

Delivery via email to: ShAnderson@dorsetplaceseniorliving.com

October 20, 2023

License Number: AL5515

Ms. SheKita Anderson, Administrator
Dorset Place-Memory Care
12401 Dorset Drive
Oklahoma City, OK 73120

RE: Survey Event ID: 01T611

Dear Ms. Anderson:

On **October 11, 2023**, agents from our office concluded a State Licensure survey with complaint investigations at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **October 11, 2023**.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully,



Lisa Calvin, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: DORSET PLACE MEMORY CARE
Address: 12401 DORSET DRIVE
City, State, Zip: OKLAHOMA CITY, OK 73120
Provider #: AL5515
Complaint #: 0K00060077
Investigation Date(s): 10/09/23 through 10/11/23

ALLEGATION(S)

The center failed to ensure adequate supervision to prevent falls with injury and ensure residents were not overmedicated.
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The center failed to report falls with major injury and injuries of unknown origin to the State Agency (OSDH).
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An unannounced on-site investigation was initiated 10/09/2023 at 11:00 a.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Residents were observed for falls and abuse. Resident rooms were observed for fall precaution interventions.

Facility policy and procedures were reviewed. **Nurses' notes, physician orders**, State reportable, in-service, and employee training records were reviewed. Medication administration records were reviewed.

Residents and resident representatives were interviewed regarding physician orders, medication administration, abuse, and falls. Staff were interviewed regarding facility policy and procedures for abuse, falls, medication administration, and State reportable.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/12/2023

INVESTIGATIVE REPORT

Facility: Dorset Place Memory Care
Address: 12401 Dorset Drive
City, State, Zip: Oklahoma City, OK, 73120
Provider #: AL5515
Complaint #: OK00060704
Investigation Date(s): 10/09/23 through 10/11/23

ALLEGATION(S)

The center failed to ensure residents who required a higher level of care were not admitted to the center.
The center failed to ensure residents did not develop new/worsening pressure wounds and injuries of unknown origin.
The center failed to notify the dependent resident's representative of a change in condition.
The center failed to provide a comfortable, homelike environment.

An unannounced on-site investigation was initiated 10/09/2023 at 11:00 a.m.

A sample of 11 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the center was conducted upon entrance and at other times throughout the survey. Resident rooms were observed for comfortable, homelike environment. Staff were observed assisting residents. Wound care was observed.

Resident records reviewed included assessments, physician orders, care plans, service plans, service notes, wound notes, and service contracts.

Facility policy and procedures were reviewed.

Residents were interviewed related to the provisions of the care they received at the center, new/worsening pressure wounds and injuries, changes in their condition and comfortable, homelike environment.

Staff members were interviewed regarding the facility policies and procedures for ensuring a comfortable homelike environment, changes in condition, new or worsening pressure wounds and the level of care residents receive.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/12/2023

INVESTIGATIVE REPORT

Facility: Dorset Place Memory Care
Address: 12401 Dorset Drive
City, State, Zip: Oklahoma City, OK, 73120
Provider #: AL5515
Complaint #: OK00060704
Investigation Dates: 10/09/23 through 10/11/23

ALLEGATION(S)

The center failed to assess, monitor, and intervene for a resident in distress.

The center failed to ensure residents received assistance with ADL care.
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The center failed to report an injury of unknown origin to the State Agency

An unannounced on-site investigation was initiated 10/09/2023 at 11:00 a.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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other times throughout the survey. Resident rooms were observed. Staff were observed assisting residents with ADL care. Residents were observed for cleanliness and indications of distress. Incontinent care was observed.

Residents' records reviewed included assessments, physicians orders, service notes, and service plans.

Facility policy and procedures were reviewed. State reports and incidents were reviewed. In-services and training were reviewed.

Residents were interviewed about the provisions of staff assistance with ADL's, changes in their conditions and new injuries.

Staff were interviewed regarding the facility policies for identification of residents with changes in their conditions and new injuries and providing ADL care.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/12/2023

INVESTIGATIVE REPORT

Facility: DORSET PLACE MEMORY CARE
Address: 12401 DORSET DRIVE
City, State, Zip: OKLAHOMA CITY, OK 73120
Provider #: AL5515
Complaint #: 0K00060803
Investigation Date(s): 10/09/23 through 10/11/23

ALLEGATION(S)

The facility failed to ensure medications were administered according to the physicians' orders.
The facility failed to ensure assistance with incontinent care in a timely manner.
The facility failed to ensure the right to be treated with dignity and respect and failed to ensure reasonable access to the Internet.

