Oklahoma State Department of Health
Creating a State of Health

December 12, 2019

License Number: AL5591

Mr. Alex Baggs, Administrator
The Mansion At Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

RE: Survey Event ID: 9WXX11

Dear Mr. Baggs:

Enclosed is a report of the inspection with a complaint investigation conducted at your Assisted Living Center on **October 30, 2019.** No deficiencies were cited. Oklahoma Statutes 63-1-1910 require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **The Mansions at Waterford**
Address: **6110 North Penn Avenue**
City, State, Zip: **Oklahoma City, OK, 73112**
Provider #: **AL5591**
Complaint #: **OK00054470**
Investigation Date(s): **10/17/19 and 10/28/19 through 10/31/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to protect residents from abuse	S

An unannounced on-site investigation was initiated on Thursday, October 17, 2019 at 5:47 p.m.

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

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

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

Allegation #1: An investigation specific to resident abuse was conducted. Even though the allegation was substantiated, no deficient practice was cited. The center followed their abuse protocol of conducting an investigation, reporting the incident to the department and suspending the employee, who was ultimately terminated. No further action is required. The center completed all requirements necessary involving the investigation and the plan of correction prior to the surveyor entrance.

Determination Summary and Follow-Up Action:

Deficient practice was not cited for allegation #1.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation that the allegation did occur. However, no deficient practice or violation of the state regulations had occurred.

Jennifer Major, RN Clinical Health Facility Surveyor

Melissa Swaim, RN Clinical Health Facility Surveyor

Date report completed: 10/31/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5591	A. BUILDING _____ B. WING _____	C 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANSION AT WATERFORD	6110 NORTH PENN AVENUE OKLAHOMA CITY, OK 73112

(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 re-licensure survey was conducted 10/17/19 and 10/28/19 through 10/30/19. Complaint #OK00054470 was also investigated. Resident census was 102. No deficient practice was cited.	C 000		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5591	THE MANSION AT WATERFORD

Type of Survey (select all that apply) [2][3][ ][ ][ ]

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

Extent of Survey (select all that apply) [A][ ][ ][ ][ ]

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 42023	10/17/2019	10/30/2019	1.00	0.00	23.75	3.75	2.25	2.00
2. 34460	10/17/2019	10/30/2019	1.00	0.00	0.00	3.50	1.00	0.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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

DEC 13 2019