Oklahoma State Department of Health
Creating a State of Health

March 17, 2020

License Number: AL5529

Ms. Guyna Reynolds, Administrator
The Health Center At Concordia
7707 West Britton Road
Oklahoma City, OK 73132

RE: Survey Event ID: NFRE11

Dear Ms. Reynolds:

On **March 5, 2020**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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 March 5, 2020.

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

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

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

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;

(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;

(5) Include dates when corrective action and monitoring will be completed for each violation;

(6) Be signed by the administrator.

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Katie Stagner

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

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
	AL5529	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTH CENTER AT CONCORDIA	7707 WEST BRITTON ROAD OKLAHOMA CITY, OK 73132

(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 re-licensure survey was conducted on 03/02/2020 through 03/05/2020. Current census was 53. The following deficiencies were cited.	N 000		
N1105 SS=F	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 by: Based on interview and record review, it was determined the center failed to complete an annual performance reviews for 3 (#8, 9, and #10) of 3 sampled long term care aides (LTCA) who had been employed for greater than one year. This failed practice had the widespread potential for more than minimal harm. Findings: On 03/04/20 at 3:31 p.m., a review of employee files revealed the following LTCA had not completed an annual performance review:	N1105		

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N1105	Continued From page 1 Employee #8 - hired 11/10/07; Employee #9 - hired 02/10/15; and Employee #10 - hired 03/23/17. At 5:02 p.m., human resources director/employee #14 stated the LTCA employees files had not contained a form which documented an annual performance review had been conducted on each LTCA. On 03/05/20 at 10:00 a.m., a registered nurse stated she nor the licensed practical nurses had not conducted an annual performance review on the LTCA employees. POLICY A policy, dated 11/01/07, documented "...6. Licensed Nursing will complete a performance review of every nurse aide at least once every 12 months..."	N1105		
N1442 SS=F	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:	N1442		

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N1442	Continued From page 2 Based on interview and record review, it was determined the center failed to: a. Validate medication administration skills for 3 (#1, 2, and #3) of 3 certified medication aides (CMA) prior to medication administration; and b. Perform an annual skills competency for 4 (#4 through #7) of 4 CMA who had administered medications for more than one year. These failed practices had the widespread potential for more than minimal harm for all residents who received employee administered medications. Findings: SKILLS VALIDATION On 03/04/2020 at 3:31 p.m., a review of employees' files revealed the following CMA employees did not have their medication skills validated before independent medication administration, nor had an annual medication administration skills competency been performed for the following CMA who were employed greater than one year : Employee #1 - hired 04/23/19; Employee #2 - hired 09/11/19; Employee #3 - hired 04/24/19; Employee #4 - hired 11/15/16; Employee #5 - hired 02/18/19; Employee #6 - hired 05/02/17; and Employee #7 - hired 02/04/13. At 5:02 p.m., human resources director/employee #14 stated the CMA employees' files did not contain a form which documented their skills had been validated prior to independent medication administration, nor the CMA employees' files	N1442		

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N1442	Continued From page 3 contained a form which documented their medication administration skills competency had been performed annually. On 03/05/2020 at 10:00 a.m., a registered nurse stated she or the licensed practical nurses had not documented the CMAs annual medication administration skills competency.	N1442		
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 03/02/2020 through 03/05/2020. Current census was 53. The following deficiencies were cited.	C 000		
C 391 SS=F	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 and interview, it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regards to covered facial hair. This failed practice had the widespread potential for more than minimal harm for all 53 residents who received their nutrition from the kitchen. Findings: 310:257-3-20. Effectiveness (a) Except as provided in (b) of this Section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from	C 391		

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C 391	Continued From page 4 contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. 310:257-3-20 (a) ...food employees shall wear...beard restraints...that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment; utensils, and linens; and unwrapped single-service and single-use articles. On 03/02/2020 at 4:40 p.m., cook/employee #11 and cook/employee #13 were observed with their facial hair uncovered/not restrained as they prepared and served the evening meal. On 03/03/2020 at 10:47 a.m., chef/employee #12 prepared the noon meal with his mustache uncovered. Cook/employee #13 prepared and served the noon meal with his facial hair uncovered/not restrained. At 5:24 p.m., chef/employee #12 was observed cutting potatoes without his facial hair being covered with a beard restraint. On 03/04/20 at 9:05 a.m., chef/employee #12 stated he did not have an excuse for not covering his facial hair with a beard restraint the previous evening while cutting potatoes. At 11:40 a.m., cook/employee #13 stated he had not worn a beard restraint over his facial hair the previous day because he was not used to having facial hair.	C 391		
C1330 SS=E	310:663-13-2(10) CONTENTS OF CONTRACT Each resident service contract shall contain a	C1330		

