

Delivery via email to: nklepac@villagioliving.com

July 13, 2021

License Number: AL5514

Ms. Nancy Klepac, Administrator
Villagio of Oklahoma City
14300 North Portland
Oklahoma City, OK 73134

Survey Event ID: K44511

Dear Ms. Klepac:

On **June 22, 2021**, 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.

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) 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,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.07.13 11:06:19 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Villagio of Oklahoma City
Address: 14300 North Portland
City, State, Zip: Oklahoma City, OK 73134
Provider #: AL5514
Complaint #: OK00055331
Investigation Date(s): 06/15/21 through 06/18/21, 06/21/21 and 06/22/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have adequate staff to ensure proper transfer procedures and medication administration.	US

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

An unannounced on-site investigation was initiated on Tuesday, June 15, 2021 at 8:45p.m.

A sample of four 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 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 staffing to meet the needs of the residents was conducted.

Upon entrance to the center on the evening shift the center had five employees working. The center maintained adequate staff to care for the residents during the survey.

The staff on various shifts were asked if they had ever been the only employee in the building. They stated no. The staffing coordinator stated they always had more than one staff member in the building. She stated at times there may have only been one staff member in the memory support unit.

The residents were asked if there had been a time when they had not received their medications due to not having a medication aide in the building. The residents stated no.

Clinical records, medication administration records and state reportable incidents were reviewed. The medication administration records for a specific time period were reviewed and documented the evening medications were administered.

At the time of the survey no deficient practice was found related to staffing.

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.





Billie Seeman, RN, CHFS

Date report completed: 07/09/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Villagio of Oklahoma City
Address: 14300 North Portland
City, State, Zip: Oklahoma City, OK 73134
Provider #: AL5514
Complaint #: OK00055682
Investigation Date(s): 06/15/21 through 06/18/21, 06/21/21 and 06/22/21

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The center failed to assess, monitor and intervene when a resident has a change in condition.	S
2. The center failed to have adequate staff to ensure residents received care as contracted.	US
3. The center failed to ensure residents were treated with dignity and respect.	US
4. The center failed to provide required documents for incident reports and/or provide these documents within the required time frame.	S

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

An unannounced on-site investigation was initiated on Tuesday, June 15, 2021 at 8:45 p.m.

A sample of seven 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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to staffing to meet the needs of the residents was conducted.

Upon entrance to the center on the evening shift, the center had five employees working. Two employees on the assisted living side of the building and three employees in the memory support unit. The center maintained an adequate number of staff during the survey.

The staff were not on their phones except to contact other staff in the building. No resident falls were observed at the time of the survey. The residents were assisted with incontinent care. The staff responded to resident care needs.

Clinical records, state reportable incidents and medication administration records were reviewed. The staff was available, qualified and provided the care to meet the resident needs.

At the time of the survey no deficient practice was found related to staffing

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to treatment of the residents with dignity and respect was conducted.

Staff interacted with the residents appropriately. The staff knocked on the resident doors before they entered. The memory support residents were not pushed down or told to sit down and shut up during the survey.

The residents were asked if they were treated with dignity and respect. They stated yes. The residents were asked if they were told to sit down and shut up. They stated no.

Clinical records, state reportable incidents, abuse and neglect policies and procedures were reviewed. The state reportable incidents revealed the center acted upon the allegations of abuse and mistreatment and followed their policies and procedures.

At the time of the survey no deficient practice was found related to dignity and respect.

Allegation #4: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1917 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #4. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #2 and #3. 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.

Billie Seeman

By E & P

Billie Seeman, RN, CHFS

Date report completed: 07/09/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Villagio of Oklahoma City
Address: 14300 North Portland
City, State, Zip: Oklahoma City, OK 73134
Provider #: AL5514
Complaint #: OK00056180
Investigation Date(s): 06/15/21 through 06/18/21, 06/21/21 and 06/22/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have and/or implement their abuse policy.	US

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

An unannounced on-site investigation was initiated on Tuesday, June 15, 2021 at 8:45 p.m.

A sample of four 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 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 abuse was conducted.

The staff and residents interacted with each other appropriately. The residents did not appear to be afraid of the staff.

The residents stated they felt safe and had not been hit by the staff. The staff were able to state examples of abuse and knew when and who to report the alleged abuse. The staff was asked if they had observed abuse or

knew of abuse against a specific resident. They stated no. They stated they remembered the resident but had no knowledge of the alleged abuse. The allegation was reported to the administrator.