An unannounced on-site investigation was initiated 10/09/2023 at 11:00 a.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance, and at other various times throughout the survey. Residents were observed for cleanliness and incontinent care. Resident's rooms were observed for odors. Staff and resident interactions were observed.

Facility policy and procedures were reviewed. Nurses' notes, physician orders, in-service, and employee training records were reviewed. Medication administration records were reviewed.

Residents and resident representatives were interviewed regarding medication administration, timely incontinent care, call lights, staff treatment, and internet use. Staff were interviewed regarding facility policy and procedures for call lights, timely incontinent care, dignity and respect, internet use, and medication administration.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 10/12/2023

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 C 10/11/2023
NAME OF PROVIDER OR SUPPLIER DORSET PLACE-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 A relicensure survey was conducted from 10/09/23 through 10/11/23. Complaint investigations (#OK00060077, OK00060326, OK00060704, and #OK00060803) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide DON - director of nursing MAR- medication administration record MG- milligram RN- registered nurse	C 000		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview the center failed to ensure an admission assessment was coordinated to ensure the required signatures of completion from the nurse for one (#3) of 12 sampled residents whose assessments were reviewed. The Administrator identified 21 residents resided in the facility.	C 521		

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 C 10/11/2023
NAME OF PROVIDER OR SUPPLIER DORSET PLACE-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 521	Continued From page 1 Findings: A review of Resident #3's records documented the resident was admitted on 11/04/22. The "Assessment and Negotiated Service Plan Summary", dated 10/29/22, did not have any signatures of completion. On 10/11/23 at 12:20 p.m., the DON and the Administrator stated there were no signatures on the summary and there should have been.	C 521		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to complete a comprehensive assessment for one (#3) of 12 sampled residents reviewed for comprehensive assessments. The DON identified 21 residents resided in the facility. Findings:	C 522		

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 C 10/11/2023
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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C 522	Continued From page 2 The "Assessment/Service Plan" policy, dated 07/01/21, read in part, "The Community will have procedures in place to assess Residents, at a minimum...by Day 14...in order to develop a Service Plan that will meet the needs of a Resident..." Resident #3 admitted on 11/04/22 and had diagnoses of dementia, transient ischemic attack, cardiac arrhythmia, and supraventricular tachycardia. A review of the clinical record did not yield the comprehensive assessment. On 10/11/23 at 12:15 p.m., the DON stated they were not able to locate the comprehensive assessment.	C 522		
C 542 SS=E	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 record review and interview, the center failed to ensure resident assessments were coordinated and signed by a registered nurse, or the resident's physician for five (#1, 2, 6, 10, and #11) of 12 sampled residents whose assessments were reviewed. The Administrator identified 21 residents resided in the facility.	C 542		

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 C 10/11/2023
NAME OF PROVIDER OR SUPPLIER DORSET PLACE-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 542	Continued From page 3 Findings: 1. Resident #11 was admitted to the facility on 12/08/21. Resident #11's admission assessment, dated 12/08/21, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 2. Resident #10 was admitted to the facility on 04/17/23. Resident #10's significant change assessment, dated 06/27/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 3. Resident #2 was admitted to the facility on 05/01/23. Resident #2's comprehensive assessment, dated 05/12/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 4. Resident #1 was admitted to the facility on 05/23/23. Resident #1's comprehensive assessment, dated 05/30/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 5. Resident #6 was admitted to the facility on 09/08/23. Resident #6's admission assessment, dated 09/08/23, did not document the assessment had	C 542		

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 C 10/11/2023
NAME OF PROVIDER OR SUPPLIER DORSET PLACE-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 542	Continued From page 4 been coordinated and signed by an RN or the resident's physician. On 10/11/23 at 12:20 p.m., the DON and Administrator stated there was no RN signatures for any of the assessments mentioned.	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 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 record review and interview, the center failed to ensure resident assessments included a personal interview between the resident and/ or representative for five (#1, 2, 6, 10, and #11) of 12 sampled residents whose assessments were reviewed. The Administrator identified 21 residents resided in the facility. Findings: A facility policy titled "Assessment/Service Plan", dated 07/01/21, read in part, "...The Resident and/or Responsible Party will participate in each Assessment and the development of their Service Plan..."	C 543		

