



Oklahoma State Department of Health
Creating a State of Health

December 30, 2019

License Number: AL5531

Mr. Jim McWhirter, Administrator
Wellington Parke, LLC
3107 Tinker Diagonal
Del City, OK 73115

RE: Survey Event ID: 5H2I11

Dear Mr. McWhirter:

On **December 11, 2019**, agents from our office concluded a State Licensure survey with a complaint investigation 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 December 11, 2019.

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;

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- (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,


Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lde

Enclosure



INVESTIGATIVE REPORT LICENSURE

Facility: Wellington Parke, LLC
Address: 3107 Tinker Diagonal
City, State, Zip: Del City, OK 73115
Provider #: AL5531
Complaint #: OK00054370
Investigation Date(s): 12/04/19, 12/05/19 and 12/11/19

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The center failed to ensure qualified staff administered medications.	S

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 12/04/2019 at 10:35 a.m.

A sample of 3 residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag N1427 and Tag C921 for details.

An investigation specific to breathing treatments and topical wound treatments provided by unqualified staff was conducted.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies..

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read "Melissa Swaim RN", is written over a horizontal line.

Melissa Swaim RN

Date report completed: 12/17/2019

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. AL5531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/11/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON PARKE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3107 TINKER DIAGONAL DEL CITY, OK 73115		
(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
N1427	Continued From page 1 diagnoses to include hypertension and dementia. The resident could bear weight and required a one person assist for 4 activities of daily living (ADL's) and a two person assist for ambulation with walker. The resident was placed on home health 07/30/19 for rash and other nonspecific skin eruptions. The centers staff of CMA's and MAT's were applying the benzoin compound tincture topically to the resident's heels once a day in the morning and the zinc oxide ointment topically to the resident's buttocks twice a day. September 16, 2019 the physician's order was updated to venelex ointment apply to bilateral buttocks twice a day. The centers staff of CMA's and MAT's began treatment for the wounds and applied the venelex topically. September 28, 2019 the resident's home health diagnosis was pressure ulcer of the right buttocks, stage 2. The physician order was updated to venelex topical ointment to apply to the buttocks twice a day. The centers staff of CMA's and MAT's provided wound treatment and applied venelex ointment topically. The wound physician documented: 08/06/19, the resident has multiple wounds. The resident has a stage 2 pressure wound sacrum for at least 7 days duration with light serous exudate; 08/13/19, the resident has a stage 3 pressure wound to the sacrum for at least 14 days with a moderate amount of serous exudate; 10/21/19, the resident has a stage 3 pressure wound of the left, medial buttock for at least 4 days with a moderate amount of serous exudate; 10/28/19, the resident has a stage 3 pressure	N1427		

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N1427	Continued From page 2 wound of the right, medial buttock for at least 85 days duration with a moderate amount of serous exudate; 11/06/19, the resident has a stage 3 pressure wound of the left, medial buttock for at least 20 days with a moderate amount of serous exudate; 11/18/19, the resident presents with a stage 3 pressure wound on the left, medial buttock for at least 31 days duration; and 11/25/19, the resident has diaper dermatitis, groin and buttocks. On 12/04/19 at 3:45 p.m. employee #1 was asked about topical medication treatments. Employee #1 stated the ointment was applied each morning for the resident. On 12/05/19 at 4:03 p.m. employee #7 stated the resident had a dime sized wound at the buttocks and applied wound cream/ointment to the affected area daily. Employee #7 stated the medication aides applied the wound ointment twice a day.	N1427			
C 000	INITIAL COMMENTS A re-licensure survey was conducted on 12/4/19, 12/5/19, and 12/11/19. Complaint OK00054370 was investigated in conjunction with this survey. Census was 53. Deficient practice was cited as follows.	C 000			
C 921 SS=E	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	C 921			