Clinical records, personnel files, in-services, incident reports, policies and procedures were reviewed and revealed the center performed background checks prior to staff employment, provided abuse education and followed their abuse policy when incidents of abuse were reported including the termination and reporting to the nurse aide registry of several employees who were accused of abuse and neglect.

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.

 

Billie Seeman, RN, CHFS

Date report completed: 07/09/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Villagio of Oklahoma City
Address: 14300 North Portland
City, State, Zip: Oklahoma City, OK 73134
Provider #: AL5514
Complaint #: OK00056422
Investigation Date(s): 06/15/21 through 06/18/21, 06/21/21 and 06/22/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate care according to resident contracts.	S
2. The center failed to follow proper infection control procedures.	S

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

An unannounced on-site investigation was initiated on Tuesday, June 15, 2021 at 8:45 p.m.

A sample of nine residents including any identified resident(s), 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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Billie Seeman

By Ed Ren.

Billie Seeman, RN, CHFS

Date report completed: 07/09/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Villagio of Oklahoma City
Address: 14300 North Portland
City, State, Zip: Oklahoma City, Ok 73134
Provider #: AL5514
Complaint #: OK00057204
Investigation Date(s): 06/15/21 through 06/18/21, 06/21/21 and 06/22/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to provide care according to the contract.	S
2. The center failed to ensure resident rights are not violated to include ensuring a safe environment and ensure resident receive adequate and appropriate medical care.	S

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

An unannounced on-site investigation was initiated on Tuesday, June 15, 2021 at 8:45 p.m.

A sample of nine 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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Billie Seeman

By Edman

Billie Seeman, RN, CHFS

Date report completed: 07/09/2021

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2021
NAME OF PROVIDER OR SUPPLIER VILLAGIO OF OKLAHOMA CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134		
(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 on 06/15/21 through 06/18/21, 06/21/21 and 06/22/21 to investigate complaint #OK00055331, #OK00055682, #OK00056180, #OK00056422 and #OK00057204. Total residents: 47	C 000		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to ensure ~residents were provided meal assistance and escorts to the dining room for three (#7, #8 and #9) of seven sampled residents who required escort and assistance with meals and; ~residents in the memory support unit and	C1304		