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 C 10/11/2023
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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C 543	Continued From page 5 1. Resident #11 was admitted to the facility on 12/08/21. Resident #11's admission assessment, dated 12/08/21, documented Resident #11 had dementia and was confused. The assessment was not signed by the resident or their representative interviewed. 2. Resident #10 was admitted to the facility on 04/17/23. Resident #10's significant change assessment, dated 06/27/23, documented Resident #10 had Alzheimer's, dementia, and was confused. The assessment was not signed by the resident or their representative interviewed. 3. Resident #2 was admitted to the facility on 05/01/23. Resident #2's comprehensive assessment, dated 05/01/23, documented Resident #2 had dementia and was confused at times. The assessment was not signed by the resident or their representative. 4. Resident #1 was admitted to the facility on 05/23/23. Resident #1's comprehensive assessment, dated 05/30/23, documented Resident #1 had Lewy body dementia and was confused. The assessment was not signed by the resident or their representative interviewed. 5. Resident #6 was admitted to the facility on 09/08/23. Resident #6's admission assessment, dated	C 543		

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 C 10/11/2023
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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C 543	Continued From page 6 09/08/23, documented Resident #6 had dementia and was confused. The assessment was not signed by the resident or their representative interviewed. On 10/11/23 at 12:20 p.m., the DON and Administrator stated there was no resident or resident representative signature for any of the assessments mentioned.	C 543			
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to administer medication as ordered by the physician for one (#1) of three sampled residents reviewed for medication administration. The Administrator identified 21 residents resided in the facility. Findings: A facility policy titled "Medication Management", dated 07/01/21, read in part, "...Medications will be administered according to Medical Provider orders..." Resident #1 had diagnoses which included Lewy	C1921			

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 C 10/11/2023
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C1921	Continued From page 7 body dementia, depression, and anxiety. A Physician's order, dated 05/23/23, documented buspirone 10 mg, give one tablet by mouth one time a day at bedtime for anxiety. Resident #1's MAR, dated 06/01/23, was blank on 06/01/23 through 06/06/23 for buspirone 10 mg. On 10/11/23 at 9:36 a.m., the DON stated the blank on the MAR meant the physician's order for buspirone 10 mg, give was not transferred to the MAR at the time. The DON stated CMA's go by the MAR. On 10/11/23 at 9:42 a.m., the DON stated Resident #1 did not receive the medication as ordered for the blank days.	C1921		

Delivery via email to: ShAnderson@dorsetplaceseniorliving.com

November 3, 2023

License Number: AL5515

SheKita Anderson, Administrator
Dorset Place-Memory Care
12401 Dorset Drive
Oklahoma City, OK 73120

RE: Survey Event 01T611

Dear Ms. Anderson:

On **October 11, 2023**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1921:** The plan of correction was missing a corrective action plan for C1921. C1921 was not addressed.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Respectfully,



Lisa Calvin, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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 C 10/11/2023
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C 000	INITIAL COMMENTS A relicensure survey was conducted from 10/09/23 through 10/11/23. Complaint investigations (#OK00060077, OK00060326, OK00060704, and #OK00060803) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CMA- certified medication aide DON - director of nursing MAR- medication administration record MG- milligram RN- registered nurse	C 000		
C 521 SS=D	310:663-5-2(a) ASSESSMENT TIMEFRAMES (a) The assisted living center shall complete the admission assessment within thirty (30) days before, or at the time of, admission. This Rule is not met as evidenced by: Based on record review and interview the center failed to ensure an admission assessment was coordinated to ensure the required signatures of completion from the nurse for one (#3) of 12 sampled residents whose assessments were reviewed. The Administrator identified 21 residents resided in the facility.	C 521	1.Assessment and ISP will be completed upon admission by facility Administrator or Director of Health and Wellness. After resident has physically moved in the facility Director of Health and Wellness will have a meeting with resident/POA to review ISP and assessment and sign off on services within 5 days of physical move in. The assessment will be re-evaluated every six months or upon change to residents needs and a new ISP will be created. 2.Each residents ISP will include who is responsible for providing services, how the services will be provided and expected goals and outcomes of the services provided. 3.A copy of each residents ISP and signed assessment will be kept in resident's file as well as in a community binder accessible to direct care staff. 4.Each current residents ISP will be updated to include who is responsible for providing services, how the services will be provided and expected goals and outcomes of the services provided. This will be completed by 11/15/2023, and will be ongoing with admission.	

