
Delivery via email to: gemini@coxinet.net

April 27, 2022

License Number: AL5531

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

RE: Survey Event ID: GOG811

Dear Mr. McWhirter:

On **April 7, 2022**, 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 **April 7, 2022**.

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

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

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

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

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- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
 - (5) Include dates when corrective action and monitoring will be completed for each violation;
 - (6) Be signed by the administrator.

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

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.04.27 14:13:37 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Wellington Parke, LLC
Address: 3107 Tinker Diagonal
City, State, Zip: Del City, OK, 73115, Oklahoma
Provider #: AL5531
Complaint #: OK00058568
Investigation Date(s): March 31st, April 4th-7th, 2022

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The facility failed to protect residents from abuse.	US
2. The facility failed to assess a resident with a significant change in condition.	S
3. The facility failed to provide sufficient quantity of food in a manner to prevent residents from losing weight.	US

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 03/31/2022 at 10:35 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

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

An investigation specific to the facility failing to protect residents from abuse was conducted.

Tours were conducted throughout the survey. Residents were observed in their rooms, their apartments, and in the various common areas. Staff were observed treating residents with dignity and respect. No residents were observed with bruises, black eyes, or other signs of injury.

Residents stated they were treated kindly by the staff. They denied any instances of abuse from staff. Direct care staff stated they were trained to notify their charge nurse immediately of any unexplained bruising or signs of injury to a resident. Charge nurses and administrative staff stated that they were immediately notified if there were any signs of abuse to a resident.

Resident records documented assessments were conducted when a resident had any type of injury. Employee records documented abuse training was provided upon hire.

At the time of the investigation, no deficient practice was found related to protecting residents from abuse.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 0522 for details.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to concerns the facility failed to provide sufficient quantity of food in a manner to prevent residents from losing weight was conducted.

Observations were made of meal services were conducted throughout the survey. Residents were observed to be served adequate portion sizes. Staff were observed to be assisting residents with eating as needed.

Residents reported they received three meals per day and snacks. Residents had no complaints about the consistency or quantity of food. Staff stated residents were served adequate amounts of food. Staff was able to identify which residents received nutritional supplements.

Clinical records documented resident's weights were monitored monthly. Monthly weights were reviewed for any residents with a noticeable weight loss. Clinical records were reviewed for identification or diagnosis of weight loss. Physician's orders for appetite stimulants or dietary supplements were noted for residents with weight loss.

At the time of the investigation, no deficient practice was found related to the facility failing to provide sufficient quantity of food in a manner to prevent residents from losing weight.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2. 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.

Deficient practice was unsubstantiated for allegation #1 and #3. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence

at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Ernestine Scovens

Ernestine Scovens RN, CHFS

Date report completed: 04/15/2022

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Wellington Parke, LLC
Address: 3107 Tinker Diagonal
City, State, Zip: Del City, OK, 73115, Oklahoma
Provider #: AL5531
Complaint #: OK00056685
Investigation Date(s): March 31st, April 4th-7th, 2022

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide care and services according to residents' contracts, failed to notify families of positive COVID-19 cases in the center, failed to ensure residents' property was not lost, and failed to ensure residents had a plan of care.	US

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 03/31/2022 at 10:35 a.m.

A sample of nine residents including any identified resident, 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 unsubstantiated related to this allegation.

An investigation specific to resident care plans, incident reports, and contracts were investigated.

Weight records were reviewed in the clinical records. Clinical records documented resident's weights were monitored monthly or weekly as ordered. In the clinical record appetite stimulants or dietary supplements were put into place for residents identified with weight loss.

Resident contracts were reviewed for care and services provided. Clinical record documented when resident discharged and family picked up belongings. Clinical records were reviewed for care plans. All sampled residents had a care plan in place.

Third party provider notes were reviewed for wound care treatments provided.

Observations were made of meal services throughout the survey. Staff were observed to be assisting residents with eating as needed. Residents reported they received three meals per day and snacks. Residents had no complaints about the consistency or quantity of food.

Staff were observed to weigh residents in wheel chairs. Staff followed correct procedure. Staff was observed to note a discrepancy with a resident weight and reweighed the resident to get an accurate weight. No blankets or pillows were observed in or on the chairs when staff weighed the residents.

Staff was able to identify which residents received nutritional supplements. Families were interviewed regarding weight loss notification.