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: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2021
NAME OF PROVIDER OR SUPPLIER VILLAGIO OF OKLAHOMA CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134		
(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
C1304	Continued From page 1 assisted living unit were provided activities as outlined in their contract. This had the potential to affect all 47 residents who resided at the center. Findings: 1. Resident #7, #8 and #9 had diagnosis which included dementia and resided in the memory support unit. The contract for resident #7, #8 and #9 documented the residents would be provided with three meals a day and snacks and it provided personal care services to assist the residents with activities of daily living which included mobility: cueing, escort, nutrition, meals and special diets. The contract also documented it offered a program of activities designed to meet the physical, spiritual, intellectual, emotional, leisure and social needs of the resident. Level of care evaluation for resident #7, #8 and #9 documented the residents needed assistance to eat with verbal/non-verbal cueing, encouragement, and needed escort to and from the dining room for meals and reminders to go to meals. On 06/16/21 between 11:45 a.m. and 1:00 p.m., the staff brought the residents to the dining room and served lunch in the memory support unit. Resident #8 was brought to the dining room and then got up and left the dining room. Resident #7 was not seated at the table in the dining room when resident #8 was brought to the dining room. At 12:11 p.m., resident #7 and resident #8 were	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2021
NAME OF PROVIDER OR SUPPLIER VILLAGIO OF OKLAHOMA CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134		
(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
C1304	Continued From page 2 not in the dining room when meal trays were served at their table. At 12:20 p.m., resident #8 was observed in the hall, while the other residents were eating lunch. At 12:30 p.m., resident #7 was walking in the hall. At 12:44 p.m., resident #7 and #8 were not in the dining room. At 1:00 p.m., resident #7 came to the counter in the dining area; she was not offered anything to eat. At 1:15 p.m., certified medication aide (CMA) #1 stated all the residents ate lunch. He was asked how he knew everyone ate. He stated he knew the residents and he had checked the rooms. He was asked who was responsible for ensuring the residents ate lunch. He stated everyone who was working on the unit and the kitchen staff. At 1:18 p.m., CMA #2 was asked if all of the residents ate lunch. She stated to the best of her knowledge they all ate. She was asked how the staff knew everyone ate. She stated we brought the residents to the dining room. At 1:20 p.m., CMA #1 was asked if resident #8 had eaten. He stated yes. The CMA turned to CNA #2 and asked her if the resident ate lunch. CNA #2 stated she did not see resident #8 eat lunch. CMA #3 stated she could not say for a fact resident #8 ate lunch. CNA #3 also stated she did not know if resident #7 ate lunch. The three employees could not say where the two residents had sat for lunch or how much food they had eaten.	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2021
NAME OF PROVIDER OR SUPPLIER VILLAGIO OF OKLAHOMA CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134		
(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
C1304	Continued From page 3 At 1:42 p.m., resident #7 and resident #8 were served lunch. The staff left the two residents in the dining room alone. The residents were not encouraged or assisted with the meal. On 06/17/21 at 8:00 a.m. the breakfast meal was served in the dining room on the memory support unit. Resident #9 was not in the dining room. At 8:50 a.m., resident #9 was in her room sitting in her recliner. She was asked if she had eaten breakfast. She stated no, she did not know it was time to eat. At 9:02 CMA #2 was asked if the meal service was done. She stated yes. At 9:09 a.m., the resident care coordinator CNA/CMA #4 was asked if all the residents had been served breakfast. She stated yes. At 9:10 a.m., resident #9 remained in her recliner in her room. She was asked if she had eaten. She stated no, she had not had breakfast. She stated, "Nobody came to get me for breakfast." The resident was asked if she was hungry. She stated she could eat a little. At 9:13 a.m., CMA #4 was asked how the staff ensured everyone ate. She stated the residents were not served until all residents were in the dining room. She was made aware resident #9 had not eaten breakfast. She stated all of the staff were from an agency and they would not know if all of the residents had eaten. She was asked if the residents should be left in the dining room alone to eat. She stated no. At 2:26 p.m., the licensed practical nurse (LPN) #1 was asked how the staff knew the residents	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2021
NAME OF PROVIDER OR SUPPLIER VILLAGIO OF OKLAHOMA CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134		
(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
C1304	Continued From page 4 had eaten. She stated the residents ate in the dining room and staff checked the rooms. She was asked if leaving residents alone in the dining room was providing verbal cueing and encouragement. She stated no. The LPN was asked how the level of care was determined for the residents. She stated it was determined by the assessment according to the amount of assistance they needed. She was asked if the residents were charged according to their level of care assessment. She stated yes. 2. The center's policy, titled, 'Community Life', dated 12/2019, documented, "...Community will make available regular opportunities for residents to participate in resident engagement both within and outside of the community..." The activity calendar was posted by the front entrance of the center and the same calendar was posted on the wall in the memory support unit. The activity calendar listed the following activities for 06/16/21: B-Active at 10:30 a.m. Creation station at 11:30 a.m. Hydration station at 1:30 p.m. No activities were observed at 10:30 a.m. in the assisted living or the memory support unit. At 10:49 a.m., six residents were in the common area listening to country music with the television on. At 10:55 a.m., resident #4 was asked if the center had an activity director. She stated no. She was asked if the center provided activities this past week. She stated no. She was asked where the	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2021
NAME OF PROVIDER OR SUPPLIER VILLAGIO OF OKLAHOMA CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134		
(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
C1304	Continued From page 5 activities were usually held. She stated in the common area between the front entrance and the dining room. At 11:32 a.m., no activities were observed in assisted living or the memory support unit. The staff in the assisted living and memory support were assisting the residents to the dining room for lunch. At 2:18 p.m., one resident was in the assisted living side of the building with two staff members for bingo. No other residents were in the area. No residents from memory support were in the assisted living side of the building for bingo. No activity was observed in the memory support unit. On 06/17/21 at 9:30 a.m., the scheduled activity was coffee and chat. No activity was observed in the memory support unit. On 06/18/21 at 10:30 a.m., three residents were in the common area of the memory support unit watching television. No activities were observed. The calendar documented B-Active as the activity scheduled for 10:30 a.m. No activity was observed in the assisted living part of the building at 10:30 a.m. No residents were observed in the activity area or the exercise room. On 06/21/21 at 9:49 a.m., the receptionist was asked if the center had an activity director. She stated the assisted living center did not have one. She was asked who helped with the activities. She stated the life enrichment coordinator (LEC) in memory support. At 10:26 a.m., the memory support LEC was asked what her job duty was for the day. She stated she was providing direct care. She was	C1304		