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

01T611

If continuation sheet 1 of 8

Jon Meyer

Div. Director of Resident Care

11/2/23

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 C 10/11/2023
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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C 521	Continued From page 1 Findings: A review of Resident #3's records documented the resident was admitted on 11/04/22. The "Assessment and Negotiated Service Plan Summary", dated 10/29/22, did not have any signatures of completion. On 10/11/23 at 12:20 p.m., the DON and the Administrator stated there were no signatures on the summary and there should have been.	C 521		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to complete a comprehensive assessment for one (#3) of 12 sampled residents reviewed for comprehensive assessments. The DON identified 21 residents resided in the facility. Findings:	C 522	1.Assessment and ISP will be completed upon admission by facility Administrator or Director of Health and Wellness. After resident has physically moved in the facility Director of Health and Wellness will have a meeting with resident/POA to review ISP and assessment and sign off on services within 5 days of physical move in. The assessment will be re-evaluated every six months or upon change to residents needs and a new ISP will be created. 2.Each residents ISP will include who is responsible for providing services, how the services will be provided and expected goals and outcomes of the services provided. 3.A copy of each residents ISP and signed assessment will be kept in resident's file as well as in a community binder accessible to direct care staff. 4.Each current residents ISP will be updated to include who is responsible for providing services, how the services will be provided and expected goals and outcomes of the services provided. This will be completed by 11/15/2023, and will be ongoing with admission.	

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C 522	Continued From page 2 The "Assessment/Service Plan" policy, dated 07/01/21, read in part, "The Community will have procedures in place to assess Residents, at a minimum...by Day 14...in order to develop a Service Plan that will meet the needs of a Resident..." Resident #3 admitted on 11/04/22 and had diagnoses of dementia, transient ischemic attack, cardiac arrhythmia, and supraventricular tachycardia. A review of the clinical record did not yield the comprehensive assessment. On 10/11/23 at 12:15 p.m., the DON stated they were not able to locate the comprehensive assessment.	C 522		
C 542 SS=E	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 record review and interview, the center failed to ensure resident assessments were coordinated and signed by a registered nurse, or the resident's physician for five (#1, 2, 6, 10, and #11) of 12 sampled residents whose assessments were reviewed. The Administrator identified 21 residents resided in the facility.	C 542	1. All assessments will be coordinated and signed by registered nurse every two weeks. 2. DHW and/or ED will notify registered nurse that assessment needs to be reviewed within 5 days of move in. 2. Once notified, DHW or person assigned to task will place in binder in facility for registered nurse to review. 3. Once registered nurse or resident's physician has reviewed and signed, DHW or assignee will place in resident's file. 4. An audit will be conducted and completed by 11/15/23 and will continue upon admission.	

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C 542	Continued From page 3 Findings: 1. Resident #11 was admitted to the facility on 12/08/21. Resident #11's admission assessment, dated 12/08/21, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 2. Resident #10 was admitted to the facility on 04/17/23. Resident #10's significant change assessment, dated 06/27/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 3. Resident #2 was admitted to the facility on 05/01/23. Resident #2's comprehensive assessment, dated 05/12/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 4. Resident #1 was admitted to the facility on 05/23/23. Resident #1's comprehensive assessment, dated 05/30/23, did not document the assessment had been coordinated and signed by an RN or the resident's physician. 5. Resident #6 was admitted to the facility on 09/08/23. Resident #6's admission assessment, dated 09/08/23, did not document the assessment had	C 542		

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C 542	Continued From page 4 been coordinated and signed by an RN or the resident's physician. On 10/11/23 at 12:20 p.m., the DON and Administrator stated there was no RN signatures for any of the assessments mentioned.	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 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 record review and interview, the center failed to ensure resident assessments included a personal interview between the resident and/ or representative for five (#1, 2, 6, 10, and #11) of 12 sampled residents whose assessments were reviewed. The Administrator identified 21 residents resided in the facility. Findings: A facility policy titled "Assessment/Service Plan", dated 07/01/21, read in part, "...The Resident and/or Responsible Party will participate in each Assessment and the development of their Service Plan..."	C 543	1.Assessment and ISP will be completed upon admission by facility Administrator or Director of Health and Wellness. After resident has physically moved in the facility Director of Health and Wellness will have a meeting/interview with resident/POA to review ISP and assessment and sign off on services within 5 days of physical move in. The assessment will be re-evaluated every six months or upon change to resident's needs and a new ISP will be created. 2.Each residents ISP will include who is responsible for providing services, how the services will be provided and expected goals and outcomes of the services provided. 3.A copy of each residents ISP and signed assessment will be kept in resident's file as well as in a community binder accessible to direct care staff. 4.Each current residents ISP will be updated to include who is responsible for providing services, how the services will be provided and expected goals and outcomes of the services provided. This will be completed by 11/15/2023, and will be ongoing with admission.	