Resident was interviewed about wound care provided by third party provider. No concerns were voiced by the resident.

Interviews were conducted with family members and regarding notification of COVID-19 cases in the facility. Family members reported being notified by the center.

Family and residents were interviewed regarding misappropriation of property. Staff were interviewed regarding procedure if any missing items were reported.

At the time of the investigation, no deficient practice was found related to resident care plans, incident reports, and contracts.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.

Mary Cooper RN

Date report completed: 04/15/2022

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 04/07/2022
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
C 000	INITIAL COMMENTS A relicensure survey and complaint investigation (#OK00056685 and #OK00058568) was conducted on March 31, April 4, 5, 6, and 7, 2022. The following abbreviations may have been used in the writing of this report. AL - assisted living am - morning amb - ambulation CMA- Certified Medication Technician CVA - Cerebral Vascular Accident [stroke] DON - Director of Nursing d/t - due to EMAR - electronic medication administration record h/o - history of hs - bedtime LLE - left lower leg MG, mg - milligrams NP - Nurse Practitioner PCP - primary care physician PRN, prn - as needed pt - patient q - every Res - resident r/t - related to SN - skilled nurse s/s - signs or symptoms w/c - wheelchair	C 000		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident;	C 522		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 522	Continued From page 1 (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the center failed to ensure 1. a yearly comprehensive assessment was completed for one (#9) of nine sampled residents reviewed for annual assessments and, 2. ensure significant change assessments were completed for two (#2, #3) of five sampled residents reviewed for a change in condition. The DON identified 43 residents resided in the center. Findings: A document titled, "Nursing Policies and Procedures", updated 08/01/2019, read in part, "...A comprehensive assessment will be completed once every 12 months ...Change in Condition...Direct care staff to notify nurse of any change in condition...Assessment/Care plan updated as necessary..." 1. Res #9 had diagnoses which included Alzheimers and pain. An annual assessment, dated 03/30/21, documented, Res #9 needed assistance of one staff for all activities of daily living.	C 522		

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C 522	Continued From page 2 Upon review of record, there was not an annual assessment in the clinical record. On 04/06/22 at 6:35 a.m., the DON stated, "I can't find [Res #9's] assessment." On 04/06/22 at 11:02 a.m., the DON did not provide Res #9's annual assessment. 2. Res #2 was admitted with diagnoses which included diabetes mellitus type 2, and Alzheimers. An admission/14 day assessment, dated 02/01/22, documented Res #2 needed assistance of one for bathing, dressing and toileting. No assistance with ambulation or transfers, and needed cues for eating. An "Incident/Accident report" dated 03/16/20 at 10:14 a.m., read in part, "...CMA heard walker when CMA turn around [Res#2] was falling to floor ...Staff to use w/c for amb as needed d/t confusion and use of walker ..." On 03/31/22 at 11:14 a.m., Res #2 was observed sitting in a wheelchair in the common room. On 04/04/22 at 9:25 a.m., Res #2's [family member] stated Res #2 had declined since he had been in the center. [Family member] stated, "[Res #2] doesn't use fork or spoon much, uses his fingers." On 04/05/22 at 8:28a.m., a staff member was observed to be feeding Res #2. Res #2 did not make an effort to feed himself, he was observed to take a drink by himself. On 04/05/22 at 8:42 a.m., a staff member was	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 3 observed to be assisting Res #2 with his breakfast. On 04/05/22 at 3:28 p.m., two staff members were observed to assist Res #2 to stand and step on weight scales. On 04/06/22 at 8:24 a.m., CNA #1 was asked if Res #2 required staff to feed him. She stated, "yes." CNA #1 was asked if Res #2 is able to walk independently by himself. She stated with a walker by himself. At 11:07 a.m., the DON was asked if Res #2's assessment to cue at meal times was accurate. She stated, "If you cue him he will pick up his food and eat, probably have to assist him at times." The DON stated, "His ambulation has changes this month. I wouldn't have done a significant change until I weighed him this month." Res #3 had diagnoses which included atrial fibrillation, weight loss, and depression. An annual assessment, dated 01/26/22, documented resident needed assistance of one for bathing, dressing and toileting. PRN standby assistance for ambulation and transfers. Cues for eating. A "Physicians Orders", dated 03/08/22, read in part, "...Admit to...hospice..." A Hospice "Chart/Clinical Notes", dated 03/21/22 at 10:15 p.m., read in part, "...Facility called reporting pt had just had 2 seizures when being taken to her room..." A Hospice "Chart/Clinical Notes", dated 03/22/22, read in part, "...Facility called reporting pt had	C 522		