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C1304	Continued From page 6 asked if she was responsible for the activities. She stated she was trying to do both. She was asked about the observations made of the residents not participating in activities. She stated she had been off and could not say what happened when she was off. At 2:00 p.m., resident #11 stated the center did not have an activity director. She stated she missed doing activities. On 06/22/21 at 10:03 a.m., the activity calendar documented, "I Remember..." was scheduled for 10:00 a.m. No activities were observed in the assisted living area. At 4:13 p.m., LPN #1 was asked about the observations of the activities. She stated the center had not provided activities on a regular basis.	C1304		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in	C1505		

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C1505	Continued From page 7 terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the center failed to ensure ~residents were administered medications according to the physician's order for seven (#1, 5 through 8, 10 and 11) of nine sampled residents who were administered medications by the center's staff; ~residents were given supplements as ordered by the physician for one (#7) of two sampled residents who had orders for supplements; ~a resident was assessed, monitored and interventions were put in place when a resident had a twenty pound weight loss in one month for	C1505		

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C1505	Continued From page 8 one (#3) of three residents who were reviewed for weight loss; ~resident's power of attorney (POA) was given the right to refuse a vaccination for one (#1) of three sampled residents who received the COVID-19 vaccine and; ~staff wore personal protective equipment correctly. This center identified 47 residents resided in the center. Findings: The center's policy, titled, ' Medication Administration Policy', dated 08/2019, documented, "...Community shall provide medication administration services to Assisted Living residents according Oklahoma State Department of Health regulations and current standards of Nursing Practice...In cases of not following the practitioner order, the practitioner and responsible party will be notified. The event will be documented in the resident's record...No expired or discontinued medications will be administered to a resident..." The center's policy titled, 'Weights and Vital Signs Policy', dated 12/2019, documented, "...The community shall routinely monitor resident weights...The Wellness Director, Assisted living Director or designee will review weights monthly The responsible party and practitioner will be notified of weight loss if weight differences are noted of +/-5 pounds...from the last weight. If unplanned weight changes are noted, reweigh resident, document, and contact responsible party and/or practitioner..."	C1505		

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C1505	Continued From page 9 CDC guidance for long term care, documented,"... Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic...HCP [health care provider] working in areas with minimal to no community transmission, should continue to adhere to Standard and Transmission-Based Precautions based on anticipated exposures and suspected or confirmed diagnoses. This might include use of eye protection, an N95 or equivalent or higher-level respirator, as well as other personal protective equipment (PPE). In addition, universal use of a well-fitting facemask for source control is recommended for HCP if not otherwise wearing a respirator...Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel as the degree to which cloth masks protect the wearer might vary..." 1. Resident #1 had diagnoses which included dementia, hypothyroidism and constipation. The resident had a physician's order for Levothyroxine for hypothyroidism to be administered daily and an order for Miralax to be administered three times a week for constipation. A medication administration record (MAR), dated 04/01/21 through 04/30/21, revealed the levothyroxine was not administered twelve times. The MAR documented the medication was not available. The resident's Miralax bottle was observed in the medication cart. The bottle documented it was filled by the pharmacy on 11/05/20 and contained 30 doses.	C1505		

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C1505	Continued From page 10 A nurse's progress note, dated 01/14/21 at 2:00 p.m., documented, "Nurse from...Home Health here to see resident. Resident is impacted. HH [home health] nurse checked resident and she hollared [sic] "that hurts somebody hit me" Nurse informed resident that no one hit her that she was impacted and that nurse was helping her pass the BM." On 06/15/21 at 9:55 p.m., licensed practical nurse (LPN) #1 was asked if the center had bulk medications (Bottles of medication administered to all residents who had an order for the medication.). She stated no. On 06/17/21 at 2:52 p.m., the LPN was asked again about the center's house stock. When asked to observe the center's house stock/bulk medications, the LPN stated the assisted living resident care coordinator stated the only house stock the center had was Tylenol. No policies or procedures were provided for bulk medications or house stock. On 06/18/21 at 1:02 p.m., LPN #1 was asked how the bottle of Miralax could last six and a half months when the bottle only contained thirty doses (Approximately a three month supply.) She stated she did not know. The LPN was asked if the levothyroxine had been administered as ordered. She stated the MAR documented the medication was not available. At 1:30 p.m., the resident's POA was asked if she had brought the resident any Miralax besides what was ordered in November. She stated no. She stated she had not been billed from the pharmacy and was concerned because the	C1505		

