
Delivery via email to: djohnson@myvitalityliving.com

January 18, 2023

License Number: AL5519

Ms. Danna Johnson, Administrator
Vitality Living Village
2333 Manchester Drive
Oklahoma City, OK 73120

RE: Survey Event ID: 33N911

Dear Ms. Johnson:

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

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 January 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.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Vitality Living Village
Address: 2333 Manchester Drive
City, State, Zip: OKC, OK 73120
Provider #: AL5519
Complaint #: OK00059860
Investigation Date(s): 01/09/23 – 01/11/23

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The facility failed to ensure residents were not neglected.	US
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 01/09/2023 at 10:45 a.m.

A sample of three residents including any identified resident(s), 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to skin, incident reports, progress notes, physician progress notes, and body audit communication forms was conducted.

Resident records were reviewed throughout the survey.

Resident care and skin were observed throughout the survey.

The staff stated they monitored resident skin when they provided showers or assisted with showers, when providing incontinent care, and assisting with activities of daily living. They stated if they saw anything different from the day before they notified the nurse.

A registered nurse stated when told by staff of changes in a resident they would assess the resident, document, and notify the doctor and resident representative of any change.

At the time of the survey, no resident complained about any skin issue or the care they received.

At the time of the survey, no family member complained about the care their family member received.

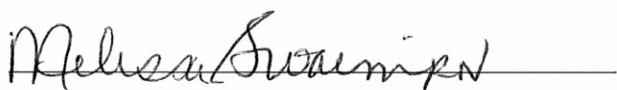
At the time of the survey, there was no deficient practice related to neglect.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script, reading "Melissa Swaim RN", followed by a horizontal line.

Melissa Swaim RN

Date report completed: 01/11/2023

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/11/2023
NAME OF PROVIDER OR SUPPLIER VITALITY LIVING VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER 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 01/09/22 through 01/11/22. A complaint investigation (#OK00059860) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CMA-certified medication aide LTCA-long term care aide RN-registered nurse	C 000		
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 each comprehensive assessment included a personal interview between the resident or the resident's representative or the resident's personal physician and the person completing the form for two (#1 and #9) of ten residents whose comprehensive assessments were reviewed. Findings: On 01/11/23 at 10:28 a.m., during record review	C 543		

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: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/11/2023
NAME OF PROVIDER OR SUPPLIER VITALITY LIVING VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER 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 1 with the RN, Resident #1's comprehensive assessment dated 11/09/22 was not signed by the resident's representative. Resident #9's comprehensive assessment dated 08/23/22 was not signed by the resident or their representative. On 01/11/23 at 10:32 a.m., the RN stated neither assessment had been signed to include a personal interview between the resident or the resident's representative and the person who completed the form.	C 543		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/11/2023
NAME OF PROVIDER OR SUPPLIER VITALITY LIVING VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER 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
N 000	Initial Comments A relicensure survey was conducted from 01/09/23 through 01/11/23. A complaint investigation (#OK00059860) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CMA-certified medication aide LTCA-long term care aide RN-registered nurse	N 000		
N1105 SS=E	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced	N1105		

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: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/11/2023
NAME OF PROVIDER OR SUPPLIER VITALITY LIVING VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER 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
N1105	Continued From page 1 by: Based on record review and interview, the center failed to ensure a performance reviews of every nurse aide at least once every twelve months for two (LTCA #2 and LTCA #3) of nine long term aide's employed over a year at the center. Findings: During skills competency review with the RN, LTCA #2 (hired 02/28/17), and LTCA #3 (hired 02/03/20) had not had their skills performance reviews completed for the year 2022. On 01/11/23 at 10:47 a.m., during the annual LTCA competency review with the RN, they stated they had not been completed.	N1105		
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure: a. Certified medication aides skills were validated	N1442		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/11/2023
NAME OF PROVIDER OR SUPPLIER VITALITY LIVING VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER 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
N1442	Continued From page 2 before the CMA performed medication administration for 2 (CMA #3 and CMA #5) of 4 newly hired CMA's; and b . Reviewed annually for skills performance competency for 1 (CMA #4) of 6 CMA's employed at the center. Findings: a. During CMA skills review with the RN, CMA #3 (hired 12/21/22) and CMA # (hired 12/22/22) had not had their skills validated before they performed medication administration. b. During CMA skills review for annual competencies with the RN, CMA #4 (hired 11/18/10) had not had their annual skill performance competency reviewed. On 01/11/23 at 10:47 a.m., the RN stated competency reviews had not been completed prior to the newly hired CMA's performed medication administration by a licensed health professional. They also stated an annual competency review had not been completed by a licensed health professional.	N1442		

Delivery via email to: djohnson@myvitalityliving.com

February 2, 2023

License Number: AL5519

Ms. Danna Johnson, Administrator
Vitality Living Village
2333 Manchester Drive
Oklahoma City, OK 73120

RE: Survey Event 33N911

Dear Ms. Johnson:

On **January 11, 2023**, a Licensure inspection and Complaint investigation were conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **February 28, 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
Digitally signed by Tempal Killman
Date: 2023.02.02 14:24:15 -06'00'