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C 921	Continued From page 3 pharmacist. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to provide qualified staff and nurse supervision to ensure nebulizer treatments for 1 (#11) of 1 sampled resident were performed according to current standards of medical practice. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #11 Resident #11 admitted to the center 04/24/18 with a diagnoses of hypertension, major depressive disorder, chronic obstructive pulmonary disease (COPD), osteoarthritis, chronic pain, and anxiety. A comprehensive assessment, dated 04/12/19, documented resident #11 as forgetful, her mobility being primarily with wheelchair assistance, needing assistance with all daily living activities including medication administration, bathing, meal time cueing and set up, dressing, transferring, toileting, personal care, and assistance with supplemental oxygen per nasal cannula as needed. A physician's order, dated 12/02/19, documented ipratropium/albuterol 0.5-2.5/3 milliliters (ml) with instructions to inhale 1 vial by mouth via nebulizer every 4 hours as needed **nurse only to administer*, with original date ordered being 02/19/19. On 12/11/19 during record review the September 2019 medication administration record (MAR) documented, untrained center staff administered her nebulizer treatments seven times between	C 921		

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C 921	Continued From page 4 09/18/19 and 09/21/19. At 11:32 the resident stated the center staff helped her set up and administer the vials of medication into the nebulizer and she would hold the mouthpiece when she used the nebulizer for her COPD diagnosis. At 5:10 p.m. the licensed practical nurse/director of nursing (LPN/DON) for the center stated the nebulizer treatments were initialed by MAT's every time the nebulizer was used during the month of September 2019. The LPN/DON stated she should have ensured the correct licensed health care professional set up and administered the nebulizer treatments.	C 921		
C 922 SS=E	310:663-9-2(b) MEDICATION STAFFING (b) Unlicensed personnel administering medications shall have completed a training program that has been reviewed and approved by the Department. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure unlicensed personnel completed a training program approved by the Department for administration of medications for 1 (employee #8) of 9 employees hired to assist residents with the administration of their medications. This deficient practice resulted in the widespread potential for more than minimal harm for 53 of 53 residents who required medication administration assistance. Findings: On 12/04/19 at 3:50 p.m. during record review with employee #13, it was determined employee	C 922		

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C 922	Continued From page 5 #8 was not trained by an approved program. The department of developmental services (DDS) provide training for their employees to work with DDS clients rather than assisted living residents. Employee #13 stated there was no other medication administration documentation . On 12/05/19 at 8:56 a.m. the administrator stated employee #8 had been enrolled in a upcoming medication administration technician class. Employee #8 had been hired 02/25/19 and had administered medication since orientation at the center.	C 922		
C1512 SS=E	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the	C1512		

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C1512	Continued From page 6 use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure 1 of (#4) of 1 sampled resident who was bed-bound and required total care was free from physical restraint by two full guardrails being placed in the up position on the residents bed out of convenience for center's staff. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings:	C1512		

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C1512	Continued From page 7 Resident #4 admitted to the center on 10/31/18 with diagnoses to include systemic lupus, multiple sclerosis, epileptic seizures, macular degeneration, neuropathy, hypothyroidism, spondylolisthesis, spinal stenosis, anemia, insomnia, and hypertension. A significant change comprehensive assessment for resident #4, dated 5/31/19, documented the resident was alert to person and place with confusion, was bed-bound and required staff assistance for all activities of daily living. The resident was incontinent of both bowel and bladder, and had a poor ability to communicate. On 12/04/19, at 1:45 p.m., 2:30 p.m., and 4:30 p.m., the resident was observed sitting up in a hospital bed in her room with bilateral full guardrails in the up position. The resident stated she was not able to place the guardrails on her bed in the down or up position and that the guardrails are always in the up position unless staff is assisting with with an activity of daily living such as brief changes. On 12/05/19 record review was conducted and there was no physician order in the resident's record concerning physical restraint by guardrails. This record review also included the center's contract for resident #4, dated 10/12/18, which documented under exclusion criteria, section d, "the resident will not be eligible for admission to or continuing residence with us if the resident:...d) physician has determined that you require physical or chemical restraints." The record review also included the hospice plan of care which documented resident #4 was admitted to hospice and was provided a hospital bed with two full guardrails on 05/31/19.	C1512		

