
Delivery via email to: superiorcarehomesofoklahoma@gmail.com; misty.leeson04@gmail.com

November 29, 2023

License Number: AL5556

Ms. Misty Dawn Leeson, Administrator
Superior Care Homes Of Oklahoma
8817 Nw 121st
Oklahoma City, OK 73162

RE: Survey Event ID: 8JZN11

Dear Ms. Leeson:

On **November 7, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **November 7, 2023**.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

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

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

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

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

The IDR request must be submitted within 10 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, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,



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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5556	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/07/2023
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOMES OF OKLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 8817 NW 121ST OKLAHOMA CITY, OK 73162		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An intital licensure survey was conducted on 11/06/23 and 11/07/23. Census: 4 Listed below are abbreviations that will be used throughout this document. CNA- certified nurse aide CPR- cardiopulmonary resuscitation MAT- medication administration technician LPN- licensed practical nurse MAR - medication administration record mg- milligrams RN- registered nurse	C 000		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the resident or their family were interviewed in conjunction with the comprehensive assessment for two (#1 and #2) of two sampled comprehensive assessment reviewed.	C 543		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5556	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/07/2023
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOMES OF OKLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 8817 NW 121ST OKLAHOMA CITY, OK 73162		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 543	Continued From page 1 Findings: 1. Resident #1 was admitted to the facility on 08/28/23 with diagnoses that included dementia, diabetes mellitus, and left hip surgery. A review of Resident #1 clinical record and the comprehensive assessment, dated 08/28/23, contained no documentation to indicate the resident and family were interviewed in conjunction with the assessment. 2. Resident #2 was admitted to the facility on 08/31/23 with diagnoses that included dementia, depression, anxiety, insomnia and hypertension. A review of Resident #2 clinical record and the comprehensive assessment, dated 08/31/23, contained no documentation to indicate the resident and family were interviewed in conjunction with the assessment. On 11/06/23 at 1:35 p.m., RN #1 the consulting nurse stated they completed the assessments for Resident #1 and Resident #2 without having the resident or family present to interview. RN #1 then stated they just get them completed without an interview.	C 543		
C 552 SS=D	310.663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident.	C 552		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5556	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/07/2023
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOMES OF OKLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 8817 NW 121ST OKLAHOMA CITY, OK 73162		
(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 552	Continued From page 2 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was completed for one (#1) of two sampled residents whose care plans were reviewed. Findings: Resident #1 was admitted to the facility on 08/28/23 with diagnoses that included dementia, diabetes mellitus, and left hip surgery. Resident #1's comprehensive assessment documented the assessment was completed on 08/28/23. There was no comprehensive care plan based on Resident #1 comprehensive assessment completed on 08/28/23. On 11/07/2023 at 7:40 a.m., MAT #1, the house manager, stated they have not completed a care plan for Resident #1 and it needed to be completed. MAT #1 then stated the care plan also served as Resident #1 service agreement.	C 552		
C 954 SS=D	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.	C 954		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5556	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/07/2023
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOMES OF OKLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 8817 NW 121ST OKLAHOMA CITY, OK 73162		
(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 954	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff had CPR and first aid training for one of eight sampled employees reviewed for training. The house manager identified 8 active employees working at the facility. Findings: A review of the employee file for the administrator documented they were hired at the facility on 05/17/21. There was no documentation the administrator had any CPR and first aid training. On 11/07/23 at 9:28 a.m., the house manager stated the administrator did not have their first aid and CPR training.	C 954		
C1110 SS=F	310:663-11-1 QUALITY ASSURANCE COMMITTEE (1) Each assisted living center shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall: (1) monitor trends and incidents; (2) monitor customer satisfaction measures; and (3) document quality assurance efforts and outcomes.	C1110		

