Oklahoma State Department of Health
Creating a State of Health

January 13, 2020

License Number: AL5504

Ms. Mary Wright, Administrator
Dorset Place - Assisted Living
2435 Northwest 122nd Street
Oklahoma City, OK 73120

Survey Event ID: 3WTV11

Dear Ms. Wright:

On December 15, 2019, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

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

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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 will be completed for each violation; and
(6) Be signed by the administrator.

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

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

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

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

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

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

Sincerely,

Katie Stagner

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

SD/kgs

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Dorset Place Assisted Living**
Address: **2435 NW 122nd Street**
City, State, Zip: **Oklahoma City, OK 73120**
Provider #: **AL5504**
Complaint #: **OK00054459**
Investigation Date(s): **12/15/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide as contracted/advertised.	**US**

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

An unannounced on-site investigation was initiated on 12/15/2019 at 1:25 p.m.

A sample of 7 residents including any identified residents was selected for the investigation based on the concerns relevant to the allegations.

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

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to contracted services was conducted.

At 1:30 p.m. during a tour of the center there were no strong odors of urine or feces. There was no staff sitting around at the time of the survey.

A resident named in the complaint no longer resided at the center. There were no dried feces observed in any resident's rooms or bathrooms. No resident complained of linens not being changed. The linens observed on the beds were clean. There were no odors or dried urine rings observed.

Resident rooms were observed to be clean including their bathrooms, floors, bed linens and mattresses.

Lunch trays were picked up by staff.

There was no resident observed to have feces on them.

The resident contracts documented "launders bed and bath linens weekly and provides weekly housekeeping."

The contract did not document a requirement of residents checked every two hours, but the shift task sheets documented rooms to receive two hour checks.

There were no residents with complaints about toileting, housekeeping, linens, or the staff.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Date report completed: 12/17/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5504	A. BUILDING: _____ B. WING _____	C 12/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DORSET PLACE - ASSISTED LIVING	2435 NORTHWEST 122ND STREET OKLAHOMA CITY, OK 73120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An abbreviated survey was conducted 12/15/19 to investigate complaint #OK 00054459. Resident census was 20. Deficient practice was written as follows.	C 000		
C 521 SS=E	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a preadmission assessment or a admission comprehensive assessment was completed for 1 (#2) of 6 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #2 Resident #2 moved into the center on 11/13/19 with diagnoses to include dementia with occasional hallucinations and delusions, congestive heart failure, brittle osteoporosis, coagulation defect, hypertension, hypothyroidism, muscle spasms, debility, weakness, and mobility alterations. On 12/15/19 during record review there was no admission or comprehensive assessment found for resident #2.	C 521		

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C 521	Continued From page 1 At 3:54 p.m., the registered nurse (RN) stated resident #2 did not have an admission assessment or 14-day comprehensive assessment. The RN stated she was responsible for completing the assessments and should have ensured the admission assessment was completed within 30 days of admission or at the time of admission and/or a comprehensive assessment was completed within 14 days of admission. The contract, dated 10/29/19, documented, "...under Section B Levels of Service and Level of Service Fee, "...#1) Assessment and Negotiated Service Plan. Prior to move-in or within fourteen days of move-in, residence staff, in consultation with you and your health care provider will evaluate your supportive, personal care and health needs...your needs will be reviewed semi-annually, unless otherwise required by law, or upon a significant change in your condition..."	C 521		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to complete a	C 522		