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C1505	Continued From page 11 resident had a history of impaction. She stated she asked the center if the Miralax was being administered and the center told her the resident was getting the Miralax from their "house stock supply." The center did not provide documentation the Miralax had been reordered or received since 11/05/20. The LPN stated they did not have any house stock/bulk medication several times and did not provide a policy for bulk medication or an administration record of the Miralax from the house stock. 2. Resident #5 had diagnoses which included dementia and anxiety disorder. The resident's level of care evaluation, dated 05/07/21, documented the resident was dependent on the care team to order her medication. The resident had a physician's order for Buspirone twice a day for anxiety and lorazepam daily at bedtime for anxiety. A MAR, dated 06/01/21 through 06/30/21, revealed the Buspirone had not been administered six times and the Lorazepam had not been administered two times. The MAR documented the medications were not available. On 06/17/21 between 7:45 a.m., and 10:00 a.m., during an observation of the morning medication administration pass by CMA #1 the following medication errors were observed: 3. Resident #6 had a physician's order for potassium chloride 10 milliequivalents daily for Lasix therapy. The potassium was not	C1505		

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C1505	Continued From page 12 administered. The CMA stated the medication was not on the medication cart or in the medication room. 4. Resident #7 had a physician's order for Lisinopril 10 mg daily for hypertension, the order documented to check the resident's blood pressure and pulse before administration, and hold the medication if the blood pressure was 90/50 or less and if the pulse was 60 or less. The CMA did not check the resident's blood pressure or pulse prior to administering the medication. The CMA stated the electronic MAR (eMAR) did not indicate he needed to take the resident's blood pressure and pulse. 5. Resident #8 had a physician's order for Losartan potassium 50 milligrams daily for hypertension, the order documented to check the resident's blood pressure and pulse before administration and hold if the blood pressure was 90/50 or less and if the pulse was 60 or less. CMA #1 did not check the resident's blood pressure or pulse prior to administering the medication. 6. Resident #10 had physician's order for Latanoprost solution 0.005% one drop to be instilled in the left eye daily for glaucoma, Timolol Maleate Solution 0.5% one drop to be instilled in the left eye two times a day for glaucoma and Omeprazole 20 milligrams daily for GERD. CMA #1 did not administer the eye drops. When asked why he did not administer the eye drops, the CMA stated they were dated as opened in January 2021 and were only good for three months after they were opened. He was asked if he administered the eye drops on 06/16/21. The CMA stated yes. He was asked why he did not administer the Omeprazole. The CMA stated the	C1505		

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C1505	Continued From page 13 resident did not have the Omeprazole available for administration. At 2:26 p.m., the LPN was asked about medications with blood pressure parameters. She stated the blood pressure should be taken prior to administering the medication. She was asked how long the Lantoprost and Timolol could be used after it was opened. She stated the Lantoprost was could be used for six weeks after it was opened and the Timolol could be used for four weeks after it was opened. She agreed the eye drops were past the six and four weeks after they had been opened. The LPN was asked if she was aware of the medications that were not administered during the morning medication pass due to not being available. She stated no. On 06/21/21 at 2:00 p.m., resident #11 was asked if the center administered her medications. She stated yes. The resident stated the staff informed her when she needed to order refills from her pharmacy. She stated she was required by the pharmacy to order them herself. The resident stated the staff did not inform her in a timely manner to get them ordered and delivered before she ran out. She also stated the center would had her order her medications from the preferred pharmacy until her medications were received in the mail. A MAR for resident #11, dated 06/01/21 through 06/30/21, revealed the resident had not been administered her Protonix (A medication for GERD.) seventeen times and had not been administered her Myrbetriq (A medication used for overactive bladder.) thirteen times due to the	C1505		

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C1505	Continued From page 14 medications not being available. 7. Resident #7 had diagnoses which included dementia and vitamin deficiency. The resident's weight logs revealed the resident weighed 132.6 pounds on 08/21/20, 129.4 pounds on 09/09/21 and 118.0 pounds on 10/26/20. The resident's current weight was 114.8 on 06/04/21. A physician's order, dated 09/24/20, documented to give one can of Ensure with meals for supplement. A MAR, dated 06/01/21 through 06/18/21, revealed the Ensure was not administered five times. On 06/16/21 at 1:45 p.m., the resident was served lunch. She was not given an Ensure supplement. On 06/17/21 at 8:36 a.m., the resident was served breakfast, she was not given an Ensure supplement. At 9:57 a.m. CMA #1 did not administer Ensure with the resident's morning medications. The CMA stated the family provided the Ensure. At 11:51 a.m. the resident's hospice nurse was asked if the Ensure was supplied by the hospice company. She stated she did not know if the resident was still getting the Ensure. The Ensure was not observed in the resident's room. On 06/18/21 at 11:08 a.m., the POA for the resident stated he used to supply the Ensure but hospice supplied it now. He was asked if anyone	C1505		

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C1505	Continued From page 15 from the center or hospice contacted to him to bring more Ensure. He stated no. He also stated he always asked if the resident needed anything when he called or came by to visit and was not informed she needed Ensure. 8. Resident #3 had diagnoses which included dementia without behavioral disturbances. A care plan, dated 03/28/20, documented the resident needed assistance to eat and the staff would report changes to the nurse. The care plan also documented the staff would report any changes from the resident's baseline to the nurse. A weight and vitals summary for the resident documented the following weights: 03/30/20 weight: 143 pounds via chair scale 04/29/20 weight: 123 pounds via chair scale 05/01/20 weight: 123 pounds via chair scale 05/29/20 weight: 124 pounds via chair scale The nurse's progress notes were reviewed and revealed the physician had not been notified of the twenty pound weight loss from 03/30/20 to 04/29/20. The physician's orders, dated 04/30/20, revealed no new orders to address the weight loss were received. The physician's progress notes for March of 2020 and April of 2020 were not located in the resident's record. A physician's progress note, dated 05/06/20, documented the resident had no change in appetite, no nausea or vomiting.	C1505		

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C1505	Continued From page 16 On 06/21/21 at 12:01 p.m., the former LPN was asked if she reported the resident's weight loss to the physician. She stated she did not report it. She stated the registered nurse would have reported the weight loss to the physician. At 12:19 p.m., the consultant registered nurse (RN) was asked if she reported the resident's weight loss to the physician. She stated she could not remember. She also stated it should be charted in the record. On 06/22/21 at 3:59 p.m., the current LPN reviewed the resident's closed record. She was asked if the physician had been notified of the resident's weight loss. She stated no, she could not find any documentation the physician was notified. The LPN was asked if a resident had a twenty pound weight loss in one month, should it be reported to the physician. She stated yes. 9. Resident #1 had diagnoses which included dementia, essential hypertension, myocardial infarction and history of COVID-19. An Informed Consent for Vaccination in Long Term Care Facility for the COVID-19 vaccine, dated 01/18/21, documented a former employee's name and "per POA" on the signature line for consent. There was not a witness to the consent, the POA's name or time she was contacted was not documented on the consent form. The consent form screening questions documented "NO" for the following questions: Do you feel sick today and Do you have any health conditions such as heart disease. On 06/22/21 at 11:29 a.m., resident care coordinator employee #4 was asked if she was in	C1505		

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C1505	Continued From page 17 the room when the daughter was called to get consent for the COVID-19 vaccine. She stated yes. She was asked if the POA gave consent to give the resident the vaccine. The employee stated she could not recall if the POA said yes or no. At 1:29 p.m., the resident's POA was contacted. She stated she did not give consent for the vaccine. She stated she was contacted on 12/15/20 by the former LPN and was told if she wanted her family member to have the vaccine she would have to come to the center and sign a consent. She stated she told the center at that time she needed to check with the resident's physician because the resident had recently had COVID-19. She stated she was never contacted again about a consent. She stated she did not know her mom was vaccinated until several months after she received the vaccine for COVID-19. The resident's POA stated the screening questions were filled in wrong her mom was feeling sick and did have heart disease. 10. On 06/15/21 at 9:15 p.m., certified nurse aide (CNA) #5 was wearing a cloth mask. At 9:50 p.m., the LPN was asked what type of masks the staff wore. She stated surgical masks. She was asked if the masks were supposed to cover the staff's nose and mouth. She stated yes. On 06/16/21 at 10:30 a.m., CNA #10 had a cloth mask on and CMA #11 had her surgical mask below her nose. At 10:40 a.m., CNA #12 had her surgical mask below her nose. At 11:34 a.m. CNA #7 was wearing a cloth mask.	C1505		

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C1505	Continued From page 18 She was in the dining room with residents. At 11:51 a.m., CMA #2 was wearing her mask below her nose. On 06/21/21 at 10:26 a.m., CNA #5 was asked if she was allowed to wear a cloth mask. She stated yes, they had not said she could not wear one. The CNA was wearing a cloth mask at the time of the interview. The CNA stated she was providing direct resident care. On 06/22/21 at 9:30 a.m., the LPN was made aware of the observations of the staff wearing the cloth masks and incorrectly wearing the surgical masks. She stated the staff typically wore surgical masks. She also stated one of the staff members had a medical reason for wearing cloth masks.	C1505		
C1917 SS=D	310:663-19-(g) REPORTS TO THE DEPARTMENT (g) Content of Incident Report (1) The preliminary report shall at the minimum include: (A) who, what, when, and where; and (B) measures taken to protect the resident(s) during the investigation. (2) The follow-up report shall at the minimum include: (A) preliminary information; (B) the extent of the injury or damage if any; and (C) preliminary findings of the investigation. (3) The final report shall, at the minimum, include preliminary and follow-up information and: (A) a summary of the investigative actions; (B) investigative findings and conclusions based on findings;	C1917		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5514	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/22/2021
NAME OF PROVIDER OR SUPPLIER VILLAGIO OF OKLAHOMA CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 14300 NORTH PORTLAND OKLAHOMA CITY, OK 73134		
(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
C1917	Continued From page 19 (C) corrective measures to prevent future occurrences; and (D) if items are omitted, why the items are omitted and when they will be provided. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure ~ an investigation of an unknown injury was conducted and; ~ investigative findings and a conclusion based on the findings was submitted to the Oklahoma State Department of Health (OSDH) for one (#3) of one sampled resident with an unknown injury. Findings: Resident #3 had diagnoses which included dementia and anxiety. An annual assessment, dated 06/20/18, documented the resident was oriented to self only, had poor judgment and was forgetful. It also documented the resident required one person assist with transfers and ambulated with the assistance of a wheelchair. An incident log for in-house incidents, dated 01/01/20 through 06/21/21 revealed resident #3 had not had any falls or injuries of unknown origin reported. A physician's progress note, dated 06/04/20, documented the resident chief complaint was a	C1917		

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C1917	Continued From page 20 bruise on her left hip. The note documented the resident had not had a fall that was documented but an x-ray was ordered due to the bruising on her left hip. The result was negative. A combined initial and final OSDH incident report, submitted on 06/12/21, documented on 06/01/20 the resident was having difficulty standing and was unable to pick up her right foot; an x-ray was ordered and was negative for a fracture. The report documented on 06/11/20 the hospice nurse reported the resident had a swollen left lower extremity. The hospice nurse notified the primary care physician and an x-ray was ordered. The result was an impacted fracture of the left femoral neck. The report also documented the resident was seen by the physician's assistant two times after 06/01/20, and seen by the hospice nurse on 06/10/21 and 06/11/20. The report did not contain any other investigation into how the resident sustained the fracture. On 06/21/21 at 3:37 p.m., the administrator was asked if she had any more documentation from the investigation. She stated she would have to look but thought she had provided all of the state reportable incidents. The incident report did not document the investigative actions, causative factors or corrective measures implemented to prevent recurrence. On 06/21/21 at 12:01 p.m., the former licensed practical nurse (LPN) #2 was asked about the resident's injury. She stated the staff reported to her the resident had a fall but she could not remember the staff member's name or when the fall occurred. The former LPN stated the resident was a high fall risk and had several falls. She was asked if she filled out an incident report. She stated no, it would have been the staff member	C1917		