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5556	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/07/2023
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOMES OF OKLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 8817 NW 121ST OKLAHOMA CITY, OK 73162		
(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
C1321	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the failed to ensure the resident contract contained the assisted living center's name and address for 2 (#1 and #2) of two sampled residents. Findings: The service contracts for residents #1 and #2 did not contain the facility name and address as part of the contract. On 11/07/23 at 10:07 a.m., MAT #1, who was also the house manager, was asked to identify where Resident #1 and Resident #2 contract contained the facility name and address. They reviewed the contracts and stated the contract does not have the facility name and address.	C1321		
C1327 SS=E	310:663-13-2(7) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (7) a provision that the written contract constitutes the entire agreement between the resident and the assisted living center not excluding the marketing materials and the requirements of this Chapter; This Rule is not met as evidenced by: Based on record review and interview, it was determined the center failed to provide the	C1327		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5556	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/07/2023
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOMES OF OKLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 8817 NW 121ST OKLAHOMA CITY, OK 73162		
(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
C1327	Continued From page 6 assurance of the contract in it's entirety for two (#1 and #2) of two sampled residents. Findings: The service contracts for residents #1 and #2 did not contain documentation that the contract constituted the entire agreement between the resident and the assisted living center. On 11/07/23 at 10:07 a.m., MAT #1, who was also the house manager, was asked to identify where Resident #1 and Resident #2 contract contained the statement the contract constituted the entire agreement between the center and Resident #1 and Resident #2. They reviewed the contracts and stated the contracts did not have the statement.	C1327		
C1329 SS=E	310:663-13-2(9) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (9) conformity with state law; This Rule is not met as evidenced by: Based on record review and interview, it was determined the center failed to ensure every resident service contract contained a clear statement that depicted the contract was in conformity with state law for two (#1 and #2) of two sampled residents. Findings: The service contracts for residents #1 and #2 did not contain a statement that the contract was in	C1329		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5556	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/07/2023
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOMES OF OKLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 8817 NW 121ST OKLAHOMA CITY, OK 73162		
(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
C1329	Continued From page 7 conformity with state law. On 11/07/23 at 10:07 a.m., MAT #1, who was also the house manager, was asked to identify where Resident #1 and Resident #2 contract contained the statement the contract was in conformity with state law. They reviewed the contracts and stated the contracts did not have the statement.	C1329		
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		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5556	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/07/2023
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOMES OF OKLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 8817 NW 121ST OKLAHOMA CITY, OK 73162		
(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
C1505	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a resident was provided medication as ordered by the physician for one (#3) of one sampled resident reviewed for medication administration. Findings: Resident #3's current physician orders documented they were to receive Vitamin C 1,000 mg by mouth daily as a nutritional supplement. A review of the MAR for November 2023 documented the resident was to receive Vitamin C 1,000 mg by mouth daily as a nutritional supplement. On 11/07/23 at 7:45 a.m., MAT #1 was observed passing medications to Resident #3. The MAT was observed administering one 500 mg tablet of Vitamin C to the resident. On 11/07/23 at 8:20 a.m., MAT #1 was asked about the Vitamin C order. They stated the resident was to get one 500 mg tablet daily. MAT #1 reviewed the physician orders and stated Resident #3 was to receive 1,000 mg daily of Vitamin C and they had not been receiving the correct dose. MAT #1 further stated they should	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5556	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/07/2023
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOMES OF OKLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 8817 NW 121ST OKLAHOMA CITY, OK 73162		
(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
C1505	Continued From page 9 have read the order closely to ensure the resident was getting the correct dose. They were asked for a policy on medication administration and following physician orders. MAT #1 stated they do not currently have any pharmacy policies.	C1505		
C1972 SS=E	310:663-19-4(c) POLICIES (c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure new employees were trained on abuse within 90 days of hire for eight (CNA #1, CNA #2, CNA #3, CNA #4, administrator, LPN #1, LPN #2, and MAT #1) of eight employee files reviewed for abuse training on hire. The house manager identified 8 active employees working at the facility. Findings: 1. A review of the employee file for CNA #1 documented they were hired at the facility on 01/23/23. There was no documentation the CNA had abuse	C1972		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5556	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/07/2023
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOMES OF OKLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 8817 NW 121ST OKLAHOMA CITY, OK 73162		
(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
C1972	Continued From page 10 training within 90 days of being hired. 2. A review of the employee file for CNA #2 documented they were hired at the facility on 06/04/21. There was no documentation the CNA had abuse training within 90 days of being hired. 3. A review of the employee file for CNA #3 documented they were hired at the facility on 02/05/21. There was no documentation the CNA had abuse training within 90 days of being hired. 4. A review of the employee file for CNA #4 documented they were hired at the facility on 02/05/21. There was no documentation the CNA had abuse training within 90 days of being hired. 5. A review of the employee file for the administrator documented they were hired at the facility on 05/17/21. There was no documentation the administrator had abuse training within 90 days of being hired. 6. A review of the employee file for LPN #1 documented they were hired at the facility on 06/07/21. There was no documentation the LPN had abuse training within 90 days of being hired. 7. A review of the employee file for LPN #2 documented they were hired at the facility on 07/12/21.	C1972		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5556	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/07/2023
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOMES OF OKLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 8817 NW 121ST OKLAHOMA CITY, OK 73162		
(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
C1972	Continued From page 11 There was no documentation the LPN had abuse training within 90 days of being hired. 8. A review of the employee file for MAT #1 documented they were hired at the facility on 02/05/21. There was no documentation the MAT had abuse training within 90 days of being hired. On 11/07/23 at 9:28 a.m., the house manager stated employees were not trained on abuse within 90 days of hire.	C1972		

Delivery via email to: superiorcarehomesofoklahoma@gmail.com; misty.leeson04@gmail.com

December 28, 2023

License Number: AL5556

Ms. Misty Leeson, Administrator
Superior Care Homes Of Oklahoma
8817 Nw 121st
Oklahoma City, OK 73162

RE: Survey Event 8JZN11

Dear Ms. Leeson:

On **November 7, 2023**, an Initial Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **January 6, 2024**.

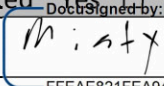
We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

Enclosure

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 12/12/2023		
	Facility Name: Superior Care Homes of Oklahoma		
	License Number: AL5556		
	Survey Event ID: 11/07/2023		
Date Survey Completed: 11/07/2023			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C543	Based on: record review and interview, the facility failed to ensure the resident or their family were interviewed in conjunction with the comprehensive assessment for two (#1 and #2) of two sampled comprehensive assessment		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
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 care center will evaluate all current resident records to ensure additional data has been collected on all residents in conjunction with the Recommended Assisted Living Resident Assessment Form.	
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 care center's nursing staff will review residents missing any comprehensive documentation at the time of admission in order to identify all affected residents.	
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?		The care home will develop an additional from to check off data provided by the family or guardian at the time of admission and obtain any additional information not previously received by the initial assessment form.	
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.		The correction will be evaluated for effectiveness by having nursing staff review all charts and documents and record any need for additional documentation based on each patient's chart review. The correction will be incorporated into the center's quarterly review quality assurance measures and completed documentation of findings by the nurse reviewing the patient's chart. All monitoring of patient's charts will be documented in the care center's quality assurance manual.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		by January 6, 2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature 		Date 12/19/2023	

OAC 310:663-25-4(F)

FFFAE821FEA94C7...

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	12/19/2023	Submitted by	Misty Leeson
----------------------	------------	---------------------	--------------

Items Below Are For OSDH Use Only

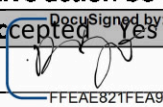
Plan of Correction: ☐Acceptable ☐Unacceptable Date: [Click here to enter a date.](#) Surveyor: Surveyor

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: 12/12/2023	
	Facility Name: Superior Care Homes of Oklahoma	
	License Number: AL5556	
	Survey Event ID: 11/07/2023	
Date Survey Completed: 11/07/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C552	Based on: on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was completed for one (#1) of two sampled residents whose care plans were reviewed.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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 care center shall implement and follow a strict deadline for care plan completion as required by the state of Oklahoma. All newly admitted residents will have their care plan meeting conducted with family present within 8 days of admission in order to be completed within the state mandated window of 14 days after admission, Annually, and as care needs change thereafter.	
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 care center's nursing staff will review all residents chart to identify potential residents who have also been impacted by missing care plans.	
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?	The care center will implement a monthly chart Audit plan for all residents in order to avoid further care plan needs delay and monitor ongoing potential for any delayed needs. Measures such as making sure daily staff have access to all care plans for residents, and being trained on the review of care plans, so that the administrator and nurse consultant can be notified promptly if a resident is missing or has a dated care plan.	
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.	The correction will be evaluated by the administrator and the nurse consultant has been provided a deadline of having all care plans completed by December 31, 2023. The correction will be implemented into the center's quality assurance system, by implementing care plan monitoring into the quality assurance system for monthly and quarterly review. With administrator being assigned as the reviewer and the nurse consultant being assigned as	

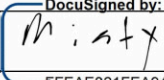
		the individual responsible for the audits and completing of care planning for each resident.	
		Monitored records will be kept in the centers quality assurance manual.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		Care plans for all current residents are to be completed by December 31, 2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)		Date 12/12/2023	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☒ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If the 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.			

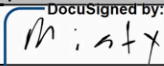
 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 12/12/2023	
	Facility Name: Superior Care Homes of Oklahoma	
	License Number: AL5556	
	Survey Event ID: 11/07/2023	
		Date Survey Completed: 11/07/2023
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C954	Based on: record review and interview, the facility failed to ensure staff had CPR and first aid training for one of eight sampled employees reviewed for training.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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 corrective actions will ensure all staff training and CPR is up to date and present in a central area to ensure residents have access to properly trained staff.	
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 care center residents can be negatively impacted by having improperly untrained staff. Residents can be identified by current community roster.	
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?	The care center is actively implementing a plan to maintain CPR records in a single location, as well as a plan for digital monitoring of CPR expirations, and upcoming training needs for all staff.	
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.	The correction will be evaluated and sustained by monitoring and tracking potential risk for future deficiencies. This corrective will be implemented into the care center's plan of correction by adding a monthly audit for CPR certifications by the administrator and house manager. Both will be tasked with notifying employees of upcoming expiration and implementing onsite training as needed. Responsible staff will receive calendar notifications for when audits need to be completed. CPR certifications will be kept in their own manual and monthly audits will be documented in the centers quality assurance manual.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	As of December 1, 2023 all staff have updated CPR training on record at the care center.	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature		Date: 12/12/2023

FFAE821FEA94C7...

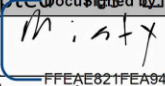
OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only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

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 12/12/2023	
	Facility Name: Superior Care Homes of Oklahoma	
	License Number: AL5556	
	Survey Event ID: 11/07/2023	
Date Survey Completed: 11/07/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1110	Based on: record review and interview, the facility failed to have a quality assurance committee to monitor trends, incidents, customer satisfaction measures, and document quality assurance efforts and outcomes.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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 corrective action will ensure all the maintenance of quality, health standards, adequate staff training, proper facilities maintenance, medication management, and any other potential harm, which could impact patient care.	
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 and responsible family members and guardians will have the opportunity to request changes and provide the home feedresident'sback so that all potential quality assurance efforts meet the residents and family's needs.	
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?	A quality assurance manual and team are to be identified with current deficiencies as the top priority for implementation and correction.	
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.	The correction will be monitored by establishing quality assurance standards for the care center. The correction will be evaluated for effectiveness once current deficiencies have been corrected and monitoring practices and standards are identified and implemented. Care center will identify monthly and quarterly dates in order to meet the state policy requirement of 310:663-11-1. Monitoring records will be kept in the care centers quality assurance manual.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	Quality control manual. dates for meetings, and team implementation to be fully completed by January 6, 2024.	
OSDH Response: Element accepted Yes ☐ No ☐		

Administrator's Signature  DocuSigned by: FEEAE821FEA94C7		Date 12/19/2023
OAC 310:663-25-4(F)		
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.		
Addendum Date	12/19/2023	Submitted by Misty Leeson
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.		