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	AL5504	A. BUILDING: _____ B. WING _____	C 12/15/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 522	Continued From page 2 significant change assessment and a annual comprehensive for 2 (#8 and #3) of 7 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #8 Resident #8 moved in to the center 04/18/18 with diagnoses to include rheumatoid arthritis, depression, post-traumatic stress disorder (PTSD), insomnia and vertigo. The comprehensive assessment, dated 04/30/18, documented the resident was alert and oriented to person and place, confused at times with fair judgement. The resident had fair mobility with fair strength and gait. He could ambulate with a walker without assistance. He was independent with all activities of daily living/ADL's (bathing, eating, transferring, toileting and ambulation.) The resident was continent of both bladder and bowel. He was good at communicating was interviewable. He had a history of agitation, anger outburst and anxiety. The resident admitted to the center with home health services. On 02/05/19 the resident had a decline and was placed on hospice services. There was no updated assessment or plan of care completed by the center's registered nurse. This resident no longer resided at the center. A hospice note, dated 09/13/19, documented "has increased urinary incontinence and is now becoming incontinent of bowel. He is dependent for 5/6 ADL's." A hospice note, dated 09/17/19, documented	C 522		

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	AL5504	A. BUILDING: _____ B. WING _____	C 12/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 522	Continued From page 3 "secludes self in room. Angry and agitated frequently and refuses care. Speech is garbled and nonsensical at times. He does not make his needs known and will not answer nurses when questioned. He is paranoid about staff doing anything for him. Weak and unsteady with the rolling walker, but has increased difficulty ambulating after a fall 09/03/19. He is sleeping greater than 18 hours per day and prefers to stay in his bed. He has very poor endurance and becomes fatigued with ambulating in his room. Cachectic (severe weight loss, anorexia, and general debility that occur as a result of chronic disease. Exhibit signs of malnutrition, including muscle wasting) in appearance with very poor appetite. He often refuses meals. Temporal wasting is apparent. Poor skin turgor with loose hanging skin visible. Dependent in ADL's 5 out of 6 to include transfers, ambulation, bathing, continence and dressing." A hospice note, dated 09/25/19, documented "hospice services for diagnosis frontotemporal dementia. He needs increased assistance. He ambulates with the use of his walker with staff assistance, but only walks from his bed to the bathroom. He is alert to himself and presents with a flat affect. He secluded himself in his apartment and does not participate in activities and does not socialize with others. He can become easily agitated, uses profanity with staff who take care of him. He is easily fatigued ambulatory less than 30 feet from his bed to bathroom. He is incontinent of bladder and bowel with increased incontinence of bowel episodes with appearing to notice. He is unaware of the need to change his brief or the need to get cleaned. He refuses personal hygiene frequently and doesn't like to have clean clothes put on him. Poor appetite. Very gaunt in appearance."	C 522		

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C 522	Continued From page 4 The hospice note also documented the resident lived in assisted living and required staff assistance with bathing, dressing, toileting, bowel/bladder, eating/feeding, medications, meals, housekeeping, laundry, telephone, shopping, finances, socialization, companionship, recreation and required assistance several times during the day and night. The resident required a significant change assessment completed at the time he was placed on hospice services in February 2019 due to a decline and an increased need in assistance with activities of daily living, mobility and behavior issues. On 12/15/19 at 4:55 p.m. the administrator and registered nurse stated the resident had changed to require hospice services routinely. They provided no additional assessment, care plan or nurses notes. RESIDENT #3 Resident #3 moved in to the center on 04/19/18 with a diagnosis to include dementia. The resident was observed to be chairfast, travels in a wheelchair and is not interviewable. On 12/15/19 at 3:54 p.m., the RN stated there was no current annual assessment completed for resident #3. The RN stated she was responsible for completing the assessments and should have ensured the current annual assessment was completed.	C 522		
C 551 SS=E	310:663-5-5(1) USE OF ASSESSMENT	C 551		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 551	Continued From page 5 The assisted living center shall use the results of the resident's assessment for the following: (1) to assist in determining the appropriateness of the resident's placement in the assisted living center in compliance with 310:663-3; and This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure the assessment was used to develop and implement interventions for 1 (#2) of 1 sampled residents who had full length bedrails on the bed. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #2 moved into the center on 11/13/19 with diagnoses to include brittle osteoporosis, coagulation defect, hypertension, hypothyroidism, muscle spasms, debility, weakness, and mobility alterations. There was no admission or comprehensive assessment in the record for resident #2. On 12/15/19, at 1:50 p.m., resident #2 was observed laying in a mechanical bed with her head slightly elevated with full length bedrails raised on both sides of the bed. The resident stated she could not move the bedrails up or down. A handwritten noted, on page 5 of the service plan summary, documented the resident has bed rails "so she can't get out of bed." The bed rails were not care planned as restraints and no interventions were identified to facilitate removal of the rails.	C 551		

