



Delivery via email to: lpark@moradaseniorliving.com

May 21, 2024

License Number: AL5503

Mr. Leo Park, Regional Director of Operations
Morada Southridge
2500 Southwest 89th Street
Oklahoma City, OK 73159

RE: Survey Event ID: 5ZUG11

Dear Mr. Park:

On **May 2, 2024**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **May 2, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care**. 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: Morada Southridge
Address: 2500 Southwest 89th Street
City, State, Zip: Oklahoma City, OK
Provider #: AL5503
Complaint #: OK00063437
Investigation Date(s): 04/24/24 and 04/29/24 through 05/02/24

ALLEGATION(S)
The center failed to ensure a safe, comfortable, and homelike environment.

An unannounced on-site investigation was initiated 04/24/2024 at 8:36 a.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls and rooms were observed for leaks, stains, and odors. The exterior of the center was observed for damage and holes.

Resident records were reviewed including assessments, service plans, physician orders, resident council notes, repair invoice, and grievances.

Residents were interviewed related to the provision of safe, comfortable, and homelike environment.

Staff were interviewed regarding building structure concerns.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 05/02/2024

INVESTIGATIVE REPORT

Facility: Morada Southridge
Address: 2500 Southwest 89th Street
City, State, Zip: Oklahoma City, OK, 73159
Provider #: AL5503
Complaint #: OK00064116
Investigation Date(s): 04/24/24 and 04/29/24 through 05/02/24.

ALLEGATION(S)
The center failed to ensure safe, comfortable, and homelike environment.
The center failed to have and/or implement and effective infection control program.
The center failed to ensure adequate staff to meet the needs of the residents.
The center failed to ensure a licensed administrator was designated according to State Law.

An unannounced on-site investigation was initiated 04/24/2023 at 8:36 a.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls and common areas were observed for staff assistance with resident care needs and the presence of obnoxious and/or foul odors, leaks, stains, and odors. The exterior of the center was observed for damage and holes.

Resident records were reviewed including assessments, service plans, physician orders, resident council notes, repair invoice, grievances, incident reports and state reportable.

Residents were interviewed related to the provision of safe, comfortable, and homelike environment, respiratory infections, staff assistance and facility administration.

Staff were interviewed regarding building structure concerns, respiratory infections, staffing and administration.



The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 05/02/2024

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5503	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/02/2024
NAME OF PROVIDER OR SUPPLIER MORADA SOUTHRIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 SOUTHWEST 89TH STREET OKLAHOMA CITY, OK 73159		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted from 04/24/24, 04/29/24 through 05/02/24. Complaint investigations (#OK00063437 and OK00064116) were conducted in conjunction with the survey. Center Census: 22 Listed below are abbreviations that will be used throughout this document: ACMA-ADVANCED CERTIFIED MEDICATION ASSISTANT CNA- CERTIFIED NURSE AIDE CPR- CARDIOPULMONARY RESUCCITATION QA- QUALITY ASSURANCE	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure food items were dated and labeled. The Interim Executive Director identified 22 residents resided at the center. Findings: A "Food service protection from contamination policy & procedure" policy, undated, read in part, "...Discard or use all food products by manufacturer's indicated date."	C 391		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5503	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/02/2024
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C 391	Continued From page 1 On 04/24/24 at 11:51 a.m. the initial tour of the kitchen was conducted. On 04/24/24 at 11:55 observations were made of the following: a. one open bag of frozen white shredded cheese dated with a hand written sticker for 10/16/23. b. one large opened and almost empty container of ice cream with no date. c. four and one half bag of boiled eggs with no date. d. two cookie sheets with cups of chocolate pudding covered with paper with no date. On 04/24/24 at 11:57 a.m., Cook #1 stated the items should have been dated for when they came in and when they were opened. They verified none of the items listed were dated.	C 391			
C 398 SS=D	310:663-3-8(e) FOOD STORAGE, PREPARATION AND SERVICE (e) All staff assisting in, or responsible for food preparation shall have attended a food service training program offered or approved by the Department. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure one (Cook #1) of two sampled dietary staff responsible for food preparation attended a food service training program approved by the Oklahoma State Department of Health.	C 398			