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C 543	Continued From page 5 1. Resident #11 was admitted to the facility on 12/08/21. Resident #11's admission assessment, dated 12/08/21, documented Resident #11 had dementia and was confused. The assessment was not signed by the resident or their representative interviewed. 2. Resident #10 was admitted to the facility on 04/17/23. Resident #10's significant change assessment, dated 06/27/23, documented Resident #10 had Alzheimer's, dementia, and was confused. The assessment was not signed by the resident or their representative interviewed. 3. Resident #2 was admitted to the facility on 05/01/23. Resident #2's comprehensive assessment, dated 05/01/23, documented Resident #2 had dementia and was confused at times. The assessment was not signed by the resident or their representative. 4. Resident #1 was admitted to the facility on 05/23/23. Resident #1's comprehensive assessment, dated 05/30/23, documented Resident #1 had Lewy body dementia and was confused. The assessment was not signed by the resident or their representative interviewed. 5. Resident #6 was admitted to the facility on 09/08/23. Resident #6's admission assessment, dated	C 543		

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C 543	Continued From page 6 09/08/23, documented Resident #6 had dementia and was confused. The assessment was not signed by the resident or their representative interviewed. On 10/11/23 at 12:20 p.m., the DON and Administrator stated there was no resident or resident representative signature for any of the assessments mentioned.	C 543			
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to administer medication as ordered by the physician for one (#1) of three sampled residents reviewed for medication administration. The Administrator identified 21 residents resided in the facility. Findings: A facility policy titled "Medication Management", dated 07/01/21, read in part, "...Medications will be administered according to Medical Provider orders..." Resident #1 had diagnoses which included Lewy	C1921			

Oklahoma State Department of Health

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C1921	Continued From page 7 body dementia, depression, and anxiety. A Physician's order, dated 05/23/23, documented buspirone 10 mg, give one tablet by mouth one time a day at bedtime for anxiety. Resident #1's MAR, dated 06/01/23, was blank on 06/01/23 through 06/06/23 for buspirone 10 mg. On 10/11/23 at 9:36 a.m., the DON stated the blank on the MAR meant the physician's order for buspirone 10 mg, give was not transferred to the MAR at the time. The DON stated CMA's go by the MAR. On 10/11/23 at 9:42 a.m., the DON stated Resident #1 did not receive the medication as ordered for the blank days.	C1921		

Delivery via email to: [Lori Myers <lmyers@moradaseniorliving.com>](mailto:lmyers@moradaseniorliving.com)

November 13, 2023

License Number: AL5515

Ms. Lori Myers, Divisional Director of Residential Care
Dorset Place-Memory Care
12401 Dorset Drive
Oklahoma City, OK 73120

Survey Event ID: 01T611

Dear Ms. Myers:

On **October 11, 2023**, a Relicensure survey and a Complaint investigation were conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **November 20, 2023**.

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

Respectfully,

Tempal Killman

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

enc

Oklahoma State Department of Health

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Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Div Dir Resident Care

(X6) DATE
11/7/23

Oklahoma State Department of Health

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C 521	Continued From page 1 Findings: A review of Resident #3's records documented the resident was admitted on 11/04/22. The "Assessment and Negotiated Service Plan Summary", dated 10/29/22, did not have any signatures of completion. On 10/11/23 at 12:20 p.m., the DON and the Administrator stated there were no signatures on the summary and there should have been.	C 521		
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C 542	Continued From page 4 been coordinated and signed by an RN or the resident's physician. On 10/11/23 at 12:20 p.m., the DON and Administrator stated there was no RN signatures for any of the assessments mentioned.	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 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 record review and interview, the center failed to ensure resident assessments included a personal interview between the resident and/ or representative for five (#1, 2, 6, 10, and #11) of 12 sampled residents whose assessments were reviewed. The Administrator identified 21 residents resided in the facility. Findings: A facility policy titled "Assessment/Service Plan", dated 07/01/21, read in part, "...The Resident and/or Responsible Party will participate in each Assessment and the development of their Service Plan..."	C 543	1.Assessment and ISP will be completed upon admission by facility Administrator or Director of Health and Wellness. After resident has physically moved in the facility Director of Health and Wellness will have a meeting/interview with resident/POA to review ISP and assessment and sign off on services within 5 days of physical move in. The assessment will be re-evaluated every six months or upon change to resident's needs and a new ISP will be created. 2.Each residents ISP will include who is responsible for providing services, how the services will be provided and expected goals and outcomes of the services provided. 3.A copy of each residents ISP and signed assessment will be kept in resident's file as well as in a community binder accessible to direct care staff. 4.Each current residents ISP will be updated to include who is responsible for providing services, how the services will be provided and expected goals and outcomes of the services provided. This will be completed by 11/15/2023, and will be ongoing with admission.	