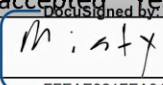
	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 12/12/2023		
	Facility Name: Superior Care Homes of Oklahoma		
	License Number: AL5556		
	Survey Event ID: 11/07/2023		
Protective Health Services Long Term Care Service	Date Survey Completed: 11/07/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C1321	Based on: review and interview, the failed to ensure the resident contract contained the assisted living center's name and address for 2 (#1 and #2) of two sampled residents.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS	
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	All current contracts will be amended to include the assisted living address.		
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 resident contracts will be reviewed in order to make the necessary corrections related to the care center contract.		
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?	All contracts will be amended for future residents in order to prevent the distribution of a defective contract to new clients.		
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.	The correction will be evaluated for effectiveness by making sure the contract meets the state requirements of policy 310:663-13-2(9). The correction will be added to the care center's quality assurance manual, where each contract will be reviewed annually to ensure compliance with state law. The monitoring records will be kept in the care center's quality assurance manual.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	by January 6, 2024		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	DocuSigned by: 		Date: 12/19/2023
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	12/19/2023	Submitted by	Misty Leeson

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: 12/12/2023		
	Facility Name: Superior Care Homes of Oklahoma		
	License Number: AL5556		
	Survey Event ID: 11/07/2023		
			Date Survey Completed: 11/07/2023
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C1327	Based on: review and interview, it was determined the center failed to provide the assurance of the contract in its entirety for two (#1 and #2) of two sampled residents.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
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 care center will draft a contract amendment to include a statement of assurance for the reviewed residents.		
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents' contracts will be reviewed for assurance statements and updated as required.		
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?	All contracts will be reviewed and amendments will be made to add assurance statements as required by the state of Oklahoma. All future contracts will contain assurance statements.		
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.	The correction will be evaluated for effectiveness by reviewing all resident contracts to ensure state requirements for assurance statements are incorporated in each document. An annual review of contracts will be conducted to ensure all resident contracts comply with the state of Oklahoma. Monitoring records will be kept in the care center's quality assurance manual.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	by January 6, 2024		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature  OAC 310:663-25-4(F)	Date 12/19/2023		
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	12/19/2023	Submitted by	Misty Leeson
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☒ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			

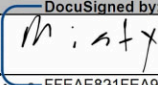
If Plan of Correction is unacceptable, the reasons are as follows: [Click here to enter text.](#)

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

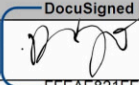
 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 12/12/2023		
	Facility Name: Superior Care Homes of Oklahoma		
	License Number: AL5556		
	Survey Event ID: 11/07/2023		
Date Survey Completed: 11/07/2023			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C1329	Based on: record review and interview, it was determined the center failed to ensure every resident service contract contained a clear statement that depicted the contract was in conformity with state law for two (#1 and #2) of two sampled residents.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
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 corrective action will be accomplished by reviewing and correcting the resident contact based on the state survey results.		
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents run the risk of receiving the non-updated contact documents as required by the state and will be identified by staff review.		
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?	New resident agreement documents will be drafted to contain the following statement "contract in conformity with the state of Oklahoma."		
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.	The care center will evaluate its effectiveness by reviewing and creating contract amendments for current residents to include the statement "contract in conformity with the state of Oklahoma." In addition to updating all new resident contracts. The correction will be included into quality assurance by completing annual reviews of all residents' contracts to ensure conformity to state law. All monitored records will be kept in the center's quality assurance manual.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		By January 6, 2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature 		Date 12/19/2023	
OAC 310:663-25-4(F) FFEAE821FEA94C7...			