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C1512	Continued From page 8 On 12/05/19, at 2:05 p.m., the resident was observed sitting up in a hospital bed in her room with bilateral full guardrails in the up position. On 12/11/19, at 1:30 p.m., and 4:47 p.m., the resident was observed sitting up in a hospital bed in her room with bilateral full guardrails in the up position. On 12/11/19, at 5:43 p.m., the licensed practical nurse/director of nursing (LPN/DON) stated resident #4 should not have two full guardrails in the up position on her bed and she was aware this was considered a physical restraint according to regulations. For seven months the center's staff did not monitor and ensure the resident was free from physical restraint according to regulations.	C1512			
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure: a. Documentation of a narcotic count at shift	C1951			

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C1951	Continued From page 9 change was conducted between the oncoming shift and the offgoing shift; and b. Care plans were updated and accurate for 1 (#9) of 1 sampled resident who received treatments for wounds. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: a. The center submitted an incident report dated 10/17/19 for misappropriation of resident narcotics. The center had no system in place to ensure there was a narcotic count between shifts or that the narcotic count was correct. They had a policy, but were not following it. On 12/11/19 at 9:36 a.m. employee #10 was asked how she knew the narcotic count was correct. She stated it was counted every shift, but when she was shown the narcotic shift count log where there should have been signatures there were none. The narcotic shift count logs were not completed. The center's policy dated 08/01/19, documented, "...All controlled medications are to be inventoried when keys are transferred from one medication aide to another...the procedure for transferring the keys is as follows: Off-going medication aide opens care or lock box for on-coming aide...off-going medication aide retains control of keys...on-coming medication aide counts medication...off-going medication aide observes this count...on-coming med aide compares the count with form to verify balance...on-coming and off-going med aides sign 12 hour verification form...keys are transferred from off-going to on-coming medication aide...on-coming	C1951			

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C1951	Continued From page 10 medication aide assumes responsibility for controlled medications..." The on-coming medication aide should never, never simply trust that all inventories are correct without counting. b. Resident #9 had received home health services 07/30/19 for rash and other nonspecific skin eruptions. By 09/16/19 the wounds to the resident's buttocks had worsened to pressure ulcer of right buttock, stage 2. The center's staff of certified medication aides (CMA's) and medication administration technicians (MAT's) were providing topical wound treatments to the resident's heels and buttocks. Skin had not been care planned by the registered nurse. There were no documented wound observations, wound measurements, and interventions to prevent further skin breakdown by the centers nurse. This was important for a nurse to assess, monitor and document to know whether or not the treatment or interventions were working to report to the physician . The resident's wounds worsened. On 12/04/19 at 3:45 p.m. employee #1 was asked about topical medication treatments. Employee #1 stated the ointment was applied each morning for the resident. On 12/05/19 at 4:03 p.m. employee #7 stated the resident had a dime sized wound at the buttocks and applied wound cream/ointment to the affected area daily. Employee #7 stated the medication aides applied the wound ointment twice a day.	C1951		