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 C 10/11/2023
NAME OF PROVIDER OR SUPPLIER DORSET PLACE-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 543	Continued From page 5 1. Resident #11 was admitted to the facility on 12/08/21. Resident #11's admission assessment, dated 12/08/21, documented Resident #11 had dementia and was confused. The assessment was not signed by the resident or their representative interviewed. 2. Resident #10 was admitted to the facility on 04/17/23. Resident #10's significant change assessment, dated 06/27/23, documented Resident #10 had Alzheimer's, dementia, and was confused. The assessment was not signed by the resident or their representative interviewed. 3. Resident #2 was admitted to the facility on 05/01/23. Resident #2's comprehensive assessment, dated 05/01/23, documented Resident #2 had dementia and was confused at times. The assessment was not signed by the resident or their representative. 4. Resident #1 was admitted to the facility on 05/23/23. Resident #1's comprehensive assessment, dated 05/30/23, documented Resident #1 had Lewy body dementia and was confused. The assessment was not signed by the resident or their representative interviewed. 5. Resident #6 was admitted to the facility on 09/08/23. Resident #6's admission assessment, dated	C 543		

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 C 10/11/2023
NAME OF PROVIDER OR SUPPLIER DORSET PLACE-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 543	Continued From page 6 09/08/23, documented Resident #6 had dementia and was confused. The assessment was not signed by the resident or their representative interviewed. On 10/11/23 at 12:20 p.m., the DON and Administrator stated there was no resident or resident representative signature for any of the assessments mentioned.	C 543		
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on observation, record review and interview, the center failed to administer medication as ordered by the physician for one (#1) of three sampled residents reviewed for medication administration. The Administrator identified 21 residents resided in the facility. Findings: A facility policy titled "Medication Management", dated 07/01/21, read in part, "...Medications will be administered according to Medical Provider orders..." Resident #1 had diagnoses which included Lewy	C1921	1. A MAR to cart audit will be completed by pharmacy by 11/ 20/23. 2. DHW or assignee will complete any findings by pharmacy. 3. Inservicing of staff on physician orders and medications by 11/20/23. 4. All new orders/ changed orders will be documented and reviewed weekly by DHW. 5. DHW will then initial that the meds were reviewed and correct. This will be reviewed by ED or DDRC weekly. 6. Continuing education at all monthly meetings, as well as new hire orientation will take place and will be documented.	

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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 C 10/11/2023
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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C1921	Continued From page 7 body dementia, depression, and anxiety. A Physician's order, dated 05/23/23, documented buspirone 10 mg, give one tablet by mouth one time a day at bedtime for anxiety. Resident #1's MAR, dated 06/01/23, was blank on 06/01/23 through 06/06/23 for buspirone 10 mg. On 10/11/23 at 9:36 a.m., the DON stated the blank on the MAR meant the physician's order for buspirone 10 mg, give was not transferred to the MAR at the time. The DON stated CMA's go by the MAR. On 10/11/23 at 9:42 a.m., the DON stated Resident #1 did not receive the medication as ordered for the blank days.	C1921		

Delivery via email to: lmyers@moradaseniorliving.com;
lpark@moradaseniorliving.com; webrown@dorsetplaceseniorliving.com

December 14, 2023

License Number: AL5515

Ms. Lori Myers, Administrator
Dorset Place-Memory Care
12401 Dorset Drive
Oklahoma City, OK 73120

RE: Survey Event 01T612

Dear Ms. Myers:

On **December 13, 2023**, an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 11, 2023**, have now been corrected effective **November 20, 2023**.

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

Respectfully,



Lisa Calvin, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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 R-C 12/13/2023
NAME OF PROVIDER OR SUPPLIER DORSET PLACE-MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 offsite/paper revisit was conducted on 12/13/23. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE