OKLAHOMA
State Department
of Health

Delivery via email to: rnowlin@concordiaseniorliving.com

March 13, 2024

License Number: AL5529

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

RE: Survey Event ID: KUZ911

Dear Ms. Nowlin:

On **February 22, 2024**, 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 **February 22, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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 Services**, then **click on Long Term Care.** 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face-to-face, or virtual 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 OSDH.LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Respectfully,

Lisa Calvin

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

Enclosure

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 _____	02/22/2024

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
C 000	INITIAL COMMENTS A relicensure survey was conducted from 02/20/24 through 02/22/24. Facility Census: 51 Listed below are the abbreviations that will be used throughout this document. ADON Assistant Director of Nursing DON Director of Nursing	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, record review, and interview, the center failed to ensure kitchen staff wore a hair net while in the kitchen during one of two kitchen observations. The ADON identified 51 residents received nutrition from the kitchen. Findings: A "Proper Food Hygiene" policy, revised 02/21/24, read in part, "...Food employees are required to wear regular hair restraints such as hair covering or nets, hats, beard restraints, and covering for body hair...The list of food handlers required to wear hair restraints includes employees in food production positions, kitchen staff, chefs, operators of machines, and other employees who will enter the kitchen..."	C 391		

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C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure annual assessments were signed by a registered nurse or a physician for two (#9 and #10) of three sampled residents reviewed for annual assessments. The ADON identified 51 residents resided in the facility.	C 542		

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C 542	Continued From page 2 Findings: A "Functional Evaluation/Assessment" policy, undated, did not document annual assessments should be signed by a registered nurse or physician. 1. Resident # 9 had diagnoses that included unspecified dementia, mood disturbances, and testicular hypofunction. The annual assessment for Resident #9, dated 01/25/23, did not contain the signature of and registered nurse or physician after the assessment was completed. 2. Resident #10 had diagnoses that included acute respiratory failure and hypertension. The annual assessment for Resident #10, dated 09/16/23, did not contain the signature of and registered nurse or physician after the assessment was completed. On 02/21/24 at 8:56 a.m., the ADON was asked to review the assessments referenced above and acknowledged they did not contain the required signatures of a registered nurse or physician after the assessments were completed. On 02/21/24 at 8:56 a.m., the DON stated they did not have a policy and procedure in place regarding required signatures by a registered nurse or physician on annual asessments prior to 02/21/24.	C 542		
C 543 SS=F	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that	C 543		

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C 543	Continued From page 4 the time of the assessment. 3. Resident #10 had diagnoses which included acute respiratory failure and hypertension. The annual assessment for Resident # 10, dated 09/16/23, did not contain the signature of the resident or resident representative interviewed at the time of the assessment. On 02/22/24 at 10:35 a.m., the ADON was asked to review the assessments referenced above and acknowledged they did not contain the required signatures for the resident or resident representatives at the time the assessments were completed. On 02/22/24 at 10:36 a.m., the Administrator was asked to review the assessments referenced above and acknowledged they did not contain the required signatures of the resident or resident representatives at the time of the asessments. The Administrator stated they did not have a policy regarding required signatures on resident annual assessments.	C 543		
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist.	C 921		

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March 21, 2024

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

RE: Survey Event KUZ911

Dear Ms. Nowlin:

On **February 22, 2024**, 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 **April 30, 2024**.

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,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
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C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist.	C 921	Refer to POC Template Survey Event ID#: KUZ911 ID Prefix Tag: C921	

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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: 3/19/2024** **Facility Name:** Concordia Life Plan Community **License Number:** AL5529 **Survey Event ID:** KUZ911 **Date Survey Completed: 2/22/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C391	Based on: observation, record review, and interview, the center failed to ensure kitchen staff wore a hair net while in the kitchen during one of two kitchen observations.

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 tuth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely 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 contaminating 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 result 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?	4/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Rhonda Noulin	**Date 3/19/2024**

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.

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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: 3/19/2024
	Facility Name: Concordia Life Plan Community
	License Number: AL5529
	Survey Event ID: KUZ911
	Date Survey Completed: 2/22/2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C542	Based on: record review and interview, the center failed to ensure annual assessments were signed by a registered nurse or a physician for two (#9 and #10) of the three sampled residents reviewed for annual assessments.

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 Sernior Citizens, Inc. of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with State and 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?	RN or Physician will review to confirm annual assessment for resident #9 is accurate and will sign the assessment. RN or Physician will review to confirm annual assessment for #10 is accurate and will sign the assessment.
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?	RN or Physician will review and sign all annual assessments for Assisted Living.
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.	Administrator or designee will audit annual assessments to confirm they are complete with signature from RN or Physician. An audit will be conducted monthly for 3 months by Administrator or Designee to ensure annual assessments are reviewed and signed by an RN or Physician. After 3 months, audits will be done quarterly there after. 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?	4/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Rhonda Noblin	**Date 3/19/2024**

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Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

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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: 3/19/2024** **Facility Name:** Concordia Life Plan Community **License Number:** AL5529 **Survey Event ID:** KUZ911 **Date Survey Completed: 2/22/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C543	Based on: record review and interview, the center failed to obtain the signature of the resident or resident representative when completing the annual assessment for three (#3, 9 and #10) of three sampled residents whose annual assessments were reviewed.

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 Statement 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 ADON will complete a new annual assessment for for residents #3, 9 and 10. When assessment is complete each resident or resident representative will sign the assessment.
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?	Assisted Living ADON will ensure that each annual assessment is signed by the resident or residents representative.
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 Administrator will audit assessments to confirm signatures of resident or residents representative. Audits will be completed monthly by DON or Administrator for 3 consecutive months and then quarterly there after. Results of audits will be presented to QAPI for review and further recommendation. Audits will be on going.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Rhonda Mullin	**Date 3/19/2024**

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Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

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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: 3/19/2024** **Facility Name:** Concordia Life Plan Community **License Number:** AL5529 **Survey Event ID:** KUZ911 **Date Survey Completed: 2/22/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C921	Based on: record review and interview, the facility failed to ensure medications were reviewed monthly by a registered nurse or pharmacist.

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 Statement 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?	All 51 residents residing in the facility were found to be affected. Pharmacist Consultant will be contacted to perform monthly reviews of all Assisted Living residents medications.
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 the potential to be affected by the same 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 will meet with the pharmacist consultant monthly to confirm that all residents medications were reviewed.
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 to meet with Pharmacist monthly and receive a copy of medication reviews. An audit will be filled out by DON. Audits will be completed monthly by DON and given to Administrator to sign off on. 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?	4/30/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Rhonda Noulin	**Date 3/19/2024**

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OKLAHOMA
State Department
of Health

Delivery via email to: Rhonda Nowlin <rnowlin@concordiaseniorliving.com>

May 10, 2024

License Number: AL5529

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

RE: Survey Event KUZ912

Dear Ms. Nowlin:

On **May 7, 2024,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **February 22, 2024,** have now been corrected effective **April 30, 2024.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
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
	AL5529	A. BUILDING: _____ B. WING _____	R 05/07/2024

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
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 05/07/24. 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