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

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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 1/29/2023		
	Facility Name: Vitality Living Village		
	License Number: AL5519		
	Survey Event ID: 33N911		
Date Survey Completed: 1/11/2023			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C543		Based on: record review and interview the facility failed to ensure comprehensive assessment includes a personal interview between resident or resident representative or resident personal physician and person completing the form.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: No residents were affected by deficient practice, item had been identified in QA for a plan in December.			
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?		Assessment form for resident #1 & #9 will be reviewed and signed by resident or resident representative or resident personal physician.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		No resident affected. Audit will be done to check for incomplete review signatures.	
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?		QA will audit weekly x4 weeks, then monthly x4 months, then random checks for reviews and signatures on assessment forms.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		DON to ensure resident or resident representative or personal physician has reviewed and signed comprehensive assessment after form is complete.	
a. How the correction will be evaluated for effectiveness;		DON or ED or designee will audit files for incomplete review signatures.	
b. How the correction will be incorporated into the center's quality assurance system; and		QA to monitor weekly for review signatures x4 weeks then monthly x4 months to ensure in compliance. QA to monitor audits of assessment review signatures.	
c. How monitoring records will be kept to evidence the correction.		QA will keep weekly audits x4 weeks then monthly x4 and put with QA logs	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/28/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Danna Johnson ED			Date 1/29/2023
OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			

If Plan of Correction is unacceptable, the reasons are as follows: [Click here to enter text.](#)

Facility in Compliance by: [Click here to enter a date.](#)

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 1/29/2023		
	Facility Name: VitalityLiving Village		
	License Number: AL5519		
	Survey Event ID: 33N911		
Date Survey Completed: 1/11/2023			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: N1105	Based on: record review and interview the facility failed to ensure performance reviews of every CMA & LTCA at least once every twelve months.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: No residents affected by deficient practice. Item had been identified in a plan on QA in December.			
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?		LTCA #2 & #3 will have updated annual skills check completed. CMA #3& #4& #5 will have skills check completed.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		No residents affected. Staff to have skills check done upon hire and annually. Skills check to be added to new hire check list.	
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?		Staff to have skills check as part of new hire orientation and have annual skills check off. Audit to be done on new hires and annual by DON or designee to ensure complete.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		New hires will have skills check off completed prior to finishing orientation days. Staff to have annual skills check completed annually. Skills to be added to new hire check list for LTCA & CMA. DON or ED or designee will audit new hires for skills check and annual files for completeness of skills check annually. QA to monitor weekly for new hires x4 weeks then monthly x4 months to ensure in compliance. QA to monitor audits of annual skills check QA will keep weekly audits x4 weeks then monthly x4 and put with QA logs	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/28/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Danna Johnson ED OAC 310:663-25-4(F)			Date 1/29/2023
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: [Surveyor](#)

If Plan of Correction is unacceptable, the reasons are as follows: [Click here to enter text.](#)

Facility in Compliance by: [Click here to enter a date.](#)

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 1/29/2023		
	Facility Name: VitalityLiving Village		
	License Number: AL5519		
	Survey Event ID: 33N911		
Date Survey Completed: 1/11/2023			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: N1442	Based on: record review and interview the facility failed to ensure performance reviews of every CMA & LTCA at least once every twelve months.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: No residents affected by deficient practice. Item had been identified in a plan on QA in December.			
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?		LTCA #2 & #3 will have updated annual skills check completed. CMA #3& #4& #5 will have skills check completed.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		No residents affected. Staff to have skills check done upon hire and annually. Skills check to be added to new hire check list.	
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?		Staff to have skills check as part of new hire orientation and have annual skills check off. Audit to be done on new hires and annual by DON or designee to ensure complete.	
OSDH Response: Element accepted Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		New hires will have skills check off completed prior to finishing orientation days. Staff to have annual skills check completed annually. Skills to be added to new hire check list.	
a. How the correction will be evaluated for effectiveness;		DON or ED or designee will audit new hires for skills check and annual files for completeness of skills check annually.	
b. How the correction will be incorporated into the center's quality assurance system; and		QA to monitor weekly for new hires x4 weeks then monthly x4 months to ensure in compliance. QA to monitor audits of annual skills check	
c. How monitoring records will be kept to evidence the correction.		QA will keep weekly audits x4 weeks then monthly x4 and put with QA logs	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/28/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Danna Johnson ED OAC 310:663-25-4(F)			Date 1/29/2023
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: [Click here to enter a date.](#) Surveyor: [Surveyor](#)

If Plan of Correction is unacceptable, the reasons are as follows: [Click here to enter text.](#)

Facility in Compliance by: [Click here to enter a date.](#)

Delivery via email to: djohnson@myvitalityliving.com

March 23, 2023

License Number: AL5519

Ms. Danna Johnson, Administrator
Vitality Living Village
2333 Manchester Drive
Oklahoma City, OK 73120

RE: Survey Event 33N912

Dear Ms. Johnson:

On **March 21, 2023**, an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 11, 2023**, have now been corrected effective **February 28, 2023**.

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/21/2023
NAME OF PROVIDER OR SUPPLIER VITALITY LIVING VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER 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 03/21/23. 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

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/21/2023
NAME OF PROVIDER OR SUPPLIER VITALITY LIVING VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2333 MANCHESTER 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
{N 000}	Initial Comments An offsite/paper revisit was conducted on 03/21/23. The facility was in substantial compliance	{N 000}		

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

TITLE

(X6) DATE