

August 25, 2020

License Number: AL5515

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

RE: Survey Event ID: Q5GY11

Dear Ms. Wright:

On **March 4, 2020**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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) 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,

Users,
Lisa D
Calvin

Digitally signed by
Users, Lisa D Calvin
Date: 2020.08.25
09:55:51 -05'00'

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

Enclosure

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

DORSET PLACE-MEMORY CARE

12401 DORSET DRIVE
OKLAHOMA CITY, OK 73120

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: AL5515	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/04/2020
NAME OF PROVIDER OR SUPPLIER DORSET PLACE-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 12401 DORSET DRIVE OKLAHOMA CITY, OK 73120		
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N1427	Continued From page 1 manager/registered nurse (RN)) noted areas to left hip, left lower buttock, coccyx on resident open. As well as right heel, not opened but dark in coloring. CSM (RN) contacted hospice. Hospice nurse provided visit and new order received Calazime cream to right hip, left hip, buttocks and left lower buttocks with each brief change. Air mattress provided. Daughter was notified of changes and care plan meeting has been scheduled." The clinical service manager was the RN currently employed at the center. Resident #1's wound orders were as follows: 1) On 12/30/19 Calazime cream to coccyx area two (2) times a day. Clean wound with normal saline. Apply Calazime cream to coccyx two (2) times a day. Facility staff may administer in absence of hospice nurse. This order was discontinued 01/02/2020. 2) On 01/02/20 with every brief change apply liberal amount of Calazime to right hip, left hip, buttocks, left lower buttocks. This order started 01/02/2020 at 7:00 AM, 11:00 AM, 3:00 PM, and 7:00 PM (four times a day) and was initialed by the center's staff for the remainder of the month. 3) On 01/15/2020 a physician order for Silver antimicrobial sacrum wound dressing to left hip and left buttock wounds. Leave in place for 7 days. Facility staff may change and reapply new dressing in absence of hospice nurse. 4) On 01/30/2020 an order for Flagyl 500 milligrams (mg) one (1) tablet daily, crush tablet and sprinkle it into buttock wound for odor. On 03/04/2020 at 12:03 p.m., the RN and administrator were asked to identify the staff	N1427		

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N1427	Continued From page 2 initials on resident #1's Calazime cream in January 2020. They identified five certified medication aides (CMA's) #1, 3, 4, 5, and #6. The RN stated she was not aware CMA's could not apply cream to a decubitus ulcer.	N1427		
C 000	INITIAL COMMENTS On 03/02/2020 through 03/04/2020 a re-licensure survey was conducted. Census was 26. The following deficient practice was cited.	C 000		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on interview and record review it was determined the registered nurse (RN) failed to coordinate and sign the comprehensive assessment for 1 (#6) of 8 sampled residents. This deficient practice resulted in the isolated potential for more than minimal harm. Findings: Resident #6 Resident #6's comprehensive assessment dated 07/01/19, documented diagnosis to include Alzheimer's. Resident was alert x 1 (person), non-verbal with poor judgment. The comprehensive assessment was not signed by the registered nurse (RN) or personal physician. On 03/04/20 at 8:55 a.m., the RN stated she had not signed resident #6's comprehensive assessment.	C 542		

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C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure each comprehensive assessment included a personal interview between the resident or resident's representative and the person completing the form for 3 (#1, 3 and #8) of 8 sampled residents with comprehensive assessments. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #3 Resident #3's comprehensive assessment dated 11/08/19, documented the resident was alert x 2 (person, place) and confused at times with good judgment. On 03/03/2020 at 2:45 p.m., the registered nurse (RN) stated there was no personal interview with the resident or resident's representative so it was not signed and the family had no involvement. Resident #8 Resident #8's comprehensive assessment dated 01/07/20, documented the resident was alert x 1	C 543		

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C 543	Continued From page 4 (person) with confusion at times and fair judgment. At 3:22 p.m., the RN stated there was no personal interview with the resident or the resident's representative so there was no resident signature and was waiting for the family. Resident #1 Resident #1's comprehensive assessment dated 4/19/19, documented resident was alert x 1 (person) with poor judgment. At 4:15 p.m., the RN stated there was no personal interview with the resident or the resident's representative. There was no signature by the resident's daughter, the resident's representative.	C 543		
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 observation, interview, and record review it was determined the center failed to develop an individualized plan of care for 1 (#6) of 2 sampled residents with open decubitus ulcers. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: On 03/04/20 at 9:45 a.m., the registered nurse (RN) stated resident #6 did not receive home	C 552		