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(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
C1971	Continued From page 11	C1971		
C1971 SS=E	310:663-19-4(b) POLICIES (b) The administrator of the assisted living center who becomes aware of abuse or neglect of a resident or misappropriation of a resident's property shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department. This Rule is not met as evidenced by: Based on interview and record review, the center failed to follow their misappropriation policy for 1 (#12) of 1 resident who was administered as needed (prn) narcotic pain medication. This failed practice resulted in the widespread potential for more than minimal harm. Findings: The narcotic pain medication was delivered to the center 08/29/19 with a count of 180, 3 separate medication cards with 60 pills on each medication card. The center provided a narcotic record/disposition form last dated 10/10/19, 7 days prior to the date of the investigation and 6 days prior to the allegation. The investigation did not include documented statements from all medication passers assigned to the assisted living medication carts. The investigation did not include a documented interview with the person reporting the missing narcotics. There was no documented interview with the	C1971		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/11/2019
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C1971	Continued From page 12 resident. Since so much time had elapsed from the time the center received the narcotics from the pharmacy (08/29/19) until the center started auditing the medication carts monthly (10/16/19) it was difficult to determine who had actually taken the full medication card of 60 narcotics. No reason was given for the registered nurse monthly medication audit or why the pharmacist had not been involved with the investigation or auditing the medication carts. The narcotic shift count logs were not completed even after the medication aides were re-educated about counting narcotics every shift and signing the signature log when they take control of the medication cart. The center's policy dated 08/01/19, documented, "...All controlled medications are to be inventoried when keys are transferred from one medication aide to another...the procedure for transferring the keys is as follows: Off-going medication aide opens care or lock box for on-coming aide...off-going medication aide retains control of keys...on-coming mediation aide counts medication...off-going mediation aide observes this count...on-coming med aide compares the count with form to verify balance...on-coming and off-going med aides sign 12 hour verification form...keys are transferred from off-going to on-coming medication aide...on-coming medication aide assumes responsibility for controlled medications..." The on-coming medication aide should never, never simply trust that all inventories are correct without counting.	C1971		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5531	(X2) MULTIPLE CONSTRUCTION A BUILDING: _____ B WING: _____		(X3) DATE SURVEY COMPLETED C 12/11/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON PARKE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3107 TINKER DIAGONAL DEL CITY, OK 73115		
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C1971	Continued From page 13 The center's policy dated 12/21/18 documented, "...All reports of theft or misappropriation of resident property shall be promptly and thoroughly investigated...The investigation shall consist of at least the following: An interview with the person reporting the missing items; An interview with any witnesses that may have knowledge of the missing items; An interview with the resident; Interviews with the resident's roommate, family members, and visitors..."	C1971			
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5531	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON PARKE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3107 TINKER DIAGONAL DEL CITY, OK 73115		
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C5010	Continued From page 14 This Rule is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure qualified staff provided direct personal care for 2 (#4 and #10) of 2 sampled residents who had private sitters. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #4 Resident #4 admitted to the center on 10/31/18 with diagnoses to include systemic lupus, multiple sclerosis, epileptic seizures, macular degeneration, neuropathy, hypothyroidism, spondylolisthesis, spinal stenosis, anemia, and hypertension. A significant change comprehensive assessment for resident #4, dated 5/31/19, documented the resident was alert to person and place with confusion, was bed-bound and required staff assistance for all activities of daily living. On 12/04/19 at 11:45 a.m. during report the licensed practical nurse/director of nursing (LPN/DON) stated resident #4 had a private	C5010			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5531	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B WING _____	(X3) DATE SURVEY COMPLETED C 12/11/2019
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(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
C5010	Continued From page 15 sitter/family friend who helped the resident with all activities of daily living during the day. On 12/04/19 at 1:45 p.m. the private sitter stated she had been hired 06/19 after her doctor gave the family of resident #4 her number and also stated she is paid by the family but was not a family friend. She stated she assisted resident #4 with all activities of daily living including incontinent care, bed baths, meal time assistance, and safety monitoring. The sitter stated she did not work through an agency and was not supervised by a licensed nurse. For six months the registered nurse (RN) and LPN/DON failed to monitor and ensure the sitter was a sitter or personal companion only not assisting with direct care and had the required training credentials through the nurse aide registry to provide direct personal care to the resident. Resident #10 Resident #10 admitted to the center on 07/25/19 with diagnoses to include hypertension, dysphagia, multiple falls, sick sinus syndrome, atrial fibrillation, congestive heart failure, debility, fatigue, anemia, abnormal gait, and osteoarthritis. The care plan, dated 07/25/19, documented resident #10 had an unstable gait, wore nocturnal supplemental oxygen, and required staff assistance with transfers and mobility, toileting, medication administration, housekeeping, hydration, and diagnoses related health monitoring. On 12/04/19 at 5:00 p.m. the private sitter stated she performed assistance for resident #10 with all	C5010		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5531	(X2) MULTIPLE CONSTRUCTION A BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED C 12/11/2019
NAME OF PROVIDER OR SUPPLIER WELLINGTON PARKE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3107 TINKER DIAGONAL DEL CITY, OK 73115		
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C5010	Continued From page 16 activities of daily to include bathing, meal preparation and set up, incontinent care, wheelchair mobility assistance, and housekeeping. She also stated she was not licensed as a health care professional and was hired by the family of resident #10 and was paid by the family. The sitter stated she had not been a family friend. For five months the RN and/or LPN/DON failed to monitor and assure the private sitter was a sitter or personal companion only not assisting with direct care and had the required training credentials through the nurse aide registry to provide direct personal care to the resident.	C5010		
C5015 SS=E	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of	C5015		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/11/2019
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C5015	Continued From page 17 accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to develop and complete a plan of accommodation for 1 (#4) of 1 sampled resident who met discharge criteria and were dependent on staff for total care. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: Resident #4 admitted to the center 10/31/18 with diagnoses to include systemic lupus, multiple sclerosis, epileptic seizures, macular degeneration, neuropathy, hypothyroidism, spondylolisthesis, spinal stenosis, anemia, and hypertension.	C5015		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/11/2019
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C5015	Continued From page 18 A significant change comprehensive assessment, dated 5/31/19, documented the resident was alert to person and place with confusion, was bed-bound and required staff assistance for all activities of daily living. On 05/05/19 during record review there was no plan of accommodation found in the record for resident #4. On 12/11/19 record review of the contract for resident #4, dated 10/12/18, documented exclusion criteria to include, "...resident a) has a need for services inconsistent with the needs of the population served by us, b) has a need for care and services that exceeds the care or services available at the facility,... d) physician has determined that you require physical or chemical restraints, e) poses a threat to yourself or others, f) requires more than two people to assist with transfer and/or ambulation or the resident has no ability to bear weight... h) is totally dependent upon facility staff to be fed, i) has behaviors that infringe on the rights of others or could be a safety threat to the resident or others, and; j) requires home health or hospice to provide services to meet the needs listed above..." At 5:48 p.m., the LPN/DON stated there was no completed plan of accommodation with personal or attending physician's signature or third party hospice provider signature for resident #4 indicating a meeting of consensus between all required parties had taken place. The LPN/DON stated she was not aware a plan for any reasonable and necessary accommodations for the resident needed to be determined by a consensus of the physician, the resident or	C5015		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL5531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2019
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C5015	Continued From page 19 resident's representative, the third party (hospice) provider, and a licensed health care professional employed by the center and must contain all signatures as well. The LPN/DON stated she should have ensured the plan of accommodation for resident #4 was complete according to regulations.	C5015			

STATE WORKLOAD REPORT

Provider/Supplier Number AL5531	Provider/Supplier Name WELLINGTON PARKE, LLC
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Type of Survey (select all that apply)

2	3			
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Extent of Survey (select all that apply)

A				
---	--	--	--	--

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other

E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code

I Recertification
J Sanctions/Hearing
K State License
L CHOW

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)
Team Leader ID								
1. 34460	12/04/2019	12/11/2019	1.00	0.00	24.50	0.75	4.75	9.50
2. 42023	12/04/2019	12/11/2019	1.00	0.00	24.50	0.75	2.50	0.00
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			

DEC 31 2019 



Oklahoma State Department of Health
Creating a State of Health

January 10, 2020

License Number: AL5531

Mr. Jim McWhirter, Administrator
Wellington Parke, LLC
3107 Tinker Diagonal
Del City, OK 73115

RE: Survey Event 5H2I11

Dear Mr. McWhirter:

On December 11, 2019, 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 **February 17, 2020**.

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) 271-6868.

Sincerely,

V. Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
Edward A Legako, MD (*Vice-President*)
Becky Payton (*Secretary*)

Jenny Alexopoulos, DO
Terry R Gerard II, DO
Charles W Grim, DDS, MHSA

R Murali Krishna, MD
Ronald D Osterhout
Charles Skillings

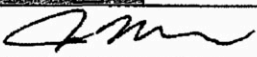
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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/6/2020	
	Facility Name: Wellington Parke, LLC	
	License Number: AL5531	
	Survey Event ID: #5H2I11	
Date Survey Completed: 12/11/2019		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: N1427	Based on: interview, and record review, it was determined the center failed to ensure certified medication aides (CMA's) or medication administration technicians (MAT's) did not apply topical medication on decubitus ulcers for 1 (#9) of 1 sampled resident who had a history of open decubitus ulcers.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of Correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Wellington Parke, LLC (the facility) as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.		
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?	Resident #9 was assessed on 12/11/19 with the surveyors and DON and observed to have no open areas. The resident is observed daily by direct care staff and remains on weekly skin assessments conducted by the nurse, due to her previously identified risk. This will ensure any open areas are immediately identified and appropriate interventions can be implemented.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	A skin assessment will be conducted on every resident to identify if any residents have open areas. If a resident(s) is observed with an open area, the treatments will be reviewed. Any preventative topical medications to that area will be discontinued to ensure it is not administered/applied by staff. Home health will then be notified in order to provide the care required to the resident.	
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?	In-service will be conducted for nursing staff to review the scope of practice for medication aides, policies and procedures, job descriptions, topical medication application, and the identification and notification of new and/or changed skin conditions.	
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	Audits will be conducted by the DON/designee as follows: The DON/designee will review/audit the medication/treatment administration records to ensure there are no CMAs or MATs administering topical medications to open areas. Audits will be conducted weekly x 4 weeks, then monthly x 2 months, then quarterly x 2 meetings	

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correction.		Progress, findings and/or concerns will be monitored by the quality assurance committee (QA) with intervention by the committee as needed. Assessments conducted, orders changed, audits conducted and interventions implemented will be documented as evidence of continued compliance with the regulation.	
OSDH Response Element accepted		yes ☐	No ☐
5. On what date will corrective action be completed?		2/14/2020	
OSDH Response Element accepted		yes ☐	No ☐
Administrator's Signature Jim McWhirter OAC 310:663-25-4(F)			Date 1/6/2020
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.			

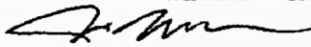
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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/6/2020	
	Facility Name: Wellington Parke, LLC	
	License Number: AL5531	
	Survey Event ID: #5H2I11	
Date Survey Completed: 12/11/2019		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1512	Based on: observation, interview, and record review, it was determined the center failed to ensure 1 (#4) of 1 sampled resident who was bed-bound and required total care was free from physical restraint by two full guardrails being placed in the up position on the residents bed out of convenience for center's staff.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of Correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Wellington Parke, LLC (the facility) as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.		
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?		Resident #4 is bed bound and not capable of getting out of the bed without the assistance of two people. The siderails/guardrails were not able to restrain her when she already required assistance with bed mobility. The full siderails were replaced with handrails to try and still give the resident some assistance with self movement that she once had with the full siderails.
OSDH Response: Element accepted Yes ☒ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		There are no other residents aging in place, bed bound and using full siderails.
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?		In-service will be conducted for nursing staff to educate them on restraints and how they are not used in the facility. The nurse will continue to conduct assessments upon admission, annually and with significant changes to ensure no restraints are used in the facility.
OSDH Response: Element accepted Yes ☒ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Audits will be conducted by the DON/designee as follows: The DON/designee will conduct comprehensive assessments as required to ensure no restraints are used in the facility. Reviews of assessments will continue to be conducted monthly. Progress will be monitored by the quality assurance committee (QA) in quarterly meetings. Assessments will be documented as evidence of continued compliance.
OSDH Response: Element accepted Yes ☒ No ☐		
5. On what date will corrective action be completed?		2/17/2020

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OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Jim McWhirter OAC 320:663-25-4(F)		 Date 1/6/2020	
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.			

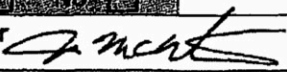
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Received Time Jan. 9. 2020 8:54AM No. 3239

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/6/2020	
	Facility Name: Wellington Parke, LLC	
	License Number: AL5531	
	Survey Event ID: #5H2111	
		Date Survey Completed: 12/11/2019
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1971	Based on: interview and record review, the center failed to follow their misappropriation policy for 1(#12) of 1 resident who was administered as needed narcotic pain medication.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of Correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Wellington Parke, LLC (the facility) as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.		
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?		An interview was conducted with resident #12 and included with the investigation.
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 who receive narcotic medications had the potential to affected.
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?		In-service will be conducted with nursing staff who pass medication to re-educate on conducting and documenting the narcotic count at shift change. In-service with the administrative nursing staff will be conducted to ensure investigations involving misappropriation of property are fully conducted and documented.
OSDH Response: Element accepted: Yes ☒ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Audits will be conducted by DON/administrator and/or designee as follows:
a. How the correction will be evaluated for effectiveness;		The DON/designee will review/audit the narcotic count sheets and shift sheets to ensure the counts are being conducted. The administrator/designee will review/audit all investigative reports for misappropriation of property to ensure full investigations have been conducted. Audits will be conducted weekly x 2 weeks, then monthly x 2 months, then quarterly x 2 meetings
b. How the correction will be incorporated into the center's quality assurance system; and		Progress, findings and/or concerns will be monitored by the quality assurance committee (QA) with intervention by the committee as needed.
c. How monitoring records will be kept to evidence the correction.		Findings and/or implemented changes will be documented as evidence of continued compliance with the regulation.
OSDH Response: Element accepted: Yes ☒ No ☐		

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5. On what date will corrective action be completed?		2/14/2020	
OSDH Response Element accepted Yes ☐ No ☐			
Administrator's Signature		Jim McWhirter 	Date 1/6/2020
OAC 330:663-25-4(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.			

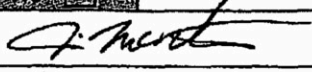
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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/6/2020	
	Facility Name: Wellington Parke, LLC	
	License Number: AL5531	
	Survey Event ID: #5H2I11	
Date Survey Completed: 12/11/2019		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1951	Based on: interview, and record review, it was determined the center failed to ensure: a. Documentation of a narcotic count at shift change was conducted between the oncoming and the offgoing shift; and b. Care plans were updated and accurate for 1 (#9) of 1 sampled resident who received treatments for wounds.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of Correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Wellington Parke, LLC (the facility) as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.		
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?	a. No residents were identified related to this part of the deficiency; and b. Resident #9 was assessed on 12/11/19 with the surveyors and DON and observed to have no open areas. The resident had no wound treatments to update on the care plan.	
OSDH Response: Element accepted: Yes ☒ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	a. All residents who take narcotics have the potential to be affected by the practice identified in part a; and b. Residents with wounds have the potential to be affected by the practice identified in part b.	
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?	In-service will be conducted for nursing staff who administer medications to review the policy and procedures and regulations related to conducting and documenting the narcotic count at shift change. In-service will also be conducted with the nurses regarding updating the care plan with wounds.	
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.	Audits will be conducted by the DON/designee as follows: The DON/designee will review/audit the narcotic count shift sheets to ensure the counts are being conducted by the CMAs as MATs as required. Audits will be conducted weekly x 4 weeks, then monthly x 2 months, then quarterly x 2 meetings Progress, findings and/or concerns will be monitored by the quality assurance committee (QA) with intervention by the committee as needed. Count sheets, care plans and audits conducted will be	

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		documented as evidence of continued compliance with the regulation.	
OSDH Response Element accepted: Yes ☐ No ☐			
5. On what date will corrective action be completed?		2/14/2020	
OSDH Response Element accepted: Yes ☐ No ☐			
Administrator's Signature Jim McWhirter  OAC 310:663-25-4(F)		Date 1/6/2020	
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.
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Facility in Compliance by: Click here to enter a date.			

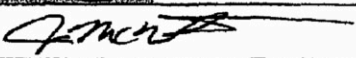
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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/6/2020	
	Facility Name: Wellington Parke, LLC	
	License Number: AL5531	
	Survey Event ID: #5H2I11	
Date Survey Completed: 12/11/2019		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C921	Based on: observation, interview, and record review, it was determined the center failed to provide qualified staff and nurse supervision to ensure nebulizer treatments for 1 (#11) of 1 sampled resident were performed according to current standards of medical practice.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of Correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Wellington Parke, LLC (the facility) as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.		
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?		Resident #11 will be re-assessed on the ability to self-administer nebulizer treatments. The resident will be re-educated on the guidelines/requirements of self-administration of medication.
OSDH Response: Element accepted: Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		The records of all residents with current orders for nebulizer treatments will be reviewed to ensure current self-administration assessments have been conducted and on file for the identified nebulizer treatments.
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?		In-service will be conducted for nursing staff to review the scope of practice for medication aides and nurses, and the requirements involving the administration of nebulizer treatments.
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.		Audits will be conducted by the DON/designee as follows: The DON/designee will review/audit the medication/treatment administration records to ensure there are no CMAs or MATs administering nebulizer treatments. Audits will be conducted weekly x 4 weeks, then monthly x 2 months, then quarterly x 2 meetings Progress, findings and/or concerns will be monitored by the quality assurance committee (QA) with intervention by the committee as needed. Assessments conducted, orders changed, audits conducted and interventions implemented will be documented as evidence of continued compliance with the regulation.
OSDH Response: Element accepted: Yes ☐ No ☐		

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5. On what date will corrective action be completed?		2/17/2020	
OSDH Response Element accepted Yes ☐ No ☐			
Administrator's Signature		Jim McWhirter 	Date 1/6/2020
OAC 310:663-25-4(F)			
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Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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Facility in Compliance by: Click here to enter a date.			

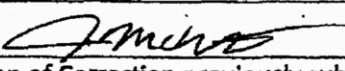
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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 1/6/2020	
	Facility Name: Wellington Parke, LLC	
	License Number: AL5531	
	Survey Event ID: #SH2111	
		Date Survey Completed: 12/11/2019
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C922	Based on: interview, and record review, it was determined the center failed to ensure unlicensed personnel completed a training program approved by the Department for administration of medications for 1 (#8) of 9 employees hired to assist residents with the administration of their medications.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of Correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Wellington Parke, LLC (the facility) as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.		
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?		No residents were identified as having been administered medications by employee #8.
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 who receive medications have the potential to be affected.
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?		In-service will be conducted with human resources and administrative staff regarding the identification of approved credentials. During the hiring process, staff credentials will be reviewed for completion of approved training programs to ensure all requirements are met prior to starting orientation.
OSDH Response: Element accepted: Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Audits will be conducted by human resources and/or the administrator as follows:
a. How the correction will be evaluated for effectiveness;		The human resources director will review/audit the current staff credentials to ensure all credentials meet the approved training program requirement. Audits will be conducted weekly x 2 weeks, then monthly x 2 months, then quarterly x 2 meetings
b. How the correction will be incorporated into the center's quality assurance system; and		Progress, findings and/or concerns will be monitored by the quality assurance committee (QA) with intervention by the committee as needed.
c. How monitoring records will be kept to evidence the correction.		Findings and/or Implemented changes will be documented as evidence of continued compliance with the regulation.
OSDH Response: Element accepted: Yes ☐ No ☐		
5. On what date will corrective action be completed?		2/12/2020

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OSDH Response: Element Accepted Yes ☐ No ☐			
Administrator's Signature Jim McWhirter. OAC 310:663-25-4(F)		 Date 1/6/2020	
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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: 1/6/2020	
	Facility Name: Wellington Parke, LLC	
	License Number: AL5531	
	Survey Event ID: #5H2I11	
		Date Survey Completed: 12/11/2019
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C5010	Based on: interview, and record review, it was determined the center failed to ensure qualified staff provided direct personal care for 2 (#4 and #10) of 2 sampled residents who had private sitters.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: This plan of Correction (POC) is submitted as required under state law. The submission of this POC does not constitute an admission on the part of Wellington Parke, LLC (the facility) as to the accuracy of the surveyors, their findings, nor conclusions drawn there from. The POC is intended to constitute the facility's written allegation of continued compliance.		
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		The credentials of the private sitters were faxed to the surveyor, as requested following exit on 12/11/19, showing all sitters were qualified to provide the care required for resident #4. Resident #10 has never had a private sitter since residing at the facility.
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 who have private sitters have the potential to be affected.
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?		In-service will be conducted with human resources and administrative staff regarding the requirement to obtain the credentials of all private sitters prior to providing care to residents. Procedure to be put in place for nurse to notify HR when private sitter is to start care of resident so credentials can be obtained as required.
OSDH Response: Element accepted: Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		Audits will be conducted by human resources/designee and/or administrator/designee as follows:
a. How the correction will be evaluated for effectiveness;		The human resources director/designee will review/audit any current resident with private sitters to ensure all credentials are on file. Audits will be conducted weekly x 2 weeks, then monthly x 2 months, then quarterly x 2 meetings
b. How the correction will be incorporated into the center's quality assurance system; and		Progress, findings and/or concerns will be monitored by the quality assurance committee (QA) with intervention by the committee as needed.
c. How monitoring records will be kept to evidence the correction.		Credentials will be maintained of current private sitters as evidence of continued compliance with the regulation.
OSDH Response: Element accepted: Yes ☐ No ☐		

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