OKLAHOMA
State Department
of Health

Delivery via email to: sanderson@enlivant.com

June 16, 2023

License Number: AL5504

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

RE: Survey Event ID: SYV711

Dear Ms. Anderson:

On **June 1, 2023**, agents from our office concluded a State Licensure survey with complaint investigations 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 June 1, 2023.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dorset Place – Assisted Living**
Address: **2435 Northwest 122nd Street**
City, State, Zip: **Oklahoma City, OK 73120**
Provider #: **AL5504**
Complaint #: **0K00058685**
Investigation Date(s): **05/31/23 through 06/01/23**

ALLEGATION

1. The center failed to ensure medications were administered as ordered

An unannounced on-site investigation was initiated 05/31/2023 at 9:30 a.m.

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

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, at other various times throughout the survey, and across multiple shifts. Staff were observed during medication administration times.

Resident records were reviewed including assessments, care plans, physician orders, physician progress notes, nursing notes, medication/treatment records, and activities of daily living records. Facility policy and procedures were reviewed. Grievance records were reviewed. State reported incidents and investigations were reviewed.

Residents were interviewed regarding medication administration.
Staff were interviewed regarding the facility policies related to medication administration.

Deficient practice was Cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Abiebatou Chatman

Digitally signed by Abiebatou Chatman
Date: 2023.06.08 10:15:28 -05'00'

Abiebatou Chatman, RN CHFS

Date report completed: 06/08/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dorset Place-Assisted Living**
Address: **2435 Northwest 122nd Street**
City, State, Zip: **Oklahoma City, OK, 73120**
Provider #: **AL5504**
Complaint #: **OK00059127**
Investigation Date(s): **May 31st, 2023 through June 1st, 2023**

ALLEGATION(S)

1. The facility failed to provide a safe environment.

An unannounced on-site investigation was initiated 05/31/2023 at 9:30 a.m.

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

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, at other various times throughout the survey, and across multiple shifts. Ceilings, air vents, residents' rooms, common areas, and the kitchen were observed for mold. Residents and staff were observed for any signs and symptoms of distress.

Residents were interviewed related to the facility providing a clean, comfortable, and safe environment.

Resident records were reviewed including assessments, care plans, physician orders, physician progress notes, nursing notes, medication/treatment records, and activities of daily living records. Facility policy and procedures were reviewed. Grievance records and maintenance logs were reviewed.

Staff members were interviewed regarding the facility policies related to providing a safe environment.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Sarah Green, LPN, CHFS

Date report completed: 06/08/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dorset Place-Assisted Living**
Address: **2435 Northwest 122nd Street**
City, State, Zip: **Oklahoma City, OK, 73120**
Provider #: **AL5504**
Complaint #: **OK00060644**
Investigation Date(s): **May 31st, 2023 through June 1st, 2023**

ALLEGATION(S)

1. The facility failed to ensure residents were not involuntarily discharged.

An unannounced on-site investigation was initiated 05/31/2023 at 9:30 a.m.

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

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, at other various times throughout the survey, and across multiple shifts. Staff were observed making frequent rounds and checking on the residents. Staff were observed assisting residents.

Residents were interviewed related to involuntary discharge.

Resident records were reviewed including assessments, care plans, physician orders, physician progress notes, nursing notes, medication/treatment records, and activities of daily living records. Facility policy and procedures were reviewed. Grievance records were reviewed. State reported incidents and investigations were reviewed.

Staff members were interviewed regarding the facility policies related to involuntary discharges.

Deficient practice was cited. See the Statement of Deficiencies, Form 2567, for details.

Thank you for bringing your concerns to our attention.

