Oklahoma State Department of Health
Creating a State of Health

November 4, 2019

License Number: AL5515

Ms. Mary Lisa Wright, Administrator
Dorset Place-Memory Care
12401 Dorset Drive
Oklahoma City, OK 73120

Survey Event ID: FZBO11

Dear Ms. Wright:

On **October 9, 2019**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: Dorset Place Memory Care
Address: 12401 Dorset Drive
City, State, Zip: OKC, OK 73120
Provider #: AL5515
Complaint #: OK00054460
Investigation Date(s): 10/09/19

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to prevent elopement	**S**
2. The center failed to provide care according to the resident's contract	**US**

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

An unannounced on-site investigation was initiated on Wednesday, October 9, 2019 at 12:05 p.m.

A sample of five 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 C0552 for details.

An investigation specific to resident elopement was conducted.

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

An investigation specific to resident care was conducted.

A tour was conducted upon entry to the center. The residents were eating lunch, and residents in both dining rooms were observed. All residents in the dining rooms were clean, their clothes were dry and no foul odors were detected. Three to five random rooms on each of the four halls were observed. The rooms were clean, no dirty clothes or used adult briefs were observed out of place and no foul odors were detected.

Four staff stated all incontinent residents were checked every two hours, or more often if required, and their adult brief was changed if needed. The staff stated any resident who needed to have incontinent care provided, would be taken to their room, cleaned up and taken back to the dining room to finish eating.

Five residents were interviewed but as this was a memory care unit, none of the residents were able to be interviewed due to dementia. All five residents were clean, their clothes were dry and no foul odors were detected.

The center provided a schedule for each resident that required incontinent care. The schedules documented each resident was provided incontinent care every two hours or as needed.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. 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. 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.

Teena Cornett

Teena Cornett, RN CHFS IV

Date report completed: 10/10/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5515	A. BUILDING: _____ B. WING _____	10/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DORSET PLACE-MEMORY CARE	12401 DORSET DRIVE OKLAHOMA CITY, OK 73120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An abbreviated survey was conducted to investigate complaint #OK00054460. The following deficient practice was cited. Resident census was 31.	C 000		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to use the results of the residents' assessment to develop individualized care plans with interventions and goals for 2 (#2 and #4) of 2 sampled residents that had been identified as an elopement risk. This failed practice had the potential for more than minimal harm, at a pattern. Findings: Resident #2 Resident #2's assessment, dated 01/16/19, documented the resident was alert and only oriented to self, independently ambulatory with the use of a cane or walker, had a history of agitation and aggression, and was identified as an elopement risk. An incident report, dated 03/17/19, documented the resident eloped from the center. An elopement risk assessment form completed after the elopement, and another elopement risk assessment, dated 10/01/18, both documented the resident was an elopement risk. The	C 552		

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
	AL5515	A. BUILDING: _____ B. WING _____	10/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DORSET PLACE-MEMORY CARE	12401 DORSET DRIVE 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 552	Continued From page 1 elopement risk assessment dated 10/01/18, documented the resident "continually exit seeks in the afternoon". Resident #4 Resident #4's assessment, dated 12/08/18, identified the resident as an elopement risk. It also documented the resident was only oriented to himself, was confused, and ambulatory. On 10/09/19 at 1:20 p.m., LTCA (long term care aide)/employee #1 identified resident #2 as an elopement risk. At 2:35 p.m., LTCA/employee #3 stated she heard either resident #2 or resident #4 had eloped from the building sometime last week. She stated she was at work when it happened, but on another hall. LTCA/employee #3 said the staff heard the alarm, so the resident was never outside the building. At 2:45 p.m., LTCA/employee #4 stated resident #2 tried to get out of the building sometime last last week. It was at dinnertime and the staff observed the resident go down the hall and push on the door. The staff started down the hallway to get her and then the alarm sounded. She stated the resident did not get out of the building. She also stated resident #2 tried to leave the building frequently. At 3:20 p.m., the RN (registered nurse) stated resident #2 was an elopement risk because she constantly exit seeks. The RN stated the resident left the building just last week, but was accompanied by staff the entire time. She also identified resident #4 as an elopement risk.	C 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5515	A. BUILDING: _____ B. WING _____	10/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DORSET PLACE-MEMORY CARE	12401 DORSET DRIVE 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 552	Continued From page 2 The RN was asked to show on the form, used by the center used for a care plan, where goals and interventions were documented. She stated the care plan did not have goals and interventions. It was a point system used for billing. At 3:30 p.m., the administrator identified residents #2 and #4 as elopement risks. The administrator and the regional director both were asked if the form the center used for a care plan included goals and interventions for elopement. They said it did not.	C 552		