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	12/19/2023	Submitted by	Misty Leeson
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: 12/12/2023	
	Facility Name: Superior Care Homes of Oklahoma	
	License Number: AL5556	
	Survey Event ID: 11/07/2023	
Date Survey Completed: 11/07/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C1505	Based on: observation, record review, and interview, the facility failed to ensure a resident was provided medication as ordered by the physician for one (#3) of one sampled resident reviewed for medication administration.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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 corrective action for the affected resident was that a changer order was completed to correct the medication administration instructions, in addition to documenting the medication error and notifying appropriate parties.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Other residents have the potential to be greatly impacted and could also be negatively impacted by receiving the incorrect dosage of medication. A medication chart review will be conducted for all residents in order to identify other residents at risk.	
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?	The care home is drafting a medication manual, which will direct staff on residents rights and medication administration rights. Additional audit reviews are also being implemented to reduce the occurrence and risk of medication errors.	
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.	The care centers will implement policy and procedures which are aligned with the state of Oklahoma for medication administration standards. The correction has been implemented by care center nursing staff. The nursing staff will monitor and report a minimum of one medication pass administered by the CMAs and MATs. Medications audits will be conducted by nursing staff at move-in, and quarterly as well. Monitored records will be kept in the home quality assurance manual and reviewed continuously.	
OSDH Response: Element accepted Yes ☐ No ☐		

5. On what date will corrective action be completed?		The medication change order was implemented on 11/07/2023 additional medication protocols and quality assurance efforts are to be completed no later than January 6,2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature 		Date 12/19/2023	
OAC 310:663-25-4(F) DocuSigned by: FFEAE821FEA94C7			
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	12/19/2023	Submitted by	Misty Leeson
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☒ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If the 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: 12/12/2023		
	Facility Name: Superior Care Homes of Oklahoma		
	License Number: AL5556		
	Survey Event ID: 11/07/2023		
Date Survey Completed: 11/07/2023			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C1972	Based on: record review and interview, the facility failed to ensure new employees were trained on abuse within 90 days of hire for eight (CNA #1, CNA #2, CNA #3, CNA #4, administrator, LPN #1, LPN #2, and MAT #1) of eight employee files reviewed for abuse training on hire.		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
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 corrective action will ensure staff members have effective training in order to properly manage abuse and neglect claims and to refrain from committing any acts of abuse and neglect whether intentional or unintentional.	
OSDH Response: Element accepted Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Other residents can be identified by continuous monitoring of staff training needs to prevent any further delay of required staff training.	
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?		The care center is researching online methods in order to deliver faster training needs and timely documentation of completion of required training.	
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.		The correction will be evaluated for effectiveness by monitoring efficiency and completion time frames associated with new training records. The care center will also develop an inservice manual in order to provide continuous training. Staff training monitoring will be implemented into the care center's quality assurance monitoring and mid-year and annual audits will be conducted to assess abuse and neglect, as well as all additional staff training needs. Monitoring records will be maintained in the staff quality assurance and training manual.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?			

OSDH Response: Element accepted Yes ☐ No ☐		All staff will have training completed by December 31, 2023. All additional training measures will be monitored continuously for annual recertification..	
Administrator's Signature OAC 310:663-25-4(F) 		Date 12/12/2023	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If the Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			

Delivery via email to: superiorcarehomesofoklahoma@gmail.com; misty.leeson04@gmail.com

December 28, 2023

License Number: AL5556

Ms. Misty Leeson, Administrator
Superior Care Homes Of Oklahoma
8817 Nw 121st
Oklahoma City, OK 73162

RE: Survey Event 8JZN11

Dear Ms. Leeson:

On **November 7, 2023**, an Initial Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **January 6, 2024**.