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

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C 711	Continued From page 3 Based on record review and interview the center failed to ensure the annual fire Marshall inspection was completed and records maintained. The interim Executive Director identified 22 residents resided at the center. Findings: On 4/29/24 at 1:41 p.m., Maintenance #1 stated they did not have the documentation from the fire Marshall inspection and all they had was the green tags that say "April" on them. On 05/01/24 at 10:54 a.m., the Regional Director of Operations provided a fire Marshall report dated 04/29/24. This document was dated for the day it was requested and there had not been an inspection done during the survey. On 05/01/24 at 10:56 a.m., the Regional Director of Operations stated the document was requested yesterday but was not done yesterday and that they could provide the green stickers with dates on them. They further stated that the fire Marshall department had a turnover as well and did not provide the report. They stated they were awaiting documentation of completion from them. On 05/01/24 at 2:51 p.m., the Regional Director of Operations stated they spoke to the captain fire Marshall whom stated the inspection was done on 04/10/24 and closed out on 04/29/24. Still did not provide documentation that stated such. On 05/01/24 at 3:29 p.m., the center provided last years inspection dated 04/18/23.	C 711		

Oklahoma State Department of Health

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C 711	Continued From page 4 On 05/02/24 by the time of exit the fire Marshall inspection documentation from 04/10/24 had not been provided.	C 711		
C 930 SS=F	310:663-9-3(1-3) STAFF QUALIFICATIONS Each assisted living center shall designate an administrator responsible for the operation of the assisted living center. The administrator shall hold at least one (1) of the following credentials: (1) a license issued by the State Board of Examiners for Nursing Home Administrators; or (2) a residential care home administrator's certificate of training from an institution of higher learning whose program has been reviewed by the Department; or (3) a nationally recognized assisted living certificate of training and competency for assisted living administrators that has been reviewed and approved by the Department. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure an Administrator was employed to perform oversight of the daily center operations. The interim Executive Director identified 22 residents resided in the center. Findings:	C 930		

Oklahoma State Department of Health

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C 930	Continued From page 5 On 04/29/24 at 8:37 a.m. stated there was no Executive Director at that time and had someone from a sister facility in Texas who came on Monday and leaves on Thursday. They stated the last Executive Director left in February of this year. On 04/24/24 at 9:10 a.m. the interim Executive Director stated they were at the facility until tonight then returning next week on an unknown date. They stated they had just started their rotation Monday of that week. On 04/24/24 at 2:22 p.m. the Director of Health and Wellness stated that the Regional Director of Operations was in the facility once a week. On 04/24/24 at 2:24 p.m. the interim Executive Director stated the Regional Director of Operations was the Administrator on file. On 04/24/24 at 3:03 p.m. the interim Executive Director stated the Regional Director of Operations was responsible for the day to day operation of the center prior to their arrival. On 04/24/24 at 2:37 p.m. the interim Executive Director provided their Certificate of Completion for "Management of Assisted Living Facilities". It documents the certification date of June 20th and 21st 2017 for Texas. The document did not state it was a nationally recognized certification. They stated they were just covering the community while there was no Executive Director. On 04/24/24 at 3:26 p.m. the Director of Health and Wellness stated they were in the facility half days at both this facility and the other facility since there was no Executive Director at either centers.	C 930		

Oklahoma State Department of Health

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C 930	Continued From page 6 On 04/29/24 at 12:53 p.m. the Regional Director of Operations stated that they nor the interim Executive Director were licensed in Oklahoma and that they were alternating weeks every other week. They stated they were acting Executive Director between the departure of the previous and the starting of the interim Executive Director and they will alternate until someone was obtained. On 04/30/24 at 10:20 a.m. the Regional Director of Operations stated they were a licensed Nursing Home Administrator but not in Oklahoma. On 05/02/24 at 11:03 a.m. ACMA #1 stated the last Executive Director had left at the end of February 2024 and there had not been anyone in the building for that position.	C 930		
C 940 SS=E	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to have a menu available for meal service preparation. The interim Executive Director identified 22 residents resided in the center. Findings:	C 940		