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C 522	Continued From page 4 seizure..." On 04/05/22 at 11:22 a.m., the DON was asked if a significant change assessment had been completed when Res #3 was admitted to hospice. The DON stated, " I don't see it. It should have been."	C 522		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the center failed to ensure medications were administered according to physician orders for one (#10) of eight residents observed during medication pass. Findings: Res #10 had a diagnosis of Pain. A center's "Administration and Record Keeping Policy", updated 08/01/2019, read in part, "...The bottle label should be checked to ensure that it corresponds with the MAR..." Res #10's "Physician Orders", dated 04/05/22, read in parts, "...Senna/Plus 8.6MG/50MG Tab take 1 tablet by mouth once daily...Vitamin C 500 MG Tab Take 1 tablet by mouth once daily...Famotidine Tab 20 MG Take 1 tablet by mouth once daily..." On 04/05/22 at 8:30 a.m., CMA #2 was observed to administer Pepcid 10 mg one tablet, Vitamin C 500 mg with rose hips one tablet, and Docusate Sodium 100 mg one tablet to Res #10. At 2:00 p.m., CMA #2 and the DON were asked to review the medications administered, and the EMAR. They were asked if the medications CMA	C1505		

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C1505	Continued From page 6 #2 administered were the same for Senna Plus and Vitamin C. CMA #2 and the DON replied, no they are not. CMA #2 was asked if the dosage of Pepcid 10 mg she administered was correct according to the physicians' order. CMA #2 stated, "No, she should have gotten 2 tabs."	C1505		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review, observation, and interview the center failed to ensure a narcotic count was accurate for one (#1) of one sampled resident reviewed for narcotic count. The DON identified 43 residents resided in the	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 7 center. Findings: Res #1 had diagnoses which included, dementia and peripheral vascular disease. A document titled, "Medication Aide Job Descriptions and Procedures", (undated), read in part, "...Schedule II medications are to be counted at admission of resident, every shift change and at any time that the medication enters or leaves the building..." On 04/05/22 at 10:29 a.m., a narcotic count was completed with CMA #1. Res #1's Hydrocodone Apap 5/325 mg card was counted and had 22 pills remaining. The "Controlled Drug Receipt/Record/Disposition Form" documented 23 pills remained. At 10:43 a.m., CMA #1 acknowledged Res #1 had one tablet missing from her card. CMA #1 was asked who did she complete the narcotic count with at shift change this morning. She stated, "I did it." CMA #1 was asked what the protocol was for completing narcotic counts. She stated, "To count with another medication aide."	C1923		
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.	C1951		

Oklahoma State Department of Health

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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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C1951	Continued From page 8 This Rule is not met as evidenced by: Based on record review, observation, and interview, the center failed to: 1. ensure care plans were updated and accurate for two (#5, #6) of nine sampled resident care plans reviewed. 2. ensure physician order for insulin dosage was updated and accurate for one (#7) of nine sampled resident physician orders reviewed. The DON identified 43 residents resided in the center. Findings: A document titled, "Nursing Policies and Procedures", updated 08/01/19, read in part, "...A comprehensive assessment will be completed once every 12 months ...Change in Condition...Direct care staff to notify nurse of any change in condition...Assessment/Care plan updated as necessary..." B. Res #5 had diagnoses which included overactive bladder and suprapubic urinary catheter. Res #5's care plan, dated 11/01/2017, read in part, "...Medications at bedside will be stored according to policy and ordered by self. Bedside medications will be on a weekly inventory count, to ensure proper administration...I am continent and able to toilet myself..." On 04/04/22, at 9:25 a.m., Res #5 was observed sitting in his chair in his apartment. A urinary drainage bag was observed below the bottom of his right pants leg.	C1951		

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 04/07/2022
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
C1951	Continued From page 9 On 04/07/22 at 10:00 a.m., the DON was asked if Res #5 was self-medicating. She replied no. The care plan was reviewed with the DON and she was asked if the Revisions/Outcomes documented for medication assistance were accurate. She replied, "No, I don't think he's ever been self-medicating." When asked if Res #5's indwelling urinary catheter should have been addressed in his care plan, she replied, "Yes." C. Res #6 had diagnoses which included Parkinson's, h/o CVA [stroke] with LLE weakness, and dementia. Res #6's care plan, dated 11/08/21, read in part, "...I am alert and oriented with good judgement...I am independent with transfers and ambulation...I am independent with bathing...I am independent with dressing..." A 14 day assessment, dated 11/08/21, read in part, "...[oriented to person, place, and time]... [judgement good]...ambulatory without assistance...walker...dressing assist prn...transferring standby assist prn...toileting assist prn..." Center's "Incident/Accident Reports" documented res #6 had seven falls between 12/03/21 and 02/10/22. On 03/31/22 at 11:16 a.m., Hospitality Aide #2 was asked if there were residents that needed assistance with ADLs. He identified Res #6 as one of the residents who needed assistance with bathing and dressing. He stated, "She needs to be checked on frequently because she can't	C1951		

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 04/07/2022
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C1951	Continued From page 10 walk." On 04/4/22 at 9:34 a.m., Res #6 was observed in her recliner [lift chair] with her feet elevated. Tremors noticed to hands when she was trying to reposition pillow behind her head. On 04/05/22 at 10:30 a.m., Res #6's care plan was reviewed for safety/falls. The care plan had no interventions documented to address Res #6's falls from 12/03/21 to 02/10/22. On 04/07/22 at 10:00 a.m., the DON was asked to review Res #6's care plan. When asked if she thought the resident had experienced a significant decline she stated, "No, that care plan was just not accurate. Her intake assessment was correct and it says she needed assistance with ADL's." 2. Res #7 had diagnoses which included Type 2 Diabetes and memory issues. Res #7 was insulin dependent and had been self-administering her insulin from date of admission to facility until 03/30/22. Res #7's "Physician Orders", dated 04/04/22 11:53 a.m., read in part, "...LANTUS SOLOSTAR PEN 100U/ML INJECT 15 UNITS...AT BEDTIME...LANTUS SOLOSTAR PEN 100U/ML INJECT 18 UNITS ONCE DAILY WITH BREAKFAST..." There was no physician's order in the clinical record documenting a change in insulin dose. A copy of the new order was requested from the DON. On 04/04/22 at 9:01 a.m., Res #7 was observed in her room sitting in her recliner. Res #7	C1951		

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 04/07/2022
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C1951	Continued From page 11 commented that she "felt really good today". When asked how much insulin she takes each day, she replied, "I take 20 units in the morning and 10 units at night." On 04/04/22 at 9:45 a.m., the DON was asked to review Res #7's current physician orders. When asked what the morning and bedtime insulin doses were, she replied, "Oh, they have changed. She gets 20 q am and 10 q hs now." The DON was asked what date the insulin dosing was changed, and stated on 03/30/22. When asked if the medication orders should have been updated? She replied, "Yes." On 04/06/22 at 9:00 a.m., the DON submitted a NP "PROGRESS NOTE (AMENDED)", dated 03/30/2022, read in part, "... ADDENDUM...clarification on insulin orders 20 q am 10 q hs." ADDENDUM was e-signed on 04/06/22 at 8:42 a.m.	C1951		
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	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 04/07/2022
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C5010	Continued From page 12 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. This Rule is not met as evidenced by: Based on record review, observation, and interview the center failed to coordinate care for four (#4, #5, #6, #7) of four sampled residents for coordination of care with third party providers. The facility identified 17 residents received third party provider services. Findings: The center's "Home Health Agencies Policy", updated 08/01/19, read in part, "...Will coordinate care with the facility... Expected to complete facility form with each visit and update the facility about resident care...Home health documentation to be kept in facility." Res #4 had diagnoses which included fluid retention and type 2 diabetes mellitus.	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 04/07/2022
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C5010	Continued From page 13 An annual/14 day assessment, dated 03/10/20, read in part, "...Bladder...Urinary Catheter-Indwelling..." Res #4's care plan, dated 03/10/20, read in part, "...Personal care...toileting: I am incontinent of bladder at times, wear briefs and require assistance with toileting...Skin...Home health for maintenance of catheter..." A Home Health Plan of Care, dated 01/05/21 thru 03/05/21, read in part, "...Instruct staff at AL to monitor urine output, keep to gravity, empty before too full and prevent back flow. monitor for s/s complications r/t foley cath..." On 04/06/22 at 11:34 a.m., the DON was asked if the care plan documented Res #4 had a catheter. She stated, "I guess not, says needs toileting assistance and is incontinent." On 04/07/22 at 10:50 a.m., Res #4's home health plan of care was reviewed with the DON. The DON was asked where the documentation was that staff was monitoring urine output. She stated, "No, we would never do that." The DON was asked if that is something staff does. She stated, "No, I don't follow the home health plan of care orders." Res #5 had diagnoses which included overactive bladder and suprapubic urinary catheter A Home Health Plan of Care, dated 03/07/22 thru 05/05/22, read in part, "... Medications...Tamsulosin 0.4mg daily..." On 04/04/22 at 12:15 p.m., Res #5's current	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 04/07/2022
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C5010	Continued From page 14 physician's orders were reviewed. Tamsulosin 0.4mg daily was not listed one of the resident's prescribed medications. At 10:05 a.m., the DON was interviewed about the Home Health Plan of Care for residents receiving home health services. When asked if the medications and treatments listed on the Home Health Plan of Care were checked for accuracy, she replied, "I don't look at their [referring to the Home Health Agency] plan of care." When asked if she had ever reviewed them, she replied, "No. That's not something I review." Res #6 had diagnoses which included Parkinson's, h/o CVA [stroke] with LLE weakness, and dementia. A 14 day assessment, dated 11/08/21, read in part, "...[oriented to person, place, and time]... [judgement good]...ambulatory without assistance...walker...dressing assist prn...transferring standby assist prn...toileting assist prn..." On 04/04/22 at 9:34 a.m., Res #6 was asked who helps you take a shower. She replied, "No one as much as I need. I stink." When asked how often does someone come to bathe you, she said, "She used to come about once a week. I think I lost her." Res #6 was asked how does not getting a bath make you feel. She replied, "Nasty." Res #6 stated, "I took a bath every morning or evening. Washed my hair and took a bath. Now I'm down to basically nothing. All I do is feel the dirt on me." On 04/05/22 at 9:30 a.m., Res #6 was observed	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 04/07/2022
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C5010	Continued From page 15 in her wheelchair in her apartment dressed and awake. Res #6 was asked if she had gotten a bath today and she stated, "No. I guess I'll get one soon. They get to me when they can." On 04/06/22 at 11:30 a.m., the DON was asked how are you able to ensure that Res #6 gets her baths. She stated, "I would look at the sign in sheet. Our staff gives her a bath sometimes too. So, I don't worry about [Res #6] getting a bath." The center's "Sign In/Sign Out Policy", updated 08/01/19, read in part, "...outside providers are asked to sign in and out upon entering and leaving the facility..." "HOME HEALTH, PHYSICAL THERAPY, AND HOSPICE SIGN IN/OUT SHEETS" dated 02/21/22 thru 03/30/22, documented that the hospice aide had signed in as visiting [Res #6] a total of five times. On 04/06/22 at 11:30 a.m., the DON was asked to review the "HOME HEALTH, PHYSICAL THERAPY, AND HOSPICE SIGN IN/OUT SHEETS", dated 02/21/22 thru 03/30/22. She was asked if it showed services had been provided to Res #6 as scheduled. She stated, "The aide does not always sign sheets." The DON was asked how she would know if center staff had given Res #6 a bath. She stated, "There is a log sheet in her room that they would sign." The "Visit Log Sheets", dated 11/22/21 thru 04/04/22, retrieved from Res # 6's apartment documented the resident receiving baths for the following days: 12/02/21, [unreadable], 12/13/21, 01/12/22, [unreadable], 01/31/22, 02/07/22, [unreadable], 02/18/22, 02/28/22, 03/02/22, 03/04/22, 03/21/22, 03/23/22, and 03/28/22.	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 04/07/2022
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C5010	Continued From page 16 The "Coordination Forms" from hospice SN visits, dated 01/03/22 thru 04/04/22, had no documentation that baths had been given during hospice SN wound care visits. Res #7 had diagnoses which included Type 2 Diabetes and memory issues. Res #7 was insulin dependent and had been self-administering her insulin from admission to facility until 03/30/22. A Home Health Plan of Care, dated 03/03/22 thru 05/01/22, read in part, "...Medications...Lantus Solostar Subcutaneous 100 UNIT/ML 16 Subcutaneous injection TWICE Daily at Breakfast and Dinner...Miralax Oral 17 GM/SCOOP 1 Daily...Simvastatin Oral 40 MG 1 Tab(s) By Mouth, Daily...NovoLOG FlexPen Subcutaneous 100 UNIT/ML 6 Subcutaneous injection THREE times daily..." Res #7's "Physician's Orders", dated 04/04/22, read in part, "...LANTUS SOLOSTAR PEN 100U/ML INJECT 15 UNITS...AT BEDTIME...LANTUS SOLOSTAR PEN 100U/ML INJECT 18 UNITS ONCE DAILY WITH BREAKFAST"...SIMVASTATIN 20MG TAB**** TAKE 1 TABLET BY MOUTH AT BEDTIME..." There was no current order for Miralax Oral or NovoLOG FlexPen on current physician orders written by the resident's PCP. A NP "PROGRESS NOTE (AMENDED)", dated 03/30/22, read in part, "...ADDENDUM...clarification on insulin orders 20 q am 10 q hs."	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 04/07/2022
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C5010	Continued From page 17 The "HOME HEALTH, PHYSICAL THERAPY, AND HOSPICE SIGN IN/OUT SHEET", documented home health SN visits for insulin administration on 04/02/22 at 7:30 [am/pm not designated] and 3:00 p.m.; and on 04/03/22 at 2:55 [am/pm not designated]. On 04/07/22, at 10:00 a.m., the DON was asked what time home health was administering Res #7's evening insulin. She replied, "They are giving it at dinner." The DON stated dinner was at 4:30 p.m.. The DON was asked what the prescribed insulin administration times were. After review of the physicians order, she stated, "In the morning and at bedtime. I was thinking the order said with dinner." When asked if the PCP had been made aware that the insulin was being given before dinner instead of at bedtime, she said, "No, because I thought it was at dinner." On 04/07/22 at 10:05 a.m., the DON was interviewed about the "HOME HEALTH CERTIFICATION AND PLAN OF CARE", for residents receiving home health services. When asked if the medications and treatments listed on them were checked for accuracy, she replied, "I don't look at their [referring to the Home Health Agency] plan of care." When asked if she had ever reviewed them, she replied, "No. That's not something I review."	C5010		

Delivery via email to: gemini@coxinet.net; marci@wellingtonparke.com

May 20, 2022

License Number: AL5531

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

Survey Event ID: GOG811

Dear Mr. McWhirter:

On **April 7, 2022**, a relicensure survey and a complaint investigation were conducted at your Assisted Living Center. 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 **June 30, 2022**.

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

Respectfully,

Tempal Killman

Digitally signed by Tempal
Killman
Date: 2022.05.20 14:34:14 -05'00'

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

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Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/18/2022

Facility Name: Wellington Parke, LLC

License Number: AL5531

Survey Event ID: GOG811

Date Survey Completed: 4/7/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522

Based on: Based on record review, observation, and interview the center failed to ensure 1. a yearly comprehensive assessment was completed for one (#9) of nine sampled residents reviewed for annual assessments and, 2. ensure significant change assessments were completed for two (#2, #3) of 5 sampled residents reviewed for a change in condition.

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 their conclusions drawn therefrom. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident #9's annual assessment had been completed as required on 03/30/2022. It was located and filed in the resident's chart. A significant change assessment was completed for resident #2. Resident #3 has discharged.

All residents require assessments and therefore all residents have the potential to be affected.

The nursing management was in-serviced on conducting assessments. A binder is being used with assessment dates and expirations to ensure timely assessments. All direct care staff was educated on monitoring and notifying the nurse of changes in condition. The nurse will evaluate and complete a significant change assessment based on the resident's needs and with every hospice admission.

Audits will be conducted by the administrator/designee to ensure timely assessments. Audits will be conducted weekly x 1 month, then monthly x 2 months.

Progress and findings will be monitored by the QA committee to ensure continued effectiveness.

Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction.

6/30/2022

Administrator's Signature Jim McWhirter OAC 310:663-25-4(F)		Date 5/18/2022	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			



Oklahoma State
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/18/2022

Facility Name: Wellington Parke, LLC

License Number: AL5531

Survey Event ID: GOG811

Date Survey Completed: 4/7/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: Based on record review, observation, and interview, the center failed to ensure medications were administered according to physicians orders for one (#10) of eight residents observed during medication pass.

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 their conclusions drawn their from. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Jim McWhirter

OAC 310:663-25-4(F)

Date 5/18/2022

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

Addendum Date Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

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

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

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



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/18/2022

Facility Name: Wellington Parke, LLC

License Number: AL5531

Survey Event ID: GOG811

Date Survey Completed: 4/7/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923

Based on: Based on record review, observation and interview, the center failed to ensure a narcotic count was accurate for one (#1) of one sampled resident reviewed for narcotic count.

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 their conclusions drawn therefrom. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

A medication report was written and the narcotic count was corrected for resident #1.

All residents who receive narcotic medications have the potential to be affected by the deficient practice.

All medication aides have been in-serviced on the narcotic shift count with shift change. The narcotic shift log is to be signed with every shift in and shift out to ensure the narcotic count is conducted with every shift change.

Audits will be conducted by the administrator/designee to ensure the narcotic count is conducted with every shift change. Audits will be conducted weekly x 1 month, then monthly x 2 months.

Progress and findings will be monitored by the QA committee to ensure continued effectiveness.

Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction.

Administrator's Signature Jim McWhirter

OAC 310:663-25-4(F)

Date 5/18/2022

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

Addendum Date

Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

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

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

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



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/18/2022

Facility Name: Wellington Parke, LLC

License Number: AL5531

Survey Event ID: GOG811

Date Survey Completed: 4/7/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1951

Based on: Based on record review, observation, and interview, the center failed to: 1. ensure care plans were updated and accurate for two (#5 and #6) of nine sampled residents care plans reviewed; and 2. ensure physician orders for insulin dosage was updated and accurate for one (#7) of nine sampled resident physician orders reviewed.

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 their conclusions drawn therefrom. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The care plans for residents #5 and #6 will be updated. The accurate insulin order for resident #7 was documented and provided during survey.

All residents are to have an accurate clinical record, therefore, all residents have the potential to be affected.

Nursing management has been educated on the accuracy of records, including care plans and physician orders.

Audits will be conducted by the administrator/designee to ensure accuracy of records related to care plans and physician orders. Audits will be conducted weekly x 1 month, then monthly x 2 months.

Progress and findings will be monitored by the QA committee to ensure continued effectiveness.

Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction.

6/30/2022

Administrator's Signature Jim McWhirter

OAC 310:663-25-4(F)

Date 5/18/2022

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



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 5/18/2022

Facility Name: Wellington Parke, LLC

License Number: AL5531

Survey Event ID: GOG811

Date Survey Completed: 4/7/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C5010

Based on: Based on record review, observation, and interview, it was determined the center failed to coordinate for four (#4, #5, #6, #7) of four sampled residents for coordination of care with third party providers.

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 their conclusions drawn therefrom. The POC is intended to constitute the facility's written allegation of continued compliance.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained?

Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident #4 no longer resides in the facility. Resident #5's Tamsulosin 0.4mg is still on the 485 since started on 06/08/2016. The showers provided by hospice to resident #6 were provided in 3 different forms during survey showing documentation of a minimum of 2 baths a week since the admission of the resident. Resident #7 only receives insulin one time a day in the am.

All residents with third party services have the potential to be affected.

A coordination form is to be completed, the third party log is to be signed and a personal binder is completed by third party providers to document each visit and the care provided to the resident. The 485s are also sent, reviewed for accuracy and filed for each resident who receives services from a third party. Nursing management and third party providers will be educated on the coordination of care and services provided.

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Audits will be conducted by the administrator/designee to ensure coordination of care with third party providers. Audits will be conducted weekly x 1 month, then monthly x 2 months.

Progress and findings will be monitored by the QA committee to ensure continued effectiveness.

Audits will be brought to the QA committee and filed in the POC binder as evidence of the correction.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		6/30/2022	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Jim McWhirter OAC 310:663-25-4(F)		Date 5/18/2022	
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.			

Delivery via email to: gemini@coxinet.net; marci@wellingtonparke.com

January 5, 2023

License Number: AL5531

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

RE: Survey Event GOG812

Dear Mr. McWhirter:

On **December 29, 2022**, a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 7, 2022**, have now been corrected effective **June 30, 2022**.

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5531	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/29/2022
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
{C 000}	INITIAL COMMENTS A follow-up survey was conducted on 12/29/22. 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