

Delivery via email to: ExecutiveDirector@MansionAtWaterfordSLC.com

November 9, 2021

License Number: AL5591

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

Survey Event ID: XPRU11

Dear Mr. Baggs:

On **October 28, 2021**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT

Facility: The Mansion at Waterford
Address: 6110 North Penn Avenue
City, State, Zip: Oklahoma City, Oklahoma 73112
Provider #: AL5591
Complaint #: OK00055264
Investigation Date(s): 10/27/21 and 10/28/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were administered as ordered by physician.	S

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

An unannounced on-site investigation was initiated 10/27/2021 at 8:35 a.m.

A sample of four 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

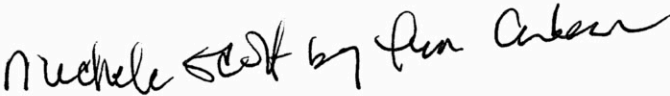
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.


Michele Scott, RN

Date report completed: 10/29/2021

INVESTIGATIVE REPORT

Facility: The Mansion at Waterford
Address: 6110 North Penn Avenue
City, State, Zip: Oklahoma City, Ok. 73112
Provider #: AL5591
Complaint #: OK00055447
Investigation Date(s): 10/27/2021 & 10/28/2021

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure resident rights to an abuse free environment were not violated.	S

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

An unannounced on-site investigation was initiated 10/27/2021 at 8:35 a.m.

A sample of 4 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1971 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 1. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Rachele Kemp

Rachele Kemp, LPN, Facility Surveyor

Date report completed: 10/29/2021

INVESTIGATIVE REPORT

Facility: The Mansion at Waterford
Address: 6110 North Penn Avenue
City, State, Zip: Oklahoma City, Oklahoma 73112
Provider #: AL5591
Complaint #: OK00057174
Investigation Date(s): 10/27/21-10/28/21

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The facility failed to provide care according to the contract.	S
2. The center failed to ensure grievances were addressed.	S

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

An unannounced on-site investigation was initiated 10/27/2021 at 8:35 a.m.

A sample of 11 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Jennifer Major RN

Digitally signed by Jennifer Major
RN
Date: 2021.10.29 07:49:56 -05'00'

Jennifer Major, RN BSN MSN

Date report completed: 10/29/2021

INVESTIGATIVE REPORT

Facility: The Mansion at Waterford
Address: 6110 North Penn Avenue
City, State, Zip: Oklahoma City, Ok. 73112
Provider #: AL5591
Complaint #: OK00057253
Investigation Date(s): 10/27/2021 & 10/28/2021

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The facility failed to provide a safe environment.	S
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 10/27/2021 at 8:35 a.m.

A sample of 4 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 1. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Rachele Kemp

Rachele Kemp, LPN, Facility Surveyor

Date report completed: 10/29/2021



INVESTIGATIVE REPORT

Facility: The Mansion at Waterford
Address: 6110 North Penn Avenue
City, State, Zip: Oklahoma City, Oklahoma 73112
Provider #: AL5591
Complaint #: OK00057405
Investigation Date(s): 10/27/21-10/28/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide care and services according to residents' contract.	S

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

An unannounced on-site investigation was initiated 10/27/2021 at 8:35 a.m.

A sample of 11 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

Jennifer Major
RN

Digitally signed by Jennifer
Major RN
Date: 2021.10.29 07:52:29
-05'00'

Jennifer Major RN BSN MSN

Date report completed: 10/29/2021

INVESTIGATIVE REPORT

Facility: The Mansion at Waterford
Address: 6110 North Penn Avenue
City, State, Zip: Oklahoma City, Oklahoma 73112
Provider #: AL5591
Complaint #: OK00057410
Investigation Date(s): 10/27/21 and 10/28/21

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The center failed to provide care and services according to residents' contracts and advertising brochures.	S
2. The facility failed to administer medications as ordered.	S

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

An unannounced on-site investigation was initiated 10/27/2021 at 8:35 a.m.

A sample of 11 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1304 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink that reads "Michele Scott RN". The signature is written in a cursive, flowing style.