Oklahoma State Department of Health

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C 940	Continued From page 7 On 04/29/24 at 12:34 p.m., there was no observation of a current menu posted in the kitchen. Cook #1 was asked for the menu. On 04/24/24 at 12:36 p.m., Cook #1 stated there was no menu available as the Director of Culinary Services did not have time to make the menu and they would adjust the menu based on what they cooked. The lunch meal was smothered pork chops, mashed potatoes, green beans, and chocolate pudding. On 05/01/24 at 1:26 p.m., the Director of Culinary Services stated they were to follow what was on the menu and that they would modify as needed. They stated they use a menu system and that was suppose to be what was used to cook. On 05/01/24 at 1:27 p.m., the Director of Culinary Services was asked how they ensure residents received meals of adequate nutritional value when a menu was not available. They stated hopefully Cook #1 was aware of what to serve. They stated the menu was there but did not have another print that was not refreshed. They stated they were working on Cook #1 getting better with following the menu. They stated they needed to work on time management to get those done. The cook following the menu had been addressed in the Dietician 02/22/24 note as well.	C 940		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.	C 954		

Oklahoma State Department of Health
STATE FORM

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C1110	Continued From page 9 committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure the QA committee met on a quarterly basis. The interim Executive Director identified 22 residents resided at the center. Findings: The center's "Quality Assurance" policy, dated 02/01/22, read in part, "The community will have procedures in place to assess the quality of care and services provided in order to monitor and improve performance when identified...Meet at least quarterly and document the meeting..." On 04/30/24 at 09:05 a.m., the Director of Health and Wellness stated they had not had a meeting since they had been there and stated they started at the facility in October of 2023. They stated they ensure residents needs were met by having the resident council meetings and speaking to	C1110		

Oklahoma State Department of Health

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C1110	Continued From page 10 residents and their families individually as well as monitoring the antibiotics. There was no documentation provided for a Quality assurance meeting being done quarterly. On 04/30/24 at 11:50 a.m., both the Regional Director of Operations and the Director of Health and Wellness were asked to provide when the last meeting was done. The center did not provide any information by the time of exit.	C1110		
C1120 SS=E	310:663-11-2 QUALITY ASSURANCE REPRESENTATIVES The quality assurance committee shall include at least the following: (1) registered nurse or physician if a medical problem is to be monitored or investigated; (2) assisted living center administrator; (3) direct care staff person or a staff person who has responsibility for administration of medications; and (4) pharmacist consultant if a medication problem is to be monitored or investigated. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Quality Assurance Committee had members that included a facility administrator. The interim Executive Director identified 22 residents resided in the center.	C1120		

Oklahoma State Department of Health

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C1120	Continued From page 11 Findings: A "Quality Assurance" policy, dated 02/01/22, read in part, "...The Community will form a Quality Assurance Committee, which will consist of: Executive Director, Department managers, or a representative of each department...Pharmacy consultant, if available and applicable (medication management concerns)..." On 04/30/24 at 11:50 a.m. the Regional Director of Operations stated that the Administrator would attend if they had one. There was no Administrator/Executive Director for the facility.	C1120		
C1972 SS=E	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure employees received abuse training within 90 days of employment for two (CNA #2 and ACMA #2) of five staff reviewed for abuse training.	C1972		

Oklahoma State Department of Health

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C1972	Continued From page 12 The interim Executive Director identified 22 residents resided in the center. Findings: Review of staff training provided by the center did not include abuse training for CNA #2 and ACMA #2. On 05/02/24 at 12:02 p.m., the Director of Health and Wellness stated they were unable to locate the training for CNA #2 and ACMA #2.	C1972		



Delivery via email to: lpark@moradaseniorliving.com

June 6, 2024

License Number: AL5503

Mr. Leo Park, Director of Operations
Morada Southridge
2500 Southwest 89th Street
Oklahoma City, OK 73159

Survey Event ID: 5ZUG11

Dear Mr. Park:

On **May 2, 2024**, agents from our office completed a Licensure survey with a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C-0930 and C-1120:** The Plan of Correction refers to an Interim Administrator of Record, but it is unclear if they are a licensed Administrator in Oklahoma.
- **C-0711 and C-0940:** The alleged date of compliance (May 1, 2024), cannot be prior to or equal to our exit date (May 2, 2024).