Sarah Green, LPN, CHFS

Date report completed: 06/08/2023

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 06/01/2023

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 A relicensure survey was conducted from 05/31/23 through 06/01/235. Complaint investigations (#OK00058685, OK00059127, and OK00060644) were conducted in conjunction with the survey. The following abbreviations will be used throughout this document: CMA- certified medication assistant DON- director of nurses ED- executive director i.e.- example mg- milligram OSDH- Oklahoma State Department of Health tab- tablet	C 000		
C 360 SS=D	310:663-3-5(c)(1-3) INVOLUNTARY TERMINATION (c) Procedures for involuntary termination of residency for reasons other than inappropriate placement, by an assisted living center, are as follows: (1) Written notice shall be provided to the resident, the resident's representative, the person responsible for payment of charges for the resident's care, if different from any of the foregoing, and the Department, at least thirty (30) days in advance of the termination of residency date. (2) The written notice shall include: (A) A full explanation of the reasons for the termination of residency; (B) The date of the notice; (C) The date notice was given to the resident and the resident's representative;	C 360		

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 06/01/2023

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 360	Continued From page 1 (D) The date by which the resident must leave the assisted living center; (E) Notice that the resident, the resident's representative or person responsible for payment of the resident's care may request a hearing with the Department; (F) Notice that the request for hearing with the Department must be filed within ten (10) Department business days of receipt of the facility notice; and (G) Notice that a written or verbal request for a hearing with the Department should be directed to the Hearing Clerk, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, OK 73117, telephone (405) 271-1269. (3) An assisted living center shall not involuntarily terminate a residency agreement for reasons other than inappropriate placement without following the procedures in this section. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to include all required components in a 30 day discharge notice to one (#5) of two sampled residents who had been issued an involuntary discharge notice. "Resident Condition and Care" report, dated 05/31/23, documented 17 residents resided in the facility. Findings: Resident #5 had diagnoses which included forgetfulness, falls, and seizures.	C 360		

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 06/01/2023

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 360	Continued From page 2 An "Assisted Living Residency Agreement," dated 09/27/19, documented the facility may terminate this agreement upon thirty days written notice to the resident. A "Notice to Quit" document, dated 05/08/23, read in part, "...Please take further notice that within five...days after service of this notice, you are required to pay the above sum or quit the subject, i.e., move out...This serves as your five...day legal notice..." A "Summary order overruling involuntary discharge," dated 05/12/23, read in part, "...Dorset Place...issued a 5-day Notice to Quit...dated May 8, 2023 to [Resident #5]...The Court finds an involuntary discharge hearing is not required because the Facility failed to comply with the provisions...regarding the written notice of involuntary termination of residency, as indicated below...If voluntary termination of residency is not arranged, transfer or discharge of resident from an assisted living center shall be preceded by a minimum written notice of thirty...days...Written notice shall be provided to...the Resident's representative...The date notice was given to the Resident and/or the Resident's representative...The date by which the Resident must leave the assisted living center...Notice that the Resident, the Resident's representative or person responsible for payment of the Resident's care may request a hearing with the OSDH...Notice that the request for hearing with the OSDH must be filed within ten...OSDH business days of receipt of the Facility notice...Notice that a written or verbal request for a hearing with the OSDH should be directed to Hearing Clerk...It is therefore ordered, adjudged and decreed that the Facility shall not involuntarily	C 360		

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 06/01/2023

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 360	Continued From page 3 discharge this Resident without obtaining a written Order of this Court allowing same in strict accordance to state regulations..." On 06/01/23 at 9:58 a.m., the ED stated the May 8th, 2023 notice did not meet the criteria of an involuntary discharge. She stated the reason they issued a five day because they had provided an appropriate notice in January of 2022 (15 months prior).	C 360		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication was available for one	C1923		

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 06/01/2023

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
C1923	Continued From page 4 (#1) of three sampled residents reviewed for medication administration. "Resident Condition and Care" report, dated 05/31/23, documented 17 residents resided in the facility. Findings: The "Medication Documentation" policy, dated 03/01/22, read in part, "...If a medication is not taken within the allowed time frame, typically one hour before to one hour after the specified time, staff will initial the appropriate square, circle their initials. Staff will notify the Care Services Manager of missed, late or refusal of medication ..." Resident #1 had diagnoses which included depression. Resident #1 had an order for citalopram tab 10 mg one tablet by mouth one time a day in the morning for depression. Resident #1's citalopram was scheduled to be administered at 8:00 a.m. On 06/01/23 at 7:40 a.m. CMA #1 stated citalopram was not available for today and the next day's supply. On 06/01/23 at 10:22 a.m. The DON stated the medications were expected to be administered one hour before or one hour after scheduled time.	C1923		

