
On 5/05/23, ED held resident council meeting to identify any areas of concern. On 5/08/23, the ED performed QI checks related to care, medication management and documentation, housekeeping, and dining to identify any other areas of concern. On 5/08/23, the CSM conducted a review of incidents to identify any possible trends.

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?

On 5/03/23, RDCS provided education to ED and CSM on the requirement for holding QA meetings a minimum of quarterly and the required components, monitoring trends and incidents, monitoring customer satisfaction measures, and documentation of quality assurance efforts and outcomes.



|                                                                                                                                                                                                                                                                                                                                                      |                           |                                                                                                                                                                                                                                                                                                                                                                          |                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                      |                           |                                                                                                                                                                                                                                                                                                                                                                          |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                           |                                                                                                                                                                                                                                                                                                                                                                          |                                           |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained?<br>Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. |                           | Beginning 5/08/23, ED and or designee will audit QA minutes monthly x 3 months to ensure ongoing compliance. Results of the audits will be discussed during the monthly QI meeting. Monitoring will be ongoing.<br><br>Enter methods to evaluate for effectiveness:<br><br>Enter methods to incorporate into QA system:<br><br>Enter methods to keep monitoring records: |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                           |                                                                                                                                                                                                                                                                                                                                                                          |                                           |
| 5. On what date will corrective action be completed?                                                                                                                                                                                                                                                                                                 |                           | 6/9/2023                                                                                                                                                                                                                                                                                                                                                                 |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                             |                           |                                                                                                                                                                                                                                                                                                                                                                          |                                           |
| <b>Administrator's Signature</b> <small>Administrator signature required.</small><br><small>OAC 310:663-25-4(F)</small>                                                                                                                                             |                           | <b>Date 5/8/2023</b>                                                                                                                                                                                                                                                                                                                                                     |                                           |
| 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.                                                                                                                                                                                                |                           |                                                                                                                                                                                                                                                                                                                                                                          |                                           |
| <b>Addendum Date</b>                                                                                                                                                                                                                                                                                                                                 | Enter a date of addendum. | <b>Submitted by</b>                                                                                                                                                                                                                                                                                                                                                      | Enter name of person submitting addendum. |
| <b>Items Below Are For OSDH Use Only</b>                                                                                                                                                                                                                                                                                                             |                           |                                                                                                                                                                                                                                                                                                                                                                          |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> 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.                                                                                                                                                                                                                                                                                               |                           |                                                                                                                                                                                                                                                                                                                                                                          |                                           |



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## OPTIONAL PLAN OF CORRECTION TEMPLATE

**Current Date:** 5/6/2023

**Facility Name:** Southridge Place

**License Number:** AL5503

**Survey Event ID:** JVDC11

**Date Survey Completed:** 4/13/2023

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1327

Based on: review and interview, the facility failed to ensure each residents service contract contained a clear statement the contract constituted the entire agreement between the resident and the facility for eight (#1, 2, 3, 4, 5, 6, 7, and #8) of eight sampled residents reviewed for service agreements.

### ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

#### REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

- a. How the correction will be evaluated for effectiveness;

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

By 6/09/23, ED and/or designee will meet with resident and/or responsible party of resident #1, 2, 3, 4, 5, 6, 7, and 8 and an addendum to the residency agreement including a provision that the written contract constituted the entire agreement between the resident and the facility will be signed and placed on file.

By 6/09/23, ED and/or designee will complete addendum for current residents residing in the community.

On 5/06/23, RDO educated the ED and the Community Relations Manager (CRM) on the requirement for new residents on use of the updated residency agreement indicating the contract constituted the entire agreement between the resident and the facility. Enter measures or systematic changes to ensure deficient practices will not recur.

Beginning 5/08/23, ED and/or designee will review new resident files weekly for 4 weeks, bi-weekly for 4 weeks, then monthly for 1 month to ensure ongoing compliance. Results of the audits will be discussed during monthly QI meeting. Monitoring will be ongoing.

|                                                                                                                                                                                                           |                           |                                                                                                                                                   |                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction.                                          |                           | Enter methods to evaluate for effectiveness:<br><br>Enter methods to incorporate into QA system:<br><br>Enter methods to keep monitoring records: |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                  |                           |                                                                                                                                                   |                                           |
| 5. On what date will corrective action be completed?                                                                                                                                                      |                           | 6/9/2023                                                                                                                                          |                                           |
| OSDH Response: Element accepted Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                  |                           |                                                                                                                                                   |                                           |
| <b>Administrator's Signature</b> <small>Administrator signature required.</small><br><small>OAC 310:663-25-4(F)</small>  |                           | <b>Date 5/8/2023</b>                                                                                                                              |                                           |
| 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.                                                     |                           |                                                                                                                                                   |                                           |
| <b>Addendum Date</b>                                                                                                                                                                                      | Enter a date of addendum. | <b>Submitted by</b>                                                                                                                               | Enter name of person submitting addendum. |
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| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> 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.                                                                                                                                                    |                           |                                                                                                                                                   |                                           |



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## OPTIONAL PLAN OF CORRECTION TEMPLATE

**Current Date:** 5/8/2023

**Facility Name:** Southridge Place

**License Number:** AL5503

**Survey Event ID:** JVDC11

**Date Survey Completed:** 4/13/2023

### SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: review, observation, and interview, the facility failed to ensure wound care was completed for one (#2) of eight sampled residents reviewed for adequate and appropriate medical care.

### ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of an conclusions set forth in this allegation by the survey agency.

#### REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

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

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

#### ASSISTED LIVING CENTER'S PLAN ELEMENTS

On 5/06/23, CSM obtained and implemented clarification wound care order for resident #2's skin tear to right posterior knee.

By 5/06/23, CSM and or designee will audit active wound care orders on current residents to ensure orders are implemented and being followed as written. CSM to address findings as necessary.

On 5/03/23, RDCS educated CSM on requirement for ensuring wound care is provided as ordered.

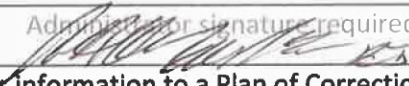
Beginning 5/08/23, CSM and or designee will review new wound care orders on current residents weekly for 4 weeks, bi-weekly for a 4 weeks, then monthly x 1 month to ensure compliance. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Enter methods to evaluate for effectiveness:

Enter methods to incorporate into QA system:

Enter methods to keep monitoring records:

6/9/2023

|                                                                                                                                                                        |                           |                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------|
| <b>Administrator's Signature</b> <small>Administrator signature required.</small><br> |                           | <b>Date 5/8/2023</b>                      |
| 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.                  |                           |                                           |
| <b>Addendum Date</b>                                                                                                                                                   | Enter a date of addendum. | <b>Submitted by</b>                       |
|                                                                                                                                                                        |                           | Enter name of person submitting addendum. |
| <b>Items Below Are For OSDH Use Only</b>                                                                                                                               |                           |                                           |
| Plan of Correction: <input type="checkbox"/> Acceptable <input type="checkbox"/> 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.                                                                                                                 |                           |                                           |