Michele Scott, RN

Date report completed: 10/29/2021

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/28/2021
NAME OF PROVIDER OR SUPPLIER THE MANSION AT WATERFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint investigations (OK00055264, OK00055447, OK00057174, OK00057253, OK00057410, and OK00057405) were conducted on 10/27/21 and 10/28/21. The following is a list of abbreviations used throughout this document: AC - air conditioner CMA- certified medication aide HCP - healthcare provider LPN - licensed practical nurse MAR - medication administration record mg - milligrams PRN- as needed PO- by mouth	C 000		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and	C1304		

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: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/28/2021
NAME OF PROVIDER OR SUPPLIER THE MANSION AT WATERFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1304	Continued From page 1 interviews, the facility failed to provide services according to the contract regarding a. activities of daily living, housekeeping, and laundry services for five (#3, 4, 5, 6, and #9), b. maintenance of the air conditioner unit for four (#8, 10, 11, and #12) and c. the grievance process for one (#3) of 12 residents reviewed for contract services. The executive director identified 90 residents resided in the facility. Findings: 1. Resident #4 had diagnoses which included chronic kidney disease. The "Residency Agreement," dated 12/31/20, read in part, "...The Community will provide weekly housekeeping...Assisted living services...are available to each resident. Assisted Living Services are determined by an Assisted Living Assessment... and a Care Plan... (together, the "Resident Service Plan")...Assistance with personal care, including...housekeeping..." The "Service Plan," effective 01/10/21, documented housekeeping weekly on Wednesdays. 2. Resident #5 had diagnoses which included memory loss. The "Move In Worksheet," dated 01/01/20 [sic], documented full month invoice services for toileting and second resident.	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/28/2021
NAME OF PROVIDER OR SUPPLIER THE MANSION AT WATERFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1304	Continued From page 2 The "Residency Agreement," dated 12/31/20, read in part, "...The Community will provide weekly housekeeping...Assisted living services...are available to each resident. Assisted Living Services are determined by an Assisted Living Assessment... and a Care Plan... (together, the "Resident Service Plan")...Assistance with personal care, including...housekeeping...scheduled cuing for toileting, special requirements for bathing assistance..." The "Service Plan," effective 01/10/21, documented housekeeping weekly on Wednesdays; staff to assist with bathing twice a week; frequently incontinent- toileting assistance as needed, wife assisted but needed assistance at times. 3. Resident #9 had diagnoses which included dementia. The "Residency Agreement," dated 10/28/19, read in part, "...The Community will provide weekly housekeeping...Personal laundry service can be provided...Assisted living services...are available to each resident. Assisted Living Services are determined by an Assisted Living Assessment... and a Care Plan...(together, the "Resident Service Plan")...Assistance with personal care, including...housekeeping...scheduled cuing for toileting, special requirements for bathing assistance..." The "Service Plan," effective 11/03/19, documented housekeeping weekly on Wednesdays; staff to assist with bathing every Wednesday and Saturday; staff to wash, dry, fold,	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/28/2021
NAME OF PROVIDER OR SUPPLIER THE MANSION AT WATERFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1304	Continued From page 3 and put away all laundry every Sunday. On 10/27/21 at 10:56 a.m., a resident who requested to remain anonymous, stated they had not received housekeeping services for the last two weeks and no communication had taken place regarding the lack of housekeeping services. 4. Resident #3 had diagnoses which included dementia. The "Residency Agreement," dated 04/13/20, read in part, "...The Community will provide ...Assisted living services...are available to each resident. Assisted Living Services are determined by an Assisted Living Assessment...and a Care Plan...(together, the "Resident Service Plan")...assist with personal care...including meals and housekeeping/laundry, assistance with grooming...scheduled cueing for toileting...special requirements for bathing assistance...meal reminders...." The "Service Plan," effective 04/13/21, documented housekeeping weekly on Tuesdays; staff to assist with bathing three times a week; staff to assist with grooming cueing and reminders every day a.m. and p.m.; staff to assist with eating cueing and reminders every day a.m. and p.m. 5. Resident #6 had diagnoses which included Alzheimer's disease. The "Service Plan," effective 01/24/19, documented housekeeping weekly every Thursday; staff to stand-by assist with bathing twice a week; housekeeping every Thursday;	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/28/2021