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C 552	Continued From page 5 health or hospice services, but was in the bridge program where the resident was to be watched weekly until she could be certified for hospice. At 9:52 a.m., the RN stated resident #6's plan of care outlined frequent checks, but did not include turning and/or repositioning resident #6 every two hours. Resident #6 was lying in bed with the physician's assistant (PA) at bedside. The PA stated the coccyx wound was open and the depth of the wound was about the size of the tip of her index finger. Policy The center's policy titled, 'Care Plan' dated 09/01/2016, documented, each resident should receive service and supervision based upon the resident's individual needs and preferences.	C 552		
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	C1505		

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C1505	Continued From page 6 proposed treatment or changes in treatment in 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: 1. Administer Secura extra protective cream topically as needed to buttocks use as directed for 1 (#6) of 2 sampled residents with open decubitus ulcers, 2. Obtain a physician's order to crush medications to ensure safe delivery of medications for 1 (#9) of 1 sampled resident with a crush order; and 3. Administer eye drops as physician ordered for 1 (#10) of 1 sampled resident with eye drops. The deficient practices related to failure to provide Secura protective cream to prevent further breakdown (#6) and failure to obtain a	C1505		

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C1505	Continued From page 7 physician's order to crush medications (#9) to alert staff of medications not intended for crushing resulted in the potential for more than minimal harm at a pattern. The deficient practice related to the administration of eye medication into the wrong eye (#10) resulted in the isolated potential for more than minimal harm. Findings: Resident #6 Resident #6 had a physician's order, dated November 2019 through March 2020, for Secura extra protective cream to be applied topically to buttocks as needed. On 03/02/2020 at 11:00 a.m., the registered nurse (RN) gave a verbal report on the residents at the center and stated resident #6 was not ambulatory, not weight bearing and had a chronic wound on the coccyx. On 03/04/2020 at 9:00 a.m., the RN stated resident #6's wound on her coccyx was a stage two. The RN stated the treatment for the wound was to apply Secura cream. At 9:32 a.m., the RN was asked if the Secura protective cream was applied to resident #6 for the month of November 2019 through February 2020. She stated it was not documented on the medication administration records (MAR's). She stated she had seen the staff put the cream on; however, they did not relay it back to the certified medication aide (CMA) for documentation. Resident #6 was lying in bed. The physician's assistant (PA) was at resident #6's bedside. The PA was asked if the wound on resident #6's	C1505		

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C1505	Continued From page 8 coccyx was open. She stated yes. She stated the depth of the wound was about the size of the tip of her index finger. Resident #9 Resident #9's MAR, dated March 2020, did not document an order to crush medications. On 03/02/2020 at 12:25 p.m., CMA #4 crushed one tablet of Hydrocodone 5/325 mg (milligrams) and mixed with it jelly for resident #9. At 1:30 p.m., CMA #4 was asked if she had a physician's orders to crush resident #9's medications. She stated, "I thought I did." On 03/04/2020 at 9:00 a.m., the RN was asked about a crush order for resident #9's medications. She presented an unsigned physician's order to crush resident #9's medications dated 03/03/2020. The physician's order had no RN's signature or physician's signature. The RN signed the physician's order on 03/04/2020 and faxed it over to pharmacy. At 1:40 p.m., the RN was asked if resident #9 required her medications to be crushed. She stated, "I would think at times." Resident #10 Resident #10's assessment dated 02/26/20, documented alert times one, confused and poor judgment. Diagnoses include cognitive impairment, legally blind, and high blood pressure. Resident #10's physician's order, dated 02/29/20, documented, blink gel tears apply to left eye one	C1505		

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C1505	Continued From page 9 time a day for dry eyes. Timolol ophthalmic solution 0.5% one (1) drop right eye one time a day for Glaucoma. On 03/04/20 at 7:40 a.m., CMA #4 applied the Blink eye drop in resident #10's right eye and the Timolol solution in resident #10's left eye. CMA #4 was asked if she applied the wrong medication in the wrong eye. She stated she was not sure if she put the wrong medication in the wrong eye or not.	C1505		
C1512 SS=G	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;	C1512		

