OKLAHOMA
State Department
of Health

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

February 20, 2025

License Number: AL5515
Survey Event ID: 2BSJ11

Mr. Demetrio Gutierrez, Administrator
Dorset Place-Memory Care
12401 Dorset Drive
Oklahoma City, OK 73120

Dear Mr. Gutierrez:

Enclosed is the summary of deficiencies from the licensure with complaint investigation survey conducted at your facility on **February 6, 2025**.

Please note the items listed in the deficiency column of the report. Your plan of correction and anticipated date of completion must be typed in the spaces provided. If additional space is needed, a supplemental sheet may be attached.

The criteria for an acceptable plan of correction are:

- A statement of exactly how the facility has or intends to correct each deficiency.
- The method of correction. This includes who is responsible for the correction.
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This is part of your quality assurance plan. At the revisit, the quality assurance plan shall be reviewed to determine the earliest date of compliance. If there is no finding of continuing non-compliance, **evidence of quality assurance being implemented will be required to establish a correction date earlier than the date of the revisit.**
- A reasonable date of correction, which will normally be within 60 days of this notice.

NOTE: Please avoid naming individuals, business firms or brand names on the enclosed form since it is a public disclosure form.

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **Failure to submit an acceptable Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process.** Please retain a copy of this completed form for your files.

Informal Dispute Resolution

In accordance with 63 OS 1-1914.5 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 833). 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 833 and the Oklahoma IDR Process.

The IDR request must be submitted within ten calendar days from receipt of the Statement of Deficiencies (CMS-2567). 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:

- Scope and severity assessments of deficiencies with the exception of scope and severity assessments that constitute substandard quality of care (SQC) or immediate jeopardy (IJ);
- Remedy (ies) imposed by the Department;
- Alleged failure of the survey team to comply with a requirement of the survey process;
- Alleged inconsistency of the survey team 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, telephone at (405) 426-8200.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dorset Place-Memory Care**
Address: **12401 Dorset Drive**
City, State, Zip: **OKC, OK., 73120**
Provider #: **AL5515**
Complaint #: **OK00066000**
Investigation Date: **02/05/25 through 02/06/25**

ALLEGATION(S)
1. The center failed to ensure residents were not physically, verbally or psychosocially abused.
2. The center failed to have and/or implement an effective pharmacy policy and procedure to ensure medications were administered according to the physicians' orders.
3. The center failed to ensure an administrator, and a full-time nurse was designated to ensure residents received the care according to the plan of care.
4. The center failed to ensure a safe, comfortable and homelike environment.

An unannounced on-site investigation was initiated 02/05/2025 at 10:30 a.m.

A sample of three participants, including any identified participants, 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 into the center. Residents were observed for abuse and neglect concerns. Staff were observed administering medication. The home environment was observed. Records reviewed included: Residents health records, facility reported incidents, grievances, staffing schedules, Medication administration records, and police reports. Residents and staff were asked questions regarding medication administration, staffing, and maintaining a homelike environment.

The attached State form, Statement of Deficiencies, 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: 02/06/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Dorset Place-Memory Care**
Address: **12401 Dorset Drive**
City, State, Zip: **OKC, OK., 73120**
Provider #: **AL5515**
Complaint #: **OK00068745**
Investigation Date: **02/05/25 through 02/06/25**

ALLEGATION(S)
1.The facility failed to ensure medications were administered according to the physician order, and ensure staff followed.

An unannounced on-site investigation was initiated 02/05/2025 at 10:30 a.m.

A sample of three participants, including any identified participants, 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 into the center. Residents were observed for abuse and neglect concerns. Staff were observed administering medication. The home environment was observed. Records reviewed included: Residents health records, facility reported incidents, grievances, staffing schedules, Medication administration records, and police reports. Residents and staff were asked questions regarding medication administration, staffing, and maintaining a homelike environment.