NAME OF PROVIDER OR SUPPLIER THE MANSION AT WATERFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1304	Continued From page 4 laundry every Wednesday, toileting: incontinent care every day AM, PM, PRN. The "Residency Agreement," dated 04/13/20, read in part, "...The Community will provide ...Assisted living services...are available to each resident. Assisted Living Services are determined by an Assisted Living Assessment...and a Care Plan...(together, the "Resident Service Plan")...including housekeeping/laundry...scheduled cueing for toileting...special requirements for bathing assistance..." On 10/27/21 at 3:00 p.m., employee #4 was asked for documentation of housekeeping services provided during January through May 2021. She stated housekeeping staff had just implemented a task log two weeks ago detailing which rooms and cleaning tasks had been completed. They had kept no documentation showing the cleaning or specific tasks had been completed before the last two weeks. At 3:22 p.m., employee #2 was asked for documentation of housekeeping services provided for residents #3, #4, #5, #6 and #9. He stated he did not have documentation to confirm housekeeping services had been provided. He stated they only had two housekeepers currently and no housekeeper was assigned to hall 100. On 10/28/21 at 10:17 a.m., the administrator and LPN #1 were asked for documentation of the activities of daily living care provided that was requested on 10/27/21 for residents #3, #4, #5, #6 and #9. They stated they had not documented when the care was provided. They were asked how they ensured the care was provided. LPN #1 stated the service plan documented when the	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/28/2021
NAME OF PROVIDER OR SUPPLIER THE MANSION AT WATERFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1304	Continued From page 5 care would be provided. They were asked if the staff had documented when the care was provided for activities of daily living. They stated no. 6. Resident #7 had diagnoses which included dementia. The "Residency Agreement," dated 01/2021, read in part, "...Assisted living services...are available to each resident..." The "Resident Service Handbook," read in part, "...Dispute Resolution and Grievance Procedures. The resident and /or family representative should report any problem and/or grievance as soon as a concern arises to allow a speedy resolution before the problem escalates. The complaint should be made in writing, if possible, to the management for consideration and resolution. Problems and/or grievances may be reported...The issue will be investigated by management, or management's designee and the investigation results will be documented..." On 10/27/21 at 11:37 a.m., the administrator and LPN #1 were asked for any grievance documentation related to resident #3. No documentation was provided. On 10/28/21 at 09:00 a.m., the administrator was asked for any grievance documentation related to resident #3. The administrator stated she found no documentation regarding grievances filed prior to August, 2021. 7. The "Resident Service Handbook," dated 12/08/17, read in part, "...Our maintenance staff is responsible for the mechanical maintenance of the entire structure...Staff will maintain/repair all	C1304		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/28/2021
NAME OF PROVIDER OR SUPPLIER THE MANSION AT WATERFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1304	Continued From page 6 building-appliances and structural systems in the residence..." On 10/27/21 at 10:20 a.m., the AC unit in room 211 was observed to have a black substance on the vent of the AC unit. At 10:29 a.m., the maintenance supervisor was asked what the black substance was on the vent of the AC unit. He stated the black specks were mildew. He was asked if the AC unit should be dirty with mildew. He stated no. At 10:33 a.m., the AC unit in room 210 was observed to have a black substance on the vent of the AC unit. On 10/28/21 at 10:16 a.m., the AC unit in room 209 was observed to have a black substance on the vent of the AC unit. At 10:30 a.m., the AC unit in room 306 was observed to have a black substance on the vent of the AC unit. The director of maintenance was asked to observe rooms 306, 209 and 210. He was asked to identify the black substance on the AC vent. He stated it was mildew. He was asked if it should have been cleaned. He stated yes.	C1304		
C1505 SS=E	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	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/28/2021