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C1512	Continued From page 10 Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to identify, develop and document interventions to prevent the development and worsening of decubitus ulcers for 1 (#1) of 2 sampled residents identified with stage II pressure ulcers. This deficient practice resulted in actual harm. Findings:	C1512		

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C1512	Continued From page 11 Resident #1's wound orders were as follows: 1) On 12/30/19 Calazime cream (skin protectant) to coccyx area two (2) times a day. Clean wound with normal saline. Apply Calazime cream to coccyx two (2) times a day. Facility staff may administer in absence of hospice nurse. This order was discontinued on 01/02/2020. 2) On 01/02/20 every brief change apply liberal amount of Calazime to right hip, left hip, buttocks, left lower buttocks. This order was started on 01/02/2020 for 7:00 AM, 11:00 AM, 3:00 PM, and 7:00 PM and initialed by the center's staff from 01/02/2020 through 01/15/2020 to indicate they provided the treatment. 3) On 01/15/2020 an order for Silver antimicrobial (destroy or inhibit the growth of microorganisms) sacrum wound dressing to left hip and left buttock wounds. Leave in place for 7 days. Facility staff may change and reapply new dressing in absence of hospice nurse. The center's staff continue Calazime treatment around this dressing. 4) On 01/30/2020 an order for Flagyl (antibiotic) 500 mg (milligrams) one (1) tab daily crush tablet and sprinkle into left buttock wound for odor. On 03/04/2020 at 12:03 p.m., the RN and executive director was asked to identify the staff initials on resident #1's Calazime cream in January 2020. They identified five certified medication aides (CMA's) (#1, 3, 4, 5, and #6). The RN was asked if she was aware CMA's could not apply cream to a decubitus ulcer. She stated, "I did not know that." Resident #1's previous hospice certification	C1512		

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C1512	Continued From page 12 period ranged from 01/29/20 to 04/27/2020. Resident #1's current hospice certification and plan of care was sent by facsimile to the center on 03/03/2020 on the day of survey. Resident #1's current certification period ranged from 02/06/2020 to 05/05/2020 for hospice services. The hospice documentation for resident #1, dated on 12/12/19 through 01/01/20 documented a hospital aide bathed the resident a total of six times during this time frame. The skilled nurse visited resident #1 a total of six times during this time frame. A hospice skilled nurse or hospice aide had visited resident #1 a total of twelve (12) times between 12/12/19 through 01/01/20 on opposite days of the week. Then on 01/02/2020 the center's registered nurse (RN) discovered and documented in the nurse's notes resident #1 had stage II pressure ulcers and notified the hospice agency. Resident #1's nurse's note dated on 01/02/2020, documented, "CSM noted areas to left hip, left lower buttock, coccyx on resident open. As well as right heel, not opened but dark in coloring. CSM contacted hospice. Hospice nurse provided visit and new order received Calazime cream to right hip, left hip, buttocks and left lower buttocks with each brief change. Air mattress provided. Daughter was notified of changes and care plan meeting has been scheduled." The clinical service manager (CSM) was the registered nurse (RN) currently employed at the center A hospice skilled nursing visit note dated 01/02/2020, documented four areas of wound care. Three of the wound areas were documented as a Stage II. Two of the three Stage II decubitus ulcers measured 3 x 3 x 0.1cm and	C1512		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5515	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/04/2020
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C1512	Continued From page 13 one measured 3 x 3cm. The Stage I wound measured 3 x 3cm. A charting form used by third party caregivers with resident #1's most current wound measurements, dated 02/19/2020, documented left hip measured 2 x 2cm (centimeters) moderate yellow drainage, slough, wound care per orders. Left gluteal fold 2.5 x 2cm with moderate yellow drainage, red/pink bed wound care per orders. Right elbow Band-Aid changed healing appropriately. On 03/02/2020 at 1:02 p.m., a hospice nurse was in resident #1's room performing wound care. A dressing covered resident #1's left hip and the left lower buttock was opened. The RN explained to the resident this was his powdered medicine and placed a gauze like material into the wound opening and covered it with a padded Band-Aid. She was asked how often she performed resident #1's wound care. She stated now it was on Mondays, Wednesdays, and Fridays and if the wound gets worse we will go back to daily. She was asked if the dressing was intact when she arrived this morning and she stated yes. On 03/04/2020 at 11:50 p.m., the RN was asked if hospice was performing wound care on 01/02/2020. She stated no there was no wound care just Calazime cream to coccyx twice a day. She was asked how hospice was not aware of resident #1's skin breakdown with the frequent visits. She stated the hospice nurse was let go shortly after this incident on 01/02/2020. RN was asked why the center's staff did not notice resident #1's wound progression. RN stated they did and notified her on 01/02/2020 and she submitted documentation for that day. She was asked if the wound was opened on 01/02/2020.	C1512		

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C1512	Continued From page 14 She stated yes. RN was asked if she measured the wound at that time. RN stated she did not measure the wound. At 12:33 p.m., the RN was asked to submit the initial measurements for resident #1's wounds and the last measurements recorded for resident #1's wounds. She was asked why the most recent wound measurements recorded on 02/19/2020 did not include depth measurements. She stated both the wounds have depth.	C1512		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to: 1) Maintain an accurate record for 1 (#2) of 2 sampled residents with finger stick blood sugar (FSBS) readings. 2) Document the administration of Magic cups daily for 1 (#6) of 2 sampled residents with a physician's order for Magic cups. These deficient practices resulted in the potential for more than minimal harm at a pattern. Findings: Resident #2	C1951		

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C1951	Continued From page 15 The charting form for third party providers do not include an area to record the time. Some third party providers documented AM or PM on the sheet; however, if they did not, it was not possible to determine whether the FSBS was performed in the AM or PM. On 03/03/2020 at 11:30 a.m., the registered nurse (RN) was asked about the FSBS log for resident #2. She stated it contained "Incomplete documentation." She was asked if resident #2 had FSBS recorded on 02/22/20 and 02/23/20. She stated no there was no FSBS recorded on that day. She was asked if resident #2's FSBS at times were recorded in the mornings but not recorded in the evenings. She stated that was correct. Resident #6 The physician's orders for resident #6, dated March 2020, documented, diet: regular, small portions, Magic Cup one time a day. The medication administration record (MAR) for resident #6, dated March 2020, documented, diet: Regular, small portions, Magic Cup every day was written at the bottom of the MAR and did not contain a place to record the staff initials when the Magic Cup was administered to resident #6. (Another resident, Resident #5, was also identified with a physician's order for Magic Cups. Resident #5's MAR did contain a place for the staff to initial each time the resident consumed a Magic Cup.) On 03/04/20 at 10:52 a.m., the registered nurse (RN) was asked if resident #6 received a Magic Cup daily and was it recorded on the MAR. She stated it should be. RN was asked if there was a	C1951		

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C1951	Continued From page 16 space provided for staff to initial the administration of the Magic Cup on the MAR. She stated there was not a place to sign.	C1951		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010		

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C5010	Continued From page 17 This Rule is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to obtain the hospice/ home health plan of care and review the services to ensure coordination of the third party provider services for 3 (#1, 2 and #7) of 6 sampled residents who contracted with third party providers. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #1 Resident #1's previous hospice certification period ranged from 10/31/19 through 01/28/2020 and the following hospice certification period ranged from 01/29/20 to 04/27/20. Resident #1's current hospice certification and plan of care was sent by facsimile to the center on 03/03/2020 on the day of survey. Resident #1's current certification period ranged from 02/06/2020 to 05/05/2020 for hospice services. The hospice documentation for resident #1, dated on 12/12/19 through 01/01/20 documented a hospital aide bathed the resident a total of six times during this time frame. The skilled nurse visited resident #1 a total of six times during this time frame. A hospice skilled nurse or hospice aide had visited resident #1 a total of twelve (12) times between 12/12/19 through 01/01/20 on opposite days of the week. Then on 01/02/2020 the center's registered nurse (RN) discovered and documented in the nurse's notes resident #1 had stage II pressure ulcers and notified the hospice agency. A hospice skilled nursing visit note dated 01/02/2020, documented four areas of wound	C5010		