The attached State form, Statement of Deficiencies, 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: 02/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5515	A. BUILDING: _____ B. WING _____	C 02/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted from 02/05/25 through 02/06/25. Complaint investigations (#OK00066000 and #OK00066745) were conducted in conjunction with the survey. Facility Census: 28 The following abbreviations will be used throughout this document: CDM - certified dietary manager CMA- certified medication aide CNA- certified nursing assistant OSDH - Oklahoma State Department of Health RN - registered nurse	C 000		
C 391 SS=D	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the center failed to: a. maintain a clean and sanitary kitchen; b. ensure open items were labeled with the open/use by date in the refrigerator; and c. ensure food items were not stored directly on the floor during one of one kitchen observations. The wellness director identified 28 residents	C 391		

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C 391	Continued From page 1 received nutrition from the kitchen. Findings: An undated facility "Food Receiving and Storage" policy, read in part, "All food stored in the refrigerator or freezer must be covered, labeled and dated ("use by" date)." On 02/05/25 at 11:45 a.m., the following observations were made in the kitchen: a. three containers of open vanilla low fat yogurt with no date open/use by label were in the reach in refrigerator, b. food debris and sticky substances were on the bottom of the reach in refrigerator, c. two open bottles of trace agave mixer with no date open/use by label were in the dry storage, d. clean empty water pitchers were stored on the bottom shelf with food debris under the microwave, e. the microwave contained food debris and was unsanitary, and f. one container of cooking oil was stored on the floor across from the stove. On 02/05/25 at 11:59 a.m. the dietary manager was shown the above concerns and asked what the policy was. The dietary manager stated all items in the refrigerator should be labeled with an open and use by date, the kitchen was not clean and sanitary, and food items should not be stored on the floor. They stated the kitchen policies were not followed.	C 391		
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	C 542		

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C 542	Continued From page 2 personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure assessments were signed and/or coordinated by a RN or physician for 3 (#1, 2, and #3) of 8 residents reviewed for assessments coordinated by a RN or physician. The health director identified 28 residents resided in the center. Findings: 1. Resident #1 was admitted on 09/03/24 with diagnoses which included dementia and Alzheimer's disease. Resident #1's annual assessment, dated 10/31/24, did not show it was signed and/or coordinated by a RN or physician. 2. Resident #2 was admitted on 09/08/23 with diagnoses which included dementia. Resident #2's annual assessment, dated 10/25/24, did not show it was signed and/or coordinated by a RN or physician. 3. Resident #3 was admitted on 09/30/23 with diagnoses which included dementia. Resident #3's annual assessment, dated 10/31/24, did not show it was signed and/or coordinated by a RN or physician. On 02/06/25 at 10:24 a.m., the health director	C 542		

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C 542	Continued From page 3 stated the above assessments were not signed by a RN or physician.	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 annual assessments were signed by the resident and/or resident representative for 3 (#1, #2, and, #3) of 8 sampled residents reviewed for assessments signed by the resident and/or resident representative. The health director identified 28 residents resided in the center. Findings: 1. Resident #1 was admitted on 09/03/24 with diagnoses which included dementia and Alzheimer's disease. The center's "Resident Annual Assessments Form," dated 10/31/24, did not show the resident and/or personal representative signed the assessment.	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 543	Continued From page 4 2. Resident #2 was admitted on 09/08/23 with diagnoses which included dementia. The center's "Resident Annual Assessments Form," dated 10/25/24, did not show the resident and/or personal representative signed the assessment. 3. Resident #3 was admitted on 09/30/23 with diagnoses which included dementia. The center's "Resident Annual Assessments Form," dated 10/31/24, did not show the resident and/or personal representative signed the assessment. On 02/06/24 at 10:24 a.m., the health director was asked the reason the resident and/or personal representative never signed the annual assessments. The health director shrugged their shoulders up and down stated, "I don't know."	C 543		
C 544 SS=E	310:663-5-4(d) CONDUCT OF ASSESSMENT (d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be available upon request to the following: (1) the resident; (2) the resident's personal physician; (3) the resident's representative; and (4) the Department. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure medical records were maintained for five years for 2 (#1 and #2) of 8 sampled residents reviewed for assessments.	C 544		

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C 544	Continued From page 5 The health director identified 28 residents resided in the center. Findings: 1. Resident #1 admitted to the center on 09/02/24. There was no initial assessment for the resident. 2. Resident #2 admitted to the center on 09/08/23. There was no initial assessment for the resident. On 02/06/25 at 10:24 a.m., the health director was asked to provide the initial assessments for Residents #1 and #2. The health director stated they had recently changed owners and they could not access resident records from the previous owners.	C 544		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure staff were trained in first aid and cardiopulmonary resuscitation for 5 (CDM #1,	C 954		

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	AL5515	A. BUILDING: _____ B. WING _____	C 02/06/2025