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C1330	Continued From page 5 clear statement of the following: (10) a provision in the event that a resident's condition merits transfer, the transfer shall be initiated within five (5) working days and progress on the transfers shall be noted in the resident's record. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure 5 (#1, 4, 5, 8, and #9) of 5 sampled residents' service contracts contained a provision for a transfer to be initiated within five (5) working days, with progress on the transfers noted in the resident's record, if a resident's condition merited a transfer. This failed practice had potential for more than minimal harm at a pattern. Findings: On 03/05/2020 at 2:49 p.m., the residents' service contracts were reviewed and did not contain a provision for the event a resident's condition merited a transfer, the transfer was to be initiated within five (5) working days and progress on the transfers would be noted in the resident's record. The residents' service contracts documented they were signed by the resident or representative on the following dates: Resident #1 - signed on 11/18/19; Resident #4 - signed on 04/15/19; Resident #5 - signed on 09/04/19; Resident #8 - signed on 07/17/18; and Resident #9 - signed on 01/29/20. At 3:14 p.m., the contracts were reviewed with the administrator who stated the body of the contract did not contain the five (5) day transfer	C1330		

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C1330	Continued From page 6 provision.	C1330		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure a medication vial of PPD (a purified protein derivative skin test which detects tuberculosis) was dated after opening and the manufacturer's instructions were followed for	C1505		

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C1505	Continued From page 7 administration for 2 (#9 and #11) of 2 sampled residents who received two step PPD skin test. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 03/03/2020 at 4:45 p.m., a medication refrigerator in the memory care unit contained a box of PPD skin test medication. The medication box and the vial of medication were not dated with the date the medication had been opened. The lot number 329401 was printed on the box. At 4:45 p.m., licensed practical nurse (LPN) #2 stated she did not observe a date on the medication box or the medication vial. She further stated they had physician's orders for new admissions to the memory care unit to be administered a two step PPD skin test unless they had received the test within the previous year. LPN #2 identified residents #9 and #11 as recently admitted residents who had received PPD skin tests after admission. LPN #2 stated she had not opened the PPD skin test medication and she did not know when the vial of medication was opened. She stated she thought the PPD skin test medication expired in 28 days. At 5:12 p.m., a nurse's note for resident #9, dated 01/29/20, documented she was administered the PPD skin test #1 to her right forearm. The lot number of the vial of medication was 329401. A nurse's note for resident #9, dated 02/05/20, documented she was administered the PPD skin test #2 to her left forearm. The lot number of the vial of medication was 329401. At 5:12 p.m., a medication administration record (MAR) for resident #11, dated January 2020, documented resident #11 received the PPD skin	C1505		

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C1505	Continued From page 8 test #1 on 02/17/20. The MAR did not document the lot number of the medication vial used to administer the PPD skin test and there was no documentation of the lot number in a nurse's note. A nurse's note for resident #11, dated 02/24/20, documented she was administered the PPD skin test #2 to her left forearm. The lot number of the vial of medication was 329401. On 03/04/20 at 2:21 p.m., the registered nurse stated she did not know why the vial of PPD skin test medication was not dated. She further stated the nurses knew they were supposed to date multi-dose medications when they were opened. The RN stated they had no way of knowing when the medication had expired because it was not dated. A manufacturer's instructions insert documented "...Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..." POLICY A policy, revised date 08/07/2012, documented, "...5. Multi-dose vials: a. After initial use are to be labeled with date opened and initials of healthcare professional. Opened vials are to be discarded within twenty-eight (28) days unless otherwise specified by the manufacturer..."	C1505		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5529	THE HEALTH CENTER AT CONCORDIA

Type of Survey (select all that apply)

2				

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

Extent of Survey (select all that apply)

A				

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 35195	03/02/2020	03/05/2020	1.00	0.00	19.50	0.00	7.00	6.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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

MAR 18 2020

OKLAHOMA
State Department
of Health

Delivery Via Email: greynolds@concordiaseniorliving.com

September 2, 2020

License Number: AL5529

Ms. Guyna Reynolds, Administrator
The Health Center at Concordia
7707 West Britton Road
Oklahoma City, OK 73132

RE: Survey Event NFRE11

Dear Ms. Reynolds:

On **March 5, 2020**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 4, 2020**.