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C5010	Continued From page 18 care. Three of the wound areas were documented as a Stage II. Two of the three Stage II decubitus ulcers measured 3 x 3 x 0.1cm and one measured 3 x 3cm. The Stage I wound measured 3 x 3cm. A charting form used by third party caregivers with resident #1's most current wound measurements, dated 02/19/20, documented left hip measured 2 x 2cm (centimeters) moderate yellow drainage, slough, wound care per orders. Left gluteal fold 2.5 x 2cm with moderate yellow drainage, red/pink bed wound care per orders. Right elbow Band-Aid changed healing appropriately. On 03/02/2020 at 1:02 p.m., a hospice nurse was in resident #1's room performing wound care. A dressing covered resident #1's left hip and the left lower buttock was opened. The RN explained to the resident this was his powdered medicine and placed a gauze like material into the wound opening and covered it with a padded bandage. She was asked how often she performed resident #1's wound care. She stated now it was on Mondays, Wednesdays, and Fridays and if the wound gets worse we will go back to daily. She was asked if the dressing was intact when she arrived this morning and she stated yes. Resident #2 Resident #2's home health certification and plan of care was sent by facsimile to the center on 03/03/2020 on the day of survey. Resident #2's certification period ranged from 01/11/2020 to 3/10/2020. Diagnoses include Type 2 Diabetes Mellitus without complications and Alzheimer's disease. Skilled nurse for instructions/reinforcement of diabetic care to	C5010		

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C5010	Continued From page 19 include diet, skin care, and monitoring for lesions, blood glucose testing and diabetic foot care. Medications: Novolin R (5) units twice daily. Reason: Diabetes. Instructions: before breakfast and before dinner. Resident #2's charting form, dated 03/03/2020, documented the doctor was notified that insulin was administered at 10:00 AM today, no new orders received. The charting form used by the third party providers did not contain a place to write the time. Some third party providers documented AM or PM on the sheet; however, if they did not, it was not always possible to determine whether the FSBS was performed in the AM or PM. On 03/03/2020 at 9:25 a.m., the regional registered nurse was asked if home health had performed resident #2's FSBS this morning. She stated she would ask the certified medication aide (CMA). She stated no, home health had not been here this morning and she was not sure what happened but would check. At 9:55 a.m., the regional registered nurse was asked about resident #2's home health certification and plan of care (form 485). She stated there was no 485 in the center and she had called the home health agency to send one over. She explained home health had a scheduling error this morning. Resident #7 Resident #7's home health certification and plan of care was sent by facsimile to the center on 03/03/2020 on the day of survey. Resident #7's certification period ranged from 2/19/2020 to 4/18/2020. Diagnoses include Type 2 Diabetes	C5010		

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C5010	Continued From page 20 Mellitus without complications and hypertensive heart disease with heart failure. Medications: Novolin R (5) units twice daily. Reason: Diabetes. Instructions: every AM before breakfast. On 03/04/20 at 8:40 a.m., the registered nurse (RN) was asked about resident #7's home health plan of care (485). She stated she thought they had requested a copy yesterday.	C5010		



Delivery Via Email: MLWright@enlivant.com

September 17, 2020

License Number: AL5515

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

RE: Survey Event Q5GY11

Dear Ms. Wright:

On **March 4, 2020**, a re-licensure inspection was 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 **October 7, 2020**.

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

Sincerely,

Katie

Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma
State Department of Health,
ou=Long Term Care,
email=kstagner@health.ok.gov, c=US
Date: 2020.09.17 08:48:13 -05'00'

Katie Stagner
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS On 03/02/2020 through 03/04/2020 a re-licensure survey was conducted. Census was 26. The following deficient practice was cited.	C 000		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on interview and record review it was determined the registered nurse (RN) failed to coordinate and sign the comprehensive assessment for 1 (#6) of 8 sampled residents. This deficient practice resulted in the isolated potential for more than minimal harm. Findings: Resident #6 Resident #6's comprehensive assessment dated 07/01/19, documented diagnosis to include Alzheimer's. Resident was alert x 1 (person), non-verbal with poor judgment. The comprehensive assessment was not signed by the registered nurse (RN) or personal physician. On 03/04/20 at 8:55 a.m., the RN stated she had not signed resident #6's comprehensive assessment.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is	C 543		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 543	Continued From page 1 mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure each comprehensive assessment included a personal interview between the resident or resident's representative and the person completing the form for 3 (#1, 3 and #8) of 8 sampled residents with comprehensive assessments. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #3 Resident #3's comprehensive assessment dated 11/08/19, documented the resident was alert x 2 (person, place) and confused at times with good judgment. On 03/03/2020 at 2:45 p.m., the registered nurse (RN) stated there was no personal interview with the resident or resident's representative so it was not signed and the family had no involvement. Resident #8 Resident #8's comprehensive assessment dated 01/07/20, documented the resident was alert x 1 (person) with confusion at times and fair judgment. At 3:22 p.m., the RN stated there was no personal interview with the resident or the resident's representative so there was no resident	C 543		

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C 543	Continued From page 2 signature and was waiting for the family. Resident #1 Resident #1's comprehensive assessment dated 4/19/19, documented resident was alert x 1 (person) with poor judgment. At 4:15 p.m., the RN stated there was no personal interview with the resident or the resident's representative. There was no signature by the resident's daughter, the resident's representative.	C 543		
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 observation, interview, and record review it was determined the center failed to develop an individualized plan of care for 1 (#6) of 2 sampled residents with open decubitus ulcers. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: On 03/04/20 at 9:45 a.m., the registered nurse (RN) stated resident #6 did not receive home health or hospice services, but was in the bridge program where the resident was to be watched weekly until she could be certified for hospice. At 9:52 a.m., the RN stated resident #6's plan of	C 552		

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C 552	Continued From page 3 care outlined frequent checks, but did not include turning and/or repositioning resident #6 every two hours. Resident #6 was lying in bed with the physician's assistant (PA) at bedside. The PA stated the coccyx wound was open and the depth of the wound was about the size of the tip of her index finger. Policy The center's policy titled, 'Care Plan' dated 09/01/2016, documented, each resident should receive service and supervision based upon the resident's individual needs and preferences.	C 552		
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 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.	C1505		

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C1505	Continued From page 4 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: 1. Administer Secura extra protective cream topically as needed to buttocks use as directed for 1 (#6) of 2 sampled residents with open decubitus ulcers, 2. Obtain a physician's order to crush medications to ensure safe delivery of medications for 1 (#9) of 1 sampled resident with a crush order; and 3. Administer eye drops as physician ordered for 1 (#10) of 1 sampled resident with eye drops. The deficient practices related to failure to provide Secura protective cream to prevent further breakdown (#6) and failure to obtain a physician's order to crush medications (#9) to alert staff of medications not intended for crushing resulted in the potential for more than minimal harm at a pattern.	C1505		

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C1505	Continued From page 5 The deficient practice related to the administration of eye medication into the wrong eye (#10) resulted in the isolated potential for more than minimal harm. Findings: Resident #6 Resident #6 had a physician's order, dated November 2019 through March 2020, for Secura extra protective cream to be applied topically to buttocks as needed. On 03/02/2020 at 11:00 a.m., the registered nurse (RN) gave a verbal report on the residents at the center and stated resident #6 was not ambulatory, not weight bearing and had a chronic wound on the coccyx. On 03/04/2020 at 9:00 a.m., the RN stated resident #6's wound on her coccyx was a stage two. The RN stated the treatment for the wound was to apply Secura cream. At 9:32 a.m., the RN was asked if the Secura protective cream was applied to resident #6 for the month of November 2019 through February 2020. She stated it was not documented on the medication administration records (MAR's). She stated she had seen the staff put the cream on; however, they did not relay it back to the certified medication aide (CMA) for documentation. Resident #6 was lying in bed. The physician's assistant (PA) was at resident #6's bedside. The PA was asked if the wound on resident #6's coccyx was open. She stated yes. She stated the depth of the wound was about the size of the tip of her index finger. Resident #9	C1505		