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5515	DORSET PLACE-MEMORY CARE

Type of Survey (select all that apply)

[3] [ ] [ ] [ ] [ ]

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

Extent of Survey (select all that apply)

[ ] [ ] [ ] [ ] [ ]

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 36967	10/09/2019	10/09/2019	0.50	0.00	4.50	0.00	4.50	2.00
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11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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

NOV 0 5 2019 jm

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 11/14/2019** **Facility Name:** Dorset Place - Memory Care **License Number:** AL5515 **Survey Event ID:** FZB011 **Date Survey Completed: 10/9/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C552 SS=E	Based on: Based on interview and record review, it wasdetermined the center failed to use the results of the residents' assessment to develop individualized care plans with interventions and goals for 2 (#2 and #4) of 2 sampled residents that had been identified as an elopement risk. This failed practice had the potential for more than minimal harm, at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident #2 no longer resides at the community. Resident #4 has an individualized care plan in place with interventions and goals for elopement risk as of 11/14/2019.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Care Services Manager (CSM) and/or Executive Director (ED) will identify current residents at risk for elopement from the resident assessment, to ensure individualized care plans are in place with interventions and goals for those identified by 12/2/19.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	1. New residents will be assessed for the risk of elopement and have an individualized care plan developed with interventions and goals for those identified to be at risk. 2. Care Service Manager (CSM) will be inserviced on individualized care plan with interventions and goals for residents identified to be at risk of elopement by 11/22/19 by Executive Director (ED). Current staff will be inserviced on individualized interventions and goals for identified residents by 12/2/19 by Executive Director (ED) and/or Care Services Manager (CSM).
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and	Care Service Manager (CSM) and/or designee will be responsible for sustained compliance. Care Service Manager (CSM) and/or designee, will audit care plan 3 times per week x 4 weeks, then 2 times per week x 4 weeks and then weekly x 4 weeks to ensure interventions and goals are in place and updated as

c. How monitoring records will be kept to evidence the correction.	warranted for those residents at risk. 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. Monitoring records will be maintained by Executive Director and/or designee as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/20/2019
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Mary Jean Wright, ED	**Date 11/14/2019**

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

January 9, 2020

License Number: AL5515

Ms. Mary Lisa Wright, Administrator
Dorset Place-Memory Care
12401 Dorset Drive
Oklahoma City, OK 73120

Survey Event ID: FZBO12

Dear Ms. Wright:

On **December 26, 2019,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 9, 2019,** have now been corrected effective **December 20, 2019.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Katie Stagner

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

SD/ks

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5515	A BUILDING _____ B WING _____	R-C 12/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DORSET PLACE-MEMORY CARE	12401 DORSET DRIVE 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 On 12/26/19 a follow-up survey was conducted. Census was 25. All deficient practice was cleared.	{C 000}		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5515	DORSET PLACE-MEMORY CARE

Type of Survey (select all that apply)

3	D			

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

Extent of Survey (select all that apply)

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

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Team Leader ID 1. 30875	12/26/2019	12/26/2019	0.25	0.00	1.00	0.00	2.75	1.00
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13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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