Please provide an amended plan of correction and return as soon as possible.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5503	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/02/2024
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NAME OF PROVIDER OR SUPPLIER MORADA SOUTHRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 SOUTHWEST 89TH STREET OKLAHOMA CITY, OK 73159
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted from 04/24/24, 04/29/24 through 05/02/24. Complaint investigations (#OK00063437 and OK00064116) were conducted in conjunction with the survey. Center Census: 22 Listed below are abbreviations that will be used throughout this document: ACMA-ADVANCED CERTIFIED MEDICATION ASSISTANT CNA- CERTIFIED NURSE AIDE CPR- CARDIOPULMONARY RESUCCITATION QA- QUALITY ASSURANCE	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure food items were dated and labeled. The Interim Executive Director identified 22 residents resided at the center. Findings: A "Food service protection from contamination policy & procedure" policy, undated, read in part, "...Discard or use all food products by manufacturer's indicated date."	C 391		see POC C391

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 391	Continued From page 1 On 04/24/24 at 11:51 a.m. the initial tour of the kitchen was conducted. On 04/24/24 at 11:55 observations were made of the following: a. one open bag of frozen white shredded cheese dated with a hand written sticker for 10/16/23. b. one large opened and almost empty container of ice cream with no date. c. four and one half bag of boiled eggs with no date. d. two cookie sheets with cups of chocolate pudding covered with paper with no date. On 04/24/24 at 11:57 a.m., Cook #1 stated the items should have been dated for when they came in and when they were opened. They verified none of the items listed were dated.	C 391			
C 398 SS=D	310:663-3-8(e) FOOD STORAGE, PREPARATION AND SERVICE (e) All staff assisting in, or responsible for food preparation shall have attended a food service training program offered or approved by the Department. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure one (Cook #1) of two sampled dietary staff responsible for food preparation attended a food service training program approved by the Oklahoma State Department of Health.	C 398	see Pac C 398		

Oklahoma State Department of Health

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C 398	Continued From page 2 The interim Executive Director identified 22 residents resided at the center. Findings: On 05/01/24 at 3:47 p.m. the Director of Culinary Services provided their Serve Safe and stated they know Cook #1 did not have Serve Safe but did not know about food handlers. The hire date for Cook #1 was 09/27/23. Upon review of the documents provided, there was no foodhandlers or serve safe for Cook #1. On 05/02/24 at 12:00 p.m. the Regional Director of Operations stated that Cook #1's food handlers was expired. They did not provide the document.	C 398			
C 711 SS=E	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21. This Rule is not met as evidenced by:	C 711	see Doc C 711		

Oklahoma State Department of Health

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C 711	Continued From page 3 Based on record review and interview the center failed to ensure the annual fire Marshall inspection was completed and records maintained. The interim Executive Director identified 22 residents resided at the center. Findings: On 4/29/24 at 1:41 p.m., Maintenance #1 stated they did not have the documentation from the fire Marshall inspection and all they had was the green tags that say "April" on them. On 05/01/24 at 10:54 a.m., the Regional Director of Operations provided a fire Marshall report dated 04/29/24. This document was dated for the day it was requested and there had not been an inspection done during the survey. On 05/01/24 at 10:56 a.m., the Regional Director of Operations stated the document was requested yesterday but was not done yesterday and that they could provide the green stickers with dates on them. They further stated that the fire Marshall department had a turnover as well and did not provide the report. They stated they were awaiting documentation of completion from them. On 05/01/24 at 2:51 p.m., the Regional Director of Operations stated they spoke to the captain fire Marshall whom stated the inspection was done on 04/10/24 and closed out on 04/29/24. Still did not provide documentation that stated such. On 05/01/24 at 3:29 p.m., the center provided last years inspection dated 04/18/23.	C 711			