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C1505	Continued From page 6 Resident #9's MAR, dated March 2020, did not document an order to crush medications. On 03/02/2020 at 12:25 p.m., CMA #4 crushed one tablet of Hydrocodone 5/325 mg (milligrams) and mixed with it jelly for resident #9. At 1:30 p.m., CMA #4 was asked if she had a physician's orders to crush resident #9's medications. She stated, "I thought I did." On 03/04/2020 at 9:00 a.m., the RN was asked about a crush order for resident #9's medications. She presented an unsigned physician's order to crush resident #9's medications dated 03/03/2020. The physician's order had no RN's signature or physician's signature. The RN signed the physician's order on 03/04/2020 and faxed it over to pharmacy. At 1:40 p.m., the RN was asked if resident #9 required her medications to be crushed. She stated, "I would think at times." Resident #10 Resident #10's assessment dated 02/26/20, documented alert times one, confused and poor judgment. Diagnoses include cognitive impairment, legally blind, and high blood pressure. Resident #10's physician's order, dated 02/29/20, documented, blink gel tears apply to left eye one time a day for dry eyes. Timolol ophthalmic solution 0.5% one (1) drop right eye one time a day for Glaucoma. On 03/04/20 at 7:40 a.m., CMA #4 applied the	C1505		

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C1505	Continued From page 7 Blink eye drop in resident #10's right eye and the Timolol solution in resident #10's left eye. CMA #4 was asked if she applied the wrong medication in the wrong eye. She stated she was not sure if she put the wrong medication in the wrong eye or not.	C1505		
C1512 SS=G	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint	C1512		

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C1512	Continued From page 8 or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to identify, develop and document interventions to prevent the development and worsening of decubitus ulcers for 1 (#1) of 2 sampled residents identified with stage II pressure ulcers. This deficient practice resulted in actual harm. Findings: Resident #1's wound orders were as follows: 1) On 12/30/19 Calazime cream (skin protectant) to coccyx area two (2) times a day. Clean wound with normal saline. Apply Calazime cream to	C1512		

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C1512	Continued From page 9 coccyx two (2) times a day. Facility staff may administer in absence of hospice nurse. This order was discontinued on 01/02/2020. 2) On 01/02/20 every brief change apply liberal amount of Calazime to right hip, left hip, buttocks, left lower buttocks. This order was started on 01/02/2020 for 7:00 AM, 11:00 AM, 3:00 PM, and 7:00 PM and initialed by the center's staff from 01/02/2020 through 01/15/2020 to indicate they provided the treatment. 3) On 01/15/2020 an order for Silver antimicrobial (destroy or inhibit the growth of microorganisms) sacrum wound dressing to left hip and left buttock wounds. Leave in place for 7 days. Facility staff may change and reapply new dressing in absence of hospice nurse. The center's staff continue Calazime treatment around this dressing. 4) On 01/30/2020 an order for Flagyl (antibiotic) 500 mg (milligrams) one (1) tab daily crush tablet and sprinkle into left buttock wound for odor. On 03/04/2020 at 12:03 p.m., the RN and executive director was asked to identify the staff initials on resident #1's Calazime cream in January 2020. They identified five certified medication aides (CMA's) (#1, 3, 4, 5, and #6). The RN was asked if she was aware CMA's could not apply cream to a decubitus ulcer. She stated, "I did not know that." Resident #1's previous hospice certification period ranged from 01/29/20 to 04/27/2020. Resident #1's current hospice certification and plan of care was sent by facsimile to the center on 03/03/2020 on the day of survey. Resident	C1512		

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C1512	Continued From page 10 #1's current certification period ranged from 02/06/2020 to 05/05/2020 for hospice services. The hospice documentation for resident #1, dated on 12/12/19 through 01/01/20 documented a hospital aide bathed the resident a total of six times during this time frame. The skilled nurse visited resident #1 a total of six times during this time frame. A hospice skilled nurse or hospice aide had visited resident #1 a total of twelve (12) times between 12/12/19 through 01/01/20 on opposite days of the week. Then on 01/02/2020 the center's registered nurse (RN) discovered and documented in the nurse's notes resident #1 had stage II pressure ulcers and notified the hospice agency. Resident #1's nurse's note dated on 01/02/2020, documented, "CSM noted areas to left hip, left lower buttock, coccyx on resident open. As well as right heel, not opened but dark in coloring. CSM contacted hospice. Hospice nurse provided visit and new order received Calazime cream to right hip, left hip, buttocks and left lower buttocks with each brief change. Air mattress provided. Daughter was notified of changes and care plan meeting has been scheduled." The clinical service manager (CSM) was the registered nurse (RN) currently employed at the center A hospice skilled nursing visit note dated 01/02/2020, documented four areas of wound care. Three of the wound areas were documented as a Stage II. Two of the three Stage II decubitus ulcers measured 3 x 3 x 0.1cm and one measured 3 x 3cm. The Stage I wound measured 3 x 3cm. A charting form used by third party caregivers with resident #1's most current wound	C1512		

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C1512	Continued From page 11 measurements, dated 02/19/2020, documented left hip measured 2 x 2cm (centimeters) moderate yellow drainage, slough, wound care per orders. Left gluteal fold 2.5 x 2cm with moderate yellow drainage, red/pink bed wound care per orders. Right elbow Band-Aid changed healing appropriately. On 03/02/2020 at 1:02 p.m., a hospice nurse was in resident #1's room performing wound care. A dressing covered resident #1's left hip and the left lower buttock was opened. The RN explained to the resident this was his powdered medicine and placed a gauze like material into the wound opening and covered it with a padded Band-Aid. She was asked how often she performed resident #1's wound care. She stated now it was on Mondays, Wednesdays, and Fridays and if the wound gets worse we will go back to daily. She was asked if the dressing was intact when she arrived this morning and she stated yes. On 03/04/2020 at 11:50 p.m., the RN was asked if hospice was performing wound care on 01/02/2020. She stated no there was no wound care just Calazime cream to coccyx twice a day. She was asked how hospice was not aware of resident #1's skin breakdown with the frequent visits. She stated the hospice nurse was let go shortly after this incident on 01/02/2020. RN was asked why the center's staff did not notice resident #1's wound progression. RN stated they did and notified her on 01/02/2020 and she submitted documentation for that day. She was asked if the wound was opened on 01/02/2020. She stated yes. RN was asked if she measured the wound at that time. RN stated she did not measure the wound. At 12:33 p.m., the RN was asked to submit the initial measurements for resident #1's wounds and the last measurements	C1512		

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C1512	Continued From page 12 recorded for resident #1's wounds. She was asked why the most recent wound measurements recorded on 02/19/2020 did not include depth measurements. She stated both the wounds have depth.	C1512		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to: 1) Maintain an accurate record for 1 (#2) of 2 sampled residents with finger stick blood sugar (FSBS) readings. 2) Document the administration of Magic cups daily for 1 (#6) of 2 sampled residents with a physician's order for Magic cups. These deficient practices resulted in the potential for more than minimal harm at a pattern. Findings: Resident #2 The charting form for third party providers do not include an area to record the time. Some third party providers documented AM or PM on the sheet; however, if they did not, it was not possible to determine whether the FSBS was performed in	C1951		

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C1951	Continued From page 13 the AM or PM. On 03/03/2020 at 11:30 a.m., the registered nurse (RN) was asked about the FSBS log for resident #2. She stated it contained "Incomplete documentation." She was asked if resident #2 had FSBS recorded on 02/22/20 and 02/23/20. She stated no there was no FSBS recorded on that day. She was asked if resident #2's FSBS at times were recorded in the mornings but not recorded in the evenings. She stated that was correct. Resident #6 The physician's orders for resident #6, dated March 2020, documented, diet: regular, small portions, Magic Cup one time a day. The medication administration record (MAR) for resident #6, dated March 2020, documented, diet: Regular, small portions, Magic Cup every day was written at the bottom of the MAR and did not contain a place to record the staff initials when the Magic Cup was administered to resident #6. (Another resident, Resident #5, was also identified with a physician's order for Magic Cups. Resident #5's MAR did contain a place for the staff to initial each time the resident consumed a Magic Cup.) On 03/04/20 at 10:52 a.m., the registered nurse (RN) was asked if resident #6 received a Magic Cup daily and was it recorded on the MAR. She stated it should be. RN was asked if there was a space provided for staff to initial the administration of the Magic Cup on the MAR. She stated there was not a place to sign.	C1951		

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C5010	Continued From page 14	C5010		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on observation, interview, and record review it was determined the center failed to obtain the hospice/ home health plan of care and review the services to ensure coordination of the	C5010		