OKLAHOMA
State Department
of Health

Delivery via email to: SAnderson@enlivant.com

July 5, 2023

License Number: AL5504

Ms. Shekita Anderson, Executive Director
Dorset Place - Assisted Living
2435 Northwest 122nd Street
Oklahoma City, OK 73120

RE: Survey Event SYV711

Dear Ms. Anderson:

On **June 1, 2023**, a Licensure inspection and a Complaint investigation were conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **August 4, 2023**.

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

Respectfully,

Tempal Killman

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 6/30/2023** **Facility Name:** Dorset Place Assisted Living **License Number:** AL5504 **Survey Event ID:** SYV711 **Date Survey Completed: 6/1/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923	Based on: record review and interview the facility failed to ensure medication was available for one (#1) of three sampled residents reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	On 6/01/23 Care Services Manager ordered and made available Resident #1's citalopram tab 10 mg one tablet by mouth one time a day in the morning for depression.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	On 6/01/23 CSM and/or designee completed medication cart audit to ensure all medications were available for administration-no additional findings noted.
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?	CSM and/or designee to complete Medication Pass Checklist with medication aides at least every quarter. By 8/04/23 CSM and/or designee to provide medication ordering and administration education to medication aides to ensure proper state/company protocols are followed.
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.	On 7/07/23 CSM and/or designee will audit medication carts to ensure medications are available for administration weekly for 4 weeks, biweekly for one month, and monthly until compliance is met. Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. Medication cart audits will be stored in "Medication Audits" binder located in CSM office. Medication administration records will be stored in resident medical file. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/4/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature shekita Anderon Shekita Anderson	**Date 6/30/2023**

OAC 310:663-25-4(F)

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
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: 6/30/2023** **Facility Name:** Dorset Assisted Living **License Number:** AL5504 **Survey Event ID:** SYV711 **Date Survey Completed: 6/1/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C360	Based on: record review and interview, the facility failed to include all required components in a 30 day discharge notice to one (#5) of two sampled residents who had been issued an involuntary discharge notice.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	**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?	On 6/08/23 Executive Director issued resident #5 a 30 day involuntary discharge notice that contained all the required discharge components.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	On 6/28/23 ED and/or designee completed review of involuntary discharge notices with current residents and address findings as necessary.
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?	Regional Executive Director and/or designee educated the ED on 6/30/23 on the use of the involuntary discharge notices.
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.	On 7/07/23 ED and/or designee will review all new involuntary discharge notices on current residents weekly for 4 weeks, bi-weekly for a month, and monthly for 3 months. Enter methods to evaluate for effectiveness: Audit results will be reviewed monthly in QI meetings and QI committee will determine if continued auditing is necessary based on three consecutive months of compliance. New involuntary discharge notices will be reviewed by ED and/or designee to verify the adherence to the required discharge components. All notices to be stored in ED office and maintained in "30 Day Notice Discharge Binder".
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/4/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Shekita Anderson OAC 310:663-25-4(F)			**Date** Enter a date of signature.
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department of Health

Delivery via email to: ShAnderson@dorsetplaceseniorliving.com; SAnderson@enlivant.com

August 30, 2023

License Number: AL5504

Shekita Anderson, Administrator
Dorset Place - Assisted Living
2435 Northwest 122nd Street
Oklahoma City, OK 73120

RE: Survey Event SYV712

Dear Ms. Anderson:

On **August 29, 2023,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 1, 2023,** have now been corrected effective **August 4, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5504	A. BUILDING: _____ B. WING _____	R-C 08/29/2023

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 conducted on 08/22/23 and 08/29/23. The facility was in substantial compliance.	{C 000}		

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