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C1917	Continued From page 21 who reported it to her. At 12:19 p.m., the registered nurse consultant was asked if she had done an investigation to determine how the fracture occurred. She stated she could not recall anything about the incident. On 06/22/21 at 10:29 a.m., the family was asked how the resident sustained a fracture. She stated one of the staff members noticed the resident's left leg splayed out to the side. The family member stated an x-ray was obtained and was reported to be negative. She stated it was hard to get a good x-ray due to the resident's severe dementia. She stated almost two weeks later another x-ray was done and showed two fractured areas. The family member stated the center did not have a report of the incident and did not know how the fractures occurred. At 2:10 p.m., while attempting to review the in-house incidents report book, the administrator took the book away and stated, "You can't look at that." The center did not submit any documentation the resident had fallen in the past and did not do an investigation to determine how the fracture occurred.	C1917		
C1921 SS=E	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order	C1921		

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C1921	Continued From page 22 This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure medications were not administered after they were discontinued for one (#1) of nine sampled residents who were reviewed for medication administration. This had the potential to affect all 47 residents who resided at the center. Findings: Resident #1 had diagnoses which included dementia and encephalopathy. A physician's order, dated 04/30/21, documented, "...Celexa take 1 tablet (10 mg) by mouth every other day for week then stop..." A medication administration record (MAR), dated 05/01/21 through 05/31/21, documented the Celexa was administered daily for the entire month. Licensed Practical Nurse (LPN) #1 was asked if the Celexa was discontinued. She stated yes on 06/02/21. She was asked if the paperwork which documented to decrease the Celexa to every other day for a week and then discontinue was an order. She stated yes. She was asked if the physician's order was followed. She stated no. The LPN was asked CBD gummies had been discontinued. She stated the order to discontinue the CBD gummies was written on 05/29/21. The MAR, dated 06/01/21 through 06/30/21, documented the CBD gummies had been administered nine times after it had been	C1921		

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C1921	Continued From page 23 discontinued.	C1921		



OKLAHOMA
State Department
of Health

Delivery via email to: nklepac@villagioliving.com

July 26, 2021

License Number: AL5514

Ms. Nancy Klepac, Administrator
Villagio Of Oklahoma City
14300 North Portland
Oklahoma City, OK 73134

Survey Event ID: K44511

Dear Ms. Klepac:

On **June 22, 2021**, 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 **September 3, 2021**.

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.

Sincerely,

Tempal Killman

Digitally signed by Tempal
Killman

Date: 2021.07.26 11:52:54 -05'00'

Tempal Killman, Administrative Assistant
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: 7/23/2021

Facility Name: Villagio of Oklahoma City

License Number: AL5514-5514

Survey Event ID: K44511

Date Survey Completed: 6/22/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304

Based on: Observation, interview and record review it was determined the center failed to ensure residents were provided meal assistance and escorts to the dining room for three of seven sampled residents who required escort and assistance with meals and residents in memory support unit and assisted living were provided activities as outlined in their contracts. This had the potential to affect 47 residents who resided in the center.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Villagio of Oklahoma City team is dedicated to ensuring our residents are provided with any needs/desires or preferences on an individual resident basis. We desire to ensure accurate, thorough and timely level of care assessments that are performed and documented with any changes made promptly. Villagio of Oklahoma City will provide any level of care on a daily basis that is needed to ensure the residents best quality of life for as long as is possible. Life Enrichment is considered very important to resident quality of life in the community environment. Life Enrichment will be provided as per the resident agreement and as needed or preferred by our resident population.

REQUIRED ELEMENTS OF A PLAN

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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

A transportation to and from meals audit will be performed by the ED/HWD to ensure increased documentation of the residents needs for escort to and from meals at a glance; the three residents affected will have this documentation underway so all staff is aware. Life Enrichment will be performed on an accurate and timely basis for residents in the memory care and assisted living areas of our community. Life Enrichment will be randomly audited by the ED/designee to ensure completion, accuracy, timeliness and resident participation. The Resident Participation Log will be initiated and documentation provided to ensure the amount of resident participation. All participation will be reviewed by the QMP team to observe for trends, likes and dislikes and changes which will be implemented as residents make known.

OSDH Response: Element accepted Yes ☐ No ☐

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

The other residents will be a part of the audit by the ED/HWD for their needs/desires concerning transportation to and from the dining room with meals; all residents will be encouraged to report promptly with each meal any desires to be assisted as well as verbal reminders of time for the dining room seating if a resident so desires. The Meal Tracking Record will be implemented and utilized during each meal served on a daily basis as well as reviewed for trending and changes on-going. The Resident Participation Log will be initiated and documentation