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C 551	Continued From page 6 At 5:43 p.m., the registered nurse and the licensed practical nurse/director of nursing (LPN/DON) stated resident #2 should not have two full bedrails in the up position on her bed and she was aware this was considered a physical restraint according to regulations. For over a month the center's staff did not monitor and ensure the resident was free from physical restraint. The contract for resident #2, dated 10/29/19, documented, "...under Exhibit I Admission Criteria, "the community may admit and retain older adults who meet the following criteria...f) does not require physical or chemical restraints. Section F Termination by Residence, " the residence may terminate this agreement upon thirty days written notice to you for the following...b) you require physical or chemical restraints. Appendix E Resident Rights #14) "every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, ...from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of the restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four hours of such an emergency..."	C 551		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5504	DORSET PLACE - ASSISTED LIVING

Type of Survey (select all that apply)

3				

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

Extent of Survey (select all that apply)

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 34460	12/15/2019	12/15/2019	0.50	0.00	4.50	0.00	1.00	4.50
2. 42023	12/15/2019	12/15/2019	0.50	0.00	4.50	0.00	1.00	6.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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

JAN 14 2020

Oklahoma State Department of Health
Creating a State of Health

February 7, 2020

License Number: AL5504

Ms. Mary Wright, Administrator
Dorset Place - Assisted Living
2435 Northwest 122nd Street
Oklahoma City, OK 73120

Survey Event ID: 3WTV11

Dear Ms. Wright:

On December 15, 2019, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **February 26, 2020**.

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

Sincerely,

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

SD/jt

Board of Health

Gary Cox, JD
Commissioner 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: 1/27/2020** **Facility Name:** Dorset Place Assisted Living **License Number:** AL5504 **Survey Event ID:** 3WTV11 **Date Survey Completed: 12/15/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C521 SS=E	Based on: Interview and record review, it was determined the center failed to ensure a preadmission assessment or a admission comprehensive assessment was completed for 1 (#2) of 6 sampled residents. This failed practice resulted in potential for more than minimal harm at a pattern.

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 any conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	A Comprehensive Assessment was completed for resident #2 on 1/16/2020.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All current resident have potential for harm by deficient practice.
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?	1. For new residents admitted to the community, the Care Services Manager (CSM) and/or designee will complete an admission/comprehensive assessment prior to/and or upon admission. 2. Care Services Manager (CSM) and Executive Director (ED) were inserviced by Regional Director of Care Services (RDCS) on requirements to complete Admission / Comprehensive Assessment prior to admission and/or upon admission on 1/16/2020. 3. Care Services Manager (CSM) and/or designee will complete an audit on current residents for completion of admission/comprehensive assessment and any findings will be addressed by 2/10/2020.
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	Care Service Manager (CSM) and/or designee will be responsible for sustained compliance. Care Service Manager (CSM) and/or designee will audit 4

effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	residents records biweekly x 4 weeks for completed Admission/Comprehensive Assessment, then weekly x 4 weeks, then monthly x 3 months. Audit results will be reviewed monthly in QI meetings and QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring records will be maintained by Executive Director and/or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/26/2020
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Mary Lisa Wright OAC 310:663-25-4(F)	**Date 1/27/2020**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.	
Addendum Date Enter a date of addendum.	**Submitted by** Enter name of person submitting addendum.
Items Below Are For OSDH Use Only	
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: 1/27/2020** **Facility Name:** Dorset Place Assisted Living **License Number:** AL5504 **Survey Event ID:** 3WTV11 **Date Survey Completed: 12/15/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522 SS=E	Based on: Interview and record review, it was determined the center failed to complete a significant change assessment and a annual comprehensive for 2 (#3 and #8) of 7 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern.