If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State Department of Health, ou=Long Term Care, email=katies@health.ok.gov, c=US
Date: 2020.09.02 14:36:54 -05'00'

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

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 3/24/2020** **Facility Name:** Concordia Life Plan Community **License Number:** AL5529 **Survey Event ID:** NFRE11 **Date Survey Completed: 3/5/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: N1105	Based on: Interview and record review, it was determined the center failed to complete an annual performance review for 3 (#8, 9 and #10) of 3 sampled long term care aides (LTCA) who had been employed for greater than one year. This failed practice had the widespread potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by Concordia and Lutheran Senior Citizens, Inc. of the truth of the facts alleged or conclusions set forth in the Staatement of Deficiencies. The Plan of Correction is prepared soley as a matter of compliance with State and/or Federal law.

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?	DON or designee to complete performance reviews on employees #8, 9 and 10.
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 residing in Assisted Living have the ability to be affected by the deficient practice.
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?	Don or designee to complete performance reviews on all current long term aide staff now and annually. Performance reviews for newly hired long term care aides to be completed at time of hire and annually.
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.	Human Resources or designee to track completion of performance reviews and notify DON prior to expiration. Human Resources will audit all long term care aide staff files quarterly to ensure performance evals are completed. Any non-compliance issues will be addressed immediately. Results of audits will be presented to DON and QAPI for review and further recommendation. Audits will be ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/4/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.
Marsha Mitchell	3/25/2020

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: 3/24/2020** **Facility Name:** Concordia Life Plan Community **License Number:** AL5529 **Survey Event ID:** NFRE11 **Date Survey Completed: 3/5/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1442	Based on: Interview and record review, it was determined the center failed to: A. Validate medication administration skills for 3 (#1, 2, and #3) of 3 certified medication aides (CMA) prior to medication administration; and B. Perform an annual skills competency for 4 (#4 through #7) of 4 CM who had administered medications for more than one year.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by Concordia and Lutheran Senior Citizens, Inc. of the truth of the facts alleged or conclusions set forth in the Staatement of Deficiencies. The Plan of Correction is prepared soley as a matter of compliance with State and/or Federal law.

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?	DON or designee to complete medication administration skills competency on employees # 1, 2, 3, 4, 5, 6, and 7.
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 residing in Assisted Living have the ability to be affected by the deficient practice.
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?	Don or designee to complete medication administration skills compentency on all current CMA's now and annually. Medication Administration Skills competency for newly hired CMA's to be completed at time of hire and annually.
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.	Human Resources or designee to track completion of Medication Administration Skills competency reviews and notify DON prior to expiration. Human Resources will audit CMA staff files quarterly to ensure skills compentencies are completed. Any non-compliance issues will be addressed immediately. Results of audits will be presented to DON and QAPI for review and further recommendation. Audits will be ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/4/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 3/25/2020

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.			
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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: 3/24/2020
Facility Name: Concordia Life Plan Community
License Number: AL5529
Survey Event ID: NFRE11
Date Survey Completed: 3/5/2020

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391	Based on: Interview and record review, it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations in regards to covered facial hair.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by Concordia and Lutheran Senior Citizens, Inc. of the truth of the facts alleged or conclusions set forth in the Staatement of Deficiencies. The Plan of Correction is prepared soley as a matter of compliance with State and/or Federal law.