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C 954	Continued From page 6 CMA #1, CNA #1, dietary aide #1, and housekeeper #1) of 5 staff reviewed for first aid and cardiopulmonary resuscitation training. The nursing director identified 28 residents resided in the facility. Findings: On 02/06/25 at 3:10 p.m., CDM #1, CMA #1, CNA #1, dietary aide #1, and housekeeper#1's employee records were reviewed. There was no documentation of first aid and cardiopulmonary resuscitation training. On 02/06/25 at 3:42 p.m., the health director was asked about first aid and cardiopulmonary resuscitation training for the above mentioned employees. They stated there was no documentation the training was completed.	C 954		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		

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C1911	Continued From page 7	C1911		

This Rule is not met as evidenced by:
Based on record review and interview, the center failed to report an incident of abuse to OSDH within one department business day of the reportable incident for 1 (#6) of 3 sampled residents reviewed for allegations of abuse.

The clinical director identified 28 residents resided in the facility.

Findings:

The facility's "Abuse, Neglect and Exploitation" policy, dated 11/14/24 read in part, "A report will be made to the appropriate authorities, including licensing agencies and law enforcement, of the suspicion or allegation of abuse, neglect or exploitation within 24 hours."

1. Resident #5 was admitted with diagnosis which included dementia, anxiety, and falls.

2. Resident #6 was admitted with diagnoses which included dementia, fractures, and protein calorie malnutrition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1911	Continued From page 8 A final incident report form 283, dated 11/26/24, documented an incident of resident-to-resident abuse did occur between Resident #5 and Resident #6 resulting in injury to Resident #6's shoulder. A resident services note, dated 11/27/24, showed Resident #6 was pushed by another resident resulting in injury to their shoulder. On 11/29/24 at 8:59 a.m., a facsimile confirmation page showed the incident was reported to OSDH. On 02/06/25 at 3:30 p.m. the executive director stated the report should have been completed and submitted to the OSDH within 24 hours of the allegation of abuse.	C1911		
C1972 SS=E	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure staff were trained in abuse and neglect within 90 days of hire for 5 (CDM #1, CMA #1, CNA #1, dietary aide #1, and	C1972		

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C1972	Continued From page 9 housekeeper #1) of 5 staff reviewed for staff trained in abuse and neglect within 90 days of hire The nursing director identified 28 residents resided in the facility. Findings: On 02/06/25 at 3:10 p.m., CDM #1, CMA #1, CNA #1, dietary aide #1, and housekeeper #1's employee records were reviewed. There was no documentation of abuse and neglect training within 90 days of hire. On 02/06/25 at 3:42 p.m., the health director was asked to provide abuse and neglect training within 90 days of hire for the above mentioned employees. They stated there was no documentation the training was completed.	C1972		

OKLAHOMA
State Department
of Health

Delivery via email to: dgutierrez@dorsetplaceseniorliving.com

March 11, 2025

License Number: AL5515

Mr. Demetrio Gutierrez, Administrator
Dorset Place-Memory Care
12401 Dorset Drive
Oklahoma City, OK 73120

RE: Survey Event 2BSJ11

Dear Mr. Gutierrez:

On **February 6, 2025**, a Licensure inspection with a Complaint investigation 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 in a timely manner. **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 **March 24, 2025**.

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

Respectfully,

Tempal Killman

Ms. Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/7/2025** **Facility Name:** Dorset Place Memory Care **License Number:** AL 5515 **Survey Event ID:** 2BSJ11 **Date Survey Completed: 2/6/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 391	Based on: This STANDARD is not met as evidenced by: based on observation, record review and interview, the center failed to: a. maintain a clean and sanitary kitchen; b. ensure open items were labeled with the open/use by date in the refrigerator; and c. ensure food items were not stored directly on the floor during one of one kitchen observations.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Corrective actions for C 391 include: a. Containers of open vanilla low fat yogurt were disposed of immediately, b. food debris and stickly substances were removed/cleaned from the bottom of reach in refrigerator, c. open bottles of trace agave mixer were disposed of, d. water ptchers have been cleaned and moved to the dry storage area, e. the microwave has been cleaned and sanitized, and f. containers of cooking oil are being stored correctly in the dry storage area.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The entire kitchen has been cleaned and sanitized. All items in refrigerators and freezers have been checked to ensure they have an open/use by date. All refrigerators have been emptied out and cleaned.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The kitchen will be checked by Executive Director or designee weekly for the next 2 months, then twice monthly for 3 months, then monthly; utilizing a check list. The Dietary Manager will be re-educated on maintaining a clean and sanitary kitchen.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Dietary Manager will report results from the check list to the QAPI Committee monthly for review/further recommendations/comments. The checklist will be kept by Dietary Manager. Any no or negative results on the checklist will be highlighted for further discussion and alternative approach to be developed. The Dietary Manager will develop/document any alternative approaches and report results to QAPI Committee at their next meeting. The checklist will be maintained by the Dietary Manager for at least 1 year.

OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/24/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Demetrio Gutierrez** OAC 310:663-25-4(F)	**Date 3/10/2025**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Demetrio Gutierrez

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Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/7/2025** **Facility Name:** Dorset Place Memory Care **License Number:** AL 5515 **Survey Event ID:** 2BSJ11 **Date Survey Completed: 2/6/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 542	Based on: This RULE is not met as evidenced by: based on record review and interview, the center failed to ensure assessments were signed and/or coordinated by a RN or physician for 3 (#1, #2, and #3) of 8 residents reviewed for assessments coordinated by a RN or physician.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Corrective actions for C 542 include: Assessments for Residents #1, #2, and #3 have been signed by a RN.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents have been reviewed and a RN has signed their current assessments.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All future assessments will be reviewed/coordinated by a RN or physician. The DHW has been educated on the requirements for assessments to include RN or Physician signature.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Director of Health and Wellness will report total number of assessments by type that were conducted every month to QAPI Committee. Any assessments that are not signed by RN or Physician will be highlighted and alternative action(s) recommended to get them signed will be discussed and addressed. The QAPI Committee will review for possible further action/recommendations/suggestions at their scheduled meetings. The DHW will maintain all assessments within the current policy and procedure for record maintenance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/24/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Demetrio Gutierrez** OAC 310:663-25-4(F)	**Date 3/10/2025**

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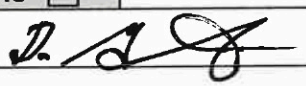
Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/7/2025** **Facility Name:** Dorset Place Memory Care **License Number:** AL 5515 **Survey Event ID:** 2BSJ11 **Date Survey Completed: 2/6/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 543	Based on: This RULE is not met as evidenced by: based on record review and interview, the center failed to ensure annual assessments were signed by the resident and/or resident's representative for 3 (#1, #2, and #3) of 8 sampled residents reviewed for assessments signed by resident and/or resident representative.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Corrective actions for C 543 include: Assessments for Residents #1, #2, and #3 have been signed by the resident and/or resident representative.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All resident annual assessments have been reviewed and resident and/or resident's representative have been coordinated with to sign assessments.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All future annual assessments will be signed by resident and/or resident's representative. The DHW has been educated on the requirements for annual assessments to include Resident/POA/Resident's representative signatures.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The Director of Health and Wellness will report total number of annual assessments that were conducted every month to QAPI Committee. Any assessments that are not signed by Resident/POA/Resident's representative will be highlighted and alternative action(s) recommended to get them signed will be discussed and addressed. The QAPI Committee will review for possible further action/recommendations/suggestions at their scheduled meetings. The DHW will maintain all assessments within the current policy and procedure for record maintenance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/24/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Demetrio Gutierrez**  OAC 310:663-25-4(F)	**Date 3/10/2025**

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/7/2025** **Facility Name:** Dorset Place Memory Care **License Number:** AL 5515 **Survey Event ID:** 2BSJ11 **Date Survey Completed: 2/6/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 544	Based on: This RULE is not met as evidenced by: based on record review and interview, the center failed to ensure medical records were maintained for five years for 2 (#1 and #2) of 8 sampled residents reviewed for assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Corrective actions for C 544 include: Assessments for Residents #1 and #2 have been documented as "lost records". Residents #1 and #2 have current assessments completed and on file.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All resident assessments have been reviewed for initial assessments and for all residents to have current assessments. Attempts to obtain additional assessments and/or records from previous management/ownership have failed.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	All future assessments will be completed and printed off to maintain copy as required. The ED, DHW and BOM have been re-educated in the maintenance of records for five years.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	All assessments will be printed off and shown to the QAPI Committee for verification that record is available. Move Ins will be tracked by BOM and reported to QAPI and then shown corresponding assessment. The QAPI Committee will review for possible further action/recommendations/suggestions at their scheduled meetings. The DHW will maintain all assessments within the current policy and procedure for record maintenance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/24/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Demetrio Gutierrez** **Date 3/10/2025**

OAC 310:663-25-4(F)

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/7/2025** **Facility Name:** Dorset Place Memory Care **License Number:** AL 5515 **Survey Event ID:** 2BSJ11 **Date Survey Completed: 2/6/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 954	Based on: This RULE is not met as evidenced by: based on record review and interview, the center failed to ensure staff were trained in first aid and CPR for 5 (CDM #1, CMA #1, C NA #1, dietary aide #1, and housekeeper #1) of 5 staff reviewed for first aid and CPR training.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Corrective actions for C 954 include: All 5 identified staff have been provided training in first aid and CPR.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All other staff identified to not have this training have also been provided training in first aid and CPR. Documentation is maintained in a In-service notebook.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	A new BOM/HR Director has been hired and educated on training requirements. Going forward, all new staff will be provided the required training in first aid and CPR.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	BOM/HR will report total new hires to the QAPI Committee at their scheduled meeting dates. DHW will report when Staff members were provided first aid and CPR training. The Mandatory In-service notebook will be reviewed by the QAPI at their regularly scheduled meetings. The QAPI Committee will review for possible further action/recommendations/suggestions at their scheduled meetings. The DHW will maintain the Mandatory In-service notebook with assistance from BOM/HR Director.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/24/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Demetrio Gutierrez OAC 310:663-25-4(F)		**Date 3/10/2025**

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/7/2025** **Facility Name:** Dorset Place Memory Care **License Number:** AL 5515 **Survey Event ID:** 2BSJ11 **Date Survey Completed: 2/6/2025**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1911	Based on: This RULE is not met as evidenced by: based on record review and interview, the center failed to report an incident of abuse to OSDH within one department business day of the reportable incident for 1 (#6) of 3 sampled residents reviewed for allegations of abuse.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The center has repaired the means of faxing and getting verification sheets printed. Incident involving Residents #5 & #6 was reported within 24 hours however fax verification sheet was not printed. The final report had all documents required.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All other reports have fax verification sheets and have been reported within the required timeframe.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The Executive Director has been re-educated on the timeframe for reporting and the documents required to be maintain to prove reporting.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The ED will report to the QAPI Committee all reportable incidents to include reporting timeframe with documents verifying the timeframe. The State Reportable notebook will be reviewed by the QAPI for verification. The QAPI Committee will review for possible further action/recommendations/suggestions at their scheduled meetings. The ED will maintain the State Reportable notebook with assistance from BOM/HR Director.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/24/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Demetrio Gutierrez** D. G. OAC 310:663-25-4(F)	**Date 3/10/2025**

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SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1972	Based on: This RULE is not met as evidenced by: based on record review and interview, the center failed to ensure staff were trained in abuse and neglect within 90 days of hire for 5 (CDM #1, CMA #1, CNA#1, dietary aide #1, and housekeeper #1) of 5 staff reviewed for staff trained in abuse and neglect within 90 days of hire.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The center has provided training for all staff in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Further verification of the training signed by staff attending will be placed in personnel files.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The center has provided training for all staff in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Further verification of the training signed by staff attending will be placed in personnel files.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The Executive Director, BOM/HR and the DHW have been re-educated on the training and documentation requirements on abuse, neglect, misappropriation of resident property, facility's P&P concerning the same. The BOM/HR will schedule this training requirement upon hire.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The ED and/or designee will report to the QAPI Committee all new hires and the date of required training and documentation verification. The employees' personnel file will be reviewed by the QAPI for verification of required training. The QAPI Committee will review for possible further action/recommendations/suggestions at their scheduled meetings. The BOM/HR will maintain all personnel records.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/24/2025

OSDH Response: Element accepted Yes No			
Administrator's Signature Demetrio Gutierrez OAC 310:663-25-4(F)			**Date 3/10/2025**
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OKLAHOMA
State Department of Health

Delivery via email to: dgutierrez@dorsetplaceseniorliving.com

March 26, 2025

License Number: AL5515
Survey Event ID: 2BSJ12

Mr. Demetrio Gutierrez, Administrator
Dorset Place-Memory Care
12401 Dorset Drive
Oklahoma City, OK 73120

Dear Mr. Gutierrez:

On **March 26, 2025**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **February 6, 2025,** have now been corrected and your facility is in compliance with licensure standards effective **March 24, 2025**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5515	A. BUILDING: _____ B. WING _____	R-C 03/26/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 03/26/25. The facility was in substantial compliance.	{C 000}		