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 any conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	1. Resident # 8 no longer resides at the community. 2. Resident # 3 had a Comprehensive Assessment completed on 1/23/2020.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have potential for harm from deficient practice.
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?	1. Care Service Manger (CSM) and/or designee will complete Significant Change Assessments for current residents within two weeks of significant change as warrented. 2. Care Services Manager (CSM) and Executive Director (ED) were inserviced by Regional Director of Care Services (RDCS) on requirements to complete Admission/Comprehensive/Significant Change Assessment as required by state regulaions on 1/16/2020. 3. Care Services Manager (CSM) and/or designee will complete an audit on current residents for completion of admission/comprehensive assessment/ significant change comprehensive assessment and any findings will be addressed. 4. For new residents admitted to the community, the Care Services Manager (CSM) and/or designee will complete an admission/ comprehensive assessment/significant change comprehensive assessment as warrented.

OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Care Service Manager (CSM) and/or designee will be responsible for sustained compliance. Care Service Manager (CSM) and/or designee will audit 4 residents records biweekly x 4 weeks for completed Significant Change Assessment, then weekly x 4 weeks, then monthly x 3 months. Audit results will be reviewed monthly in QI meetings and QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring records will be maintained by Executive Director and/or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/26/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Mary Lou Wright	**Date 1/27/2020**	

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/27/2020** **Facility Name:** Dorset Place Assisted Living **License Number:** AL5504 **Survey Event ID:** 3WTV11 **Date Survey Completed: 12/15/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C551 SS=E	Based on: Observation, interview and record review, it was determined the center failed to ensure the assessment was used to develop and implement interventions for 1 (#20 of 1 sampled residents who had full length bedrails on the bed. This failed practice resulted in the potential for more than minimal harm at a pattern.

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 any conclusions set forth in this allegation by the survey agency.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	A Comprehensive Assessment for Resident #2 was completed on 1/23/2020. Bed rails for Resident #2 were removed on 1/24/2020.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All current residents have the potential to be affected by the deficient practice.
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?	1. For residents admitted to the community, the Care Services Manager (CSM) and/or designee will utilize the assessment to develop interventions in lieu of using full bed rails in the community. 2. Care Service Manager (CSM) and Executive Director (ED) were inserviced by Regional Director of Care Services (RDCS) on requirement to utilize assessment to develop interventions that exclude the use of bed rails in the community on 1/16/2020. 3. Care Services Manageer (CSM) will complete an audit on current residents for presence of bed rails and any findings by 2/10/2020 and will be addressed.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and	Care Service Manager (CSM) and/or designee will be responsible for sustained compliance. CSM and/or designee will audit 4 residents records and observe beds for compliance of no restraint usage bi-weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months.

c. How monitoring records will be kept to evidence the correction.	Audit results will be reviewed monthly in QI meetings and QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring records will be maintained by Executive Director and/or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/26/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Mary Lisa Wright	**Date 1/27/2020**

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

OKLAHOMA
State Department
of Health

Delivery via email to: MLWright@enlivant.com

June 1, 2021

License Number: AL5504

Ms. Mary Wright, Administrator
Dorset Place - Assisted Living
2435 Northwest 122nd Street
Oklahoma City, OK 73120

Survey Event ID: 3WTV12

Dear Ms. Wright:

On **November 12, 2020,** an offsite/paper complaint revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 15, 2019** have now been corrected effective **February 26, 2020.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

LC/

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5504	A. BUILDING: _____ B. WING _____	R-C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DORSET PLACE - ASSISTED LIVING	2435 NORTHWEST 122ND STREET OKLAHOMA CITY, OK 73120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An Offsite/Paper Revisit was completed on 11/12/20. Credible evidence of correction was submitted for all deficiencies.	{C 000}		

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