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C 711	Continued From page 4 On 05/02/24 by the time of exit the fire Marshall inspection documentation from 04/10/24 had not been provided.	C 711	<i>Sec POC C930</i>	
C 930 SS=F	310:663-9-3(1-3) STAFF QUALIFICATIONS Each assisted living center shall designate an administrator responsible for the operation of the assisted living center. The administrator shall hold at least one (1) of the following credentials: (1) a license issued by the State Board of Examiners for Nursing Home Administrators; or (2) a residential care home administrator's certificate of training from an institution of higher learning whose program has been reviewed by the Department; or (3) a nationally recognized assisted living certificate of training and competency for assisted living administrators that has been reviewed and approved by the Department. This Rule is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure an Administrator was employed to perform oversight of the daily center operations. The interim Executive Director identified 22 residents resided in the center. Findings:	C 930		

Oklahoma State Department of Health

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C 930	Continued From page 5 On 04/29/24 at 8:37 a.m. stated there was no Executive Director at that time and had someone from a sister facility in Texas who came on Monday and leaves on Thursday. They stated the last Executive Director left in Feburary of this year. On 04/24/24 at 9:10 a.m. the interim Executive Director stated they were at the facility until tonight then returning next week on an unknown date. They stated they had just started their rotation Monday of that week. On 04/24/24 at 2:22 p.m. the Director of Health and Wellness stated that the Regional Director of Operations was in the facility once a week. On 04/24/24 at 2:24 p.m. the interim Executive Director stated the Regional Director of Operations was the Administrator on file. On 04/24/24 at 3:03 p.m. the interim Executive Director stated the Regional Director of Operations was responsible for the day to day operation of the center prior to their arrival. On 04/24/24 at 2:37 p.m. the interim Executive Director provided their Certificate of Completion for "Management of Assisted Living Facilities". It documents the certification date of June 20th and 21st 2017 for Texas. The document did not state it was a nationally recognized certification. They stated they were just covering the community while there was no Executive Director. On 04/24/24 at 3:26 p.m. the Director of Health and Wellness stated they were in the facility half days at both this facility and the other facility since there was no Executive Director at either centers.	C 930		

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C 930	Continued From page 6 On 04/29/24 at 12:53 p.m. the Regional Director of Operations stated that they nor the interim Executive Director were licensed in Oklahoma and that they were alternating weeks every other week. They stated they were acting Executive Director between the departure of the previous and the starting of the interim Executive Director and they will alternate until someone was obtained. On 04/30/24 at 10:20 a.m. the Regional Director of Operations stated they were a licensed Nursing Home Administrator but not in Oklahoma. On 05/02/24 at 11:03 a.m. ACMA #1 stated the last Executive Director had left at the end of February 2024 and there had not been anyone in the building for that position.	C 930		
C 940 SS=E	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to have a menu available for meal service preparation. The interim Executive Director identified 22 residents resided in the center. Findings:	C 940	See DOC C940	

Oklahoma State Department of Health

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C 940	Continued From page 7 On 04/29/24 at 12:34 p.m., there was no observation of a current menu posted in the kitchen. Cook #1 was asked for the menu. On 04/24/24 at 12:36 p.m., Cook #1 stated there was no menu available as the Director of Culinary Services did not have time to make the menu and they would adjust the menu based on what they cooked. The lunch meal was smothered pork chops, mashed potatoes, green beans, and chocolate pudding. On 05/01/24 at 1:26 p.m., the Director of Culinary Services stated they were to follow what was on the menu and that they would modify as needed. They stated they use a menu system and that was suppose to be what was used to cook. On 05/01/24 at 1:27 p.m., the Director of Culinary Services was asked how they ensure residents received meals of adequate nutritional value when a menu was not available. They stated hopefully Cook #1 was aware of what to serve. They stated the menu was there but did not have another print that was not refreshed. They stated they were working on Cook #1 getting better with following the menu. They stated they needed to work on time management to get those done. The cook following the menu had been addressed in the Dietician 02/22/24 note as well.	C 940			
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.	C 954		See PDC C954	

If continuation sheet 9 of 13

Oklahoma State Department of Health

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C1110	Continued From page 9 committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure the QA committee met on a quarterly basis. The interim Executive Director identified 22 residents resided at the center. Findings: The center's "Quality Assurance" policy, dated 02/01/22, read in part, "The community will have procedures in place to assess the quality of care and services provided in order to monitor and improve performance when identified...Meet at least quarterly and document the meeting..." On 04/30/24 at 09:05 a.m., the Director of Health and Wellness stated they had not had a meeting since they had been there and stated they started at the facility in October of 2023. They stated they ensure residents needs were met by having the resident council meetings and speaking to	C1110			

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C1110	Continued From page 10 residents and their families individually as well as monitoring the antibiotics. There was no documentation provided for a Quality assurance meeting being done quarterly. On 04/30/24 at 11:50 a.m., both the Regional Director of Operations and the Director of Health and Wellness were asked to provide when the last meeting was done. The center did not provide any information by the time of exit.	C1110		
C1120 SS=E	310:663-11-2 QUALITY ASSURANCE REPRESENTATIVES The quality assurance committee shall include at least the following: (1) registered nurse or physician if a medical problem is to be monitored or investigated; (2) assisted living center administrator; (3) direct care staff person or a staff person who has responsibility for administration of medications; and (4) pharmacist consultant if a medication problem is to be monitored or investigated. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Quality Assurance Committee had members that included a facility administrator. The interim Executive Director identified 22 residents resided in the center.	C1120	See POC C1120	

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C1120	Continued From page 11 Findings: A "Quality Assurance" policy, dated 02/01/22, read in part, "...The Community will form a Quality Assurance Committee, which will consist of: Executive Director, Department managers, or a representative of each department...Pharmacy consultant, if available and applicable (medication management concerns)..." On 04/30/24 at 11:50 a.m. the Regional Director of Operations stated that the Administrator would attend if they had one. There was no Administrator/Executive Director for the facility.	C1120		
C1972 SS=E	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure employees received abuse training within 90 days of employment for two (CNA #2 and ACMA #2) of five staff reviewed for abuse training.	C1972	See POC C1972	

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C1972	Continued From page 12 The interim Executive Director identified 22 residents resided in the center. Findings: Review of staff training provided by the center did not include abuse training for CNA #2 and ACMA #2. On 05/02/24 at 12:02 p.m., the Director of Health and Wellness stated they were unable to locate the training for CNA #2 and ACMA #2.	C1972		



Oklahoma State
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/28/2024

Facility Name: Morada Southridge

License Number: AL5503

Survey Event ID: 5ZUG11

Date Survey Completed: 4/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: Based on observation and interview, the center failed to ensure food items were dated and labeled.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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)

Date Enter a date of signature.

5-31-24

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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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: Click here to enter a date.

Facility Name: Morada Southridge

License Number: AL5503

Survey Event ID: 5ZUG11

Date Survey Completed: 4/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C398

Based on: Based on record review and interview, the center failed to ensure one (Cook #1) of two sampled dietary staff responsible for food preparation attended a food service training program approved by the Oklahoma State Department of Health.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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)

Date Enter a date of signature.

3-31-24

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/28/2024

Facility Name: Morada Southridge

License Number: AL5503

Survey Event ID: 5ZUG11

Date Survey Completed: 4/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C711

Based on: Based on record review and interview the center failed to ensure the annual fire marshall inspection was completed and records maintained.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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)

Date Enter a date of signature.

5-31-24

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date

Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.

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



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/28/2024

Facility Name: Morada Southridge

License Number: AL5503

Survey Event ID: 5ZUG11

Date Survey Completed: 4/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C930

Based on: Based on observation, record review, and interview, the center failed to ensure an Administrator was employed to perform oversight of the daily center operations.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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)

Date Enter a date of signature.

5-31-24

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Addendum Date Enter a date of addendum.

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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: 5/28/2024

Facility Name: Morada Southridge

License Number: AL5503

Survey Event ID: 5ZUG11

Date Survey Completed: 4/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C940

Based on: Based on observation and interview, the facility failed to have a menu available for meal service preparation.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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)

[Signature]

Date: Enter a date of signature.

5-31-24

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Addendum Date

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Submitted by

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



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/28/2024

Facility Name: Morada Southridge

License Number: AL5503

Survey Event ID: 5ZUG11

Date Survey Completed: 4/24/2024

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C954

Based on: Based on record review and interview, the center failed to ensure direct care staff were trained in CPR and first aid for three (CNA #1, 2 and ACMA #2) of five sampled staff reviewed for CPR and first aid training.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

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)

Date Enter a date of signature.

5-31-24

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