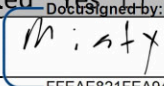
We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

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

Enclosure

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 12/12/2023		
	Facility Name: Superior Care Homes of Oklahoma		
	License Number: AL5556		
	Survey Event ID: 11/07/2023		
Date Survey Completed: 11/07/2023			
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C543	Based on: record review and interview, the facility failed to ensure the resident or their family were interviewed in conjunction with the comprehensive assessment for two (#1 and #2) of two sampled comprehensive assessment		
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
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 care center will evaluate all current resident records to ensure additional data has been collected on all residents in conjunction with the Recommended Assisted Living Resident Assessment Form.	
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 care center's nursing staff will review residents missing any comprehensive documentation at the time of admission in order to identify all affected residents.	
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?		The care home will develop an additional from to check off data provided by the family or guardian at the time of admission and obtain any additional information not previously received by the initial assessment form.	
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.		The correction will be evaluated for effectiveness by having nursing staff review all charts and documents and record any need for additional documentation based on each patient's chart review. The correction will be incorporated into the center's quarterly review quality assurance measures and completed documentation of findings by the nurse reviewing the patient's chart. All monitoring of patient's charts will be documented in the care center's quality assurance manual.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		by January 6, 2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature 		Date 12/19/2023	

OAC 310:663-25-4(F)

FFFAE821FEA94C7...

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	12/19/2023	Submitted by	Misty Leeson
----------------------	------------	---------------------	--------------

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: 12/12/2023	
	Facility Name: Superior Care Homes of Oklahoma	
	License Number: AL5556	
	Survey Event ID: 11/07/2023	
Date Survey Completed: 11/07/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C552	Based on: on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was completed for one (#1) of two sampled residents whose care plans were reviewed.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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 care center shall implement and follow a strict deadline for care plan completion as required by the state of Oklahoma. All newly admitted residents will have their care plan meeting conducted with family present within 8 days of admission in order to be completed within the state mandated window of 14 days after admission, Annually, and as care needs change thereafter.	
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 care center's nursing staff will review all residents chart to identify potential residents who have also been impacted by missing care plans.	
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?	The care center will implement a monthly chart Audit plan for all residents in order to avoid further care plan needs delay and monitor ongoing potential for any delayed needs. Measures such as making sure daily staff have access to all care plans for residents, and being trained on the review of care plans, so that the administrator and nurse consultant can be notified promptly if a resident is missing or has a dated care plan.	
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.	The correction will be evaluated by the administrator and the nurse consultant has been provided a deadline of having all care plans completed by December 31, 2023. The correction will be implemented into the center's quality assurance system, by implementing care plan monitoring into the quality assurance system for monthly and quarterly review. With administrator being assigned as the reviewer and the nurse consultant being assigned as	

		the individual responsible for the audits and completing of care planning for each resident.	
		Monitored records will be kept in the centers quality assurance manual.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		Care plans for all current residents are to be completed by December 31, 2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)		Date 12/12/2023	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☒ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If the 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: 12/12/2023	
	Facility Name: Superior Care Homes of Oklahoma	
	License Number: AL5556	
	Survey Event ID: 11/07/2023	
		Date Survey Completed: 11/07/2023
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C954	Based on: record review and interview, the facility failed to ensure staff had CPR and first aid training for one of eight sampled employees reviewed for training.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).		
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 corrective actions will ensure all staff training and CPR is up to date and present in a central area to ensure residents have access to properly trained staff.	
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 care center residents can be negatively impacted by having improperly untrained staff. Residents can be identified by current community roster.	
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?	The care center is actively implementing a plan to maintain CPR records in a single location, as well as a plan for digital monitoring of CPR expirations, and upcoming training needs for all staff.	
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.	The correction will be evaluated and sustained by monitoring and tracking potential risk for future deficiencies. This corrective will be implemented into the care center's plan of correction by adding a monthly audit for CPR certifications by the administrator and house manager. Both will be tasked with notifying employees of upcoming expiration and implementing onsite training as needed. Responsible staff will receive calendar notifications for when audits need to be completed. CPR certifications will be kept in their own manual and monthly audits will be documented in the centers quality assurance manual.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	As of December 1, 2023 all staff have updated CPR training on record at the care center.	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature	Date. 12/12/2023	

FFAE821FEA94C7...