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?	RD or designee will in-service all dietary staff on wearing hair restraints such as hats, hair nets, beard restraints to keep hair from contactin exposed food, clean equipment, utensils, linens and unwrapped single-use items.
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 residing in Assisted Living have the ability to be affected by the deficient practice.
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?	RD and/or kitchen manager to perform random checks to ensure hair restraints are available and are being used appropriately.
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.	RD and/or kitchen manager to audit staff to ensure they are wearing appropriate hair restraints. Any non-compliance issues will be addressed immediately. Continued non-compliance will resilt in written disciplinary action and/or termination of employment. Audits will be completed weekly for 4 weeks, then bi-weekly for 3 months, then monthly thereafter. Results of audits will be presented to QAPI for review and further recommendation. Audits will be ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/4/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Tonya Reynolds	**Date**	Enter a date of signature. 3/25/2020

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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: 3/24/2020
	Facility Name: Concordia Life Plan Community
	License Number: AL5529
	Survey Event ID: NFRE11
	Date Survey Completed: 3/5/2020

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1330	Based on: Interview and record review, it was determined the center failed to ensure 5 (#1, 4, 5, 8 and 9) of 5 sampled residents' service contracts contained a provision for a transfer to be initiated within five (5) working days, with progress on the transfers noted in the resident's record, if a resident's condition merited a transfer.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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?	Service contracts for resident's #1, 4, 5, 8 and 9 have been corrected to include a provision for the event the resident's condition merited a transfer, the transfer was to be initiated within five (5) working days and would be noted in the resident's record.
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 residing in Assisted Living have the ability to be affected by the deficient practice.
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?	Going forward, the Resident Service Contract has been revised to include a provision for a transfer to be initiated within five (5) working days, with progress on the transfer noted in the resident's record, if a resident's condition merited a transfer.
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.	DON or designee to in-servce Social Services Director and licensed nursing staff of updated Resident Service Contract and required documentation in resident record. DON or designee to audit all new admissions to determine if a resident's condition merits a transfer and if so, the transfer is initiated within five (5) days and is progress is noted in resident's record. Any non-compliance issues will be addressed immediately. Results of audits will be presented to QAPI for review and further recommendation. Audits will be ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/4/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Melissa Reynolds	**Date** Enter a date of signature.	3/25/2020
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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: 3/24/2020** **Facility Name:** Concordia Life Plan Community **License Number:** AL5529 **Survey Event ID:** NFRE11 **Date Survey Completed: 3/5/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Interview and record review, it was determined the center failed to ensure a medication vial of PPD (a purified protein derivative skin test which detects tuberculosis) was dated after opening and the manufacturer's instructions were followed foradministration for 2 (#9 and #11) of 2 sampled residents who received two step PPD skin test.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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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?	Disposed of undated vial of PPD. DON or designee to in-service all licensed nursing staff regarding policy of dating medication vials and box when opened and appropriate documentation in resident's record to include Lot #.
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 residing in Assisted Living have the ability to be affected by the deficient practice.
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?	DON or designee to monitor medication storage refrigerators to ensure opened vials/boxes of medication are dated.
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.	DON or designee will complete audits of medication vials/boxes. Audits will be completed weekly for 4 weeks, then bi-weekly for 3 months, then monthly thereafter. Results of audits will be presented to QAPI for review and further recommendation. Audits will be ongoing.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/4/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.
Tonya Reynolds	3/25/2020

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OKLAHOMA
State Department
of Health

Delivery via email to: greynolds@concordiaseniorliving.com

November 17, 2020

License Number: AL5529

Ms. Guyna Reynolds, Administrator
The Health Center At Concordia
7707 West Britton Road
Oklahoma City, OK 73132

RE: Survey Event NFRE12

Dear Ms. Reynolds:

On **November 16, 2020,** an offsite/paper revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 5, 2020,** have now been corrected effective **May 4, 2020.**

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

Sincerely,

Users, Lisa D Calvin
Digitally signed by Users, Lisa D Calvin
Date: 2020.11.17 16:06:21 -06'00'

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

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
	AL5529	A. BUILDING: _____ B. WING _____	R 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTH CENTER AT CONCORDIA	7707 WEST BRITTON ROAD OKLAHOMA CITY, OK 73132

(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 completed on 11/16/20. Credible evidence of correction was submitted for all deficiencies.	{N 000}		
{C 000}	INITIAL COMMENTS An Offsite/Paper Revisit was completed on 11/16/20. Credible evidence of correction was submitted for all deficiencies.	{C 000}		

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