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C1505	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a. medications were administered according to the physician's order for one (#7), and b. a prescription was obtained in a timely manner	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 8 for one (#9) of four sampled residents reviewed for administration of medications. The administrator identified 90 residents resided in the facility. Findings: 1. Resident #9 had diagnoses which included dementia and anxiety. A "Nurse Note," dated 10/21/21 at 1:46 p.m., read in part, "...family brought in Lexapro 5mg that was filled...outside pharmacy. Notified family that resident did not have current order for this medication. Asked for him to have HCP fax order. This nurse called asked for the order as it was not received..." A "Nurse Note," dated 10/21/21 at 1:49 p.m., read in part, "...Spoke with receptionist for [physician's name deleted] and she is going to have the nurse call this nurse back in regard to Lexapro 5mg 1 tab PO daily. This nurse gave receptionist our fax number to send the order..." Review of the clinical record did not include a physician's order for Lexapro. On 10/27/21 at 9:56 a.m., during an interview with the resident, the resident had tears running down her face. At 4:27 p.m., employee #5 was asked what the process was if a family member brought in a new medication for a resident. She stated she informed the nurse. She was asked for a list of the current medications for the resident. Review of the medication list did not include Lexapro.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/28/2021
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C1505	Continued From page 9 At 4:37 p.m., LPN #1 was asked the process if a family member brought in a new medication for a resident. She stated she requested a physician's order for the medication. She stated if she did not receive the order, she called the physician daily to check on it and she documented in the progress notes. She stated she had been waiting on a prescription for a medication for the resident since 10/21/21. She was asked why the resident was prescribed Lexapro. She stated the resident's family had taken her to the doctor, but the resident had not seemed depressed. She was asked if a resident should have to wait six days to start a medication for depression. She stated, "I wouldn't like it to be." She was informed of the resident being teary-eyed during an interview. 2. Resident #7 had diagnoses which included seizures and anxiety. The "Service Plan," effective 01/24/19, documented for the staff to administer medications as ordered everyday; staff to manage and reorder meds everyday. A "Physician's Order," dated 07/12/21, read in part, "...diazepam tab 2MG (VALIUM) 1/2 tablet by mouth every eight hours...for anxiety/seizure..." A "Medication Administration Record," dated 09/26/21 to 10/25/21, documented diazepam 2 mg every eight hours was not given 13 of 93 opportunities from 09/07/21 to 10/03/21. It was documented, "on hold until medication is available." On 10/27/21, at 4:45 p.m., CMA #3 stated the diazepam was not given when the MAR	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/28/2021
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C1505	Continued From page 10 documented, "on hold until medication is available." She stated any CMA or nurse administering medication would reorder the medications. Her process for reordering a medication would have been to wait until there were two tablets left for administration. At that time she would have faxed the reorder to the doctor. If the medication was not delivered the next day the CMA or nurse on shift should have called the doctor for the order reminder. She stated it had taken a while to get medications and the only thing they would have done was to keep calling the doctor. She stated they had no documentation related to the reordering process of medications. On 10/28/21, at 9:00 a.m., LPN #1 stated the process for reordering medications was to notify pharmacy or hospice by fax or phone. She was asked what happens if the medication was not delivered. She stated the only thing they would have done was to keep calling the pharmacy for the medication. At 12:03 p.m., LPN #1 was asked how long a resident with a diagnosis of anxiety should have had to wait for an anxiety medication to be administered. She stated no more than 24 hours.	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.	C1923			

Oklahoma State Department of Health

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C1923	Continued From page 11 (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 reviews, and interviews, the facility failed to complete a medication error report for one (#1) of four sampled residents reviewed for medication administration. The administrator identified 90 residents resided in the facility. Findings: The "Medication Errors/Adverse Events" policy, dated 10/2018, read in part, "...A medication error is defined as...the wrong medication...the wrong person...Procedure...An Internal Incident Report is completed and presented to the Director of Health and Wellness..." Resident #1 had diagnoses which included dementia. A "Nurse's Note," dated 03/24/20 at 11:02 a.m., read in part, "...Med error this morning about 9:30 a.m...Several of the drugs are drugs she was given...the ones she normally takes..."	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 12 On 10/28/21 at 9:34 a.m., LPN #1 was asked what the policy was regarding a medication error. She stated they completed a medication error report. She was asked to provide a copy of the medication error for this resident on 03/24/20. At 10:17 a.m., LPN #1 stated they did not find a medication error report for the error that had occurred on 03/24/20. She was asked how they investigated the medication error and how they addressed the cause of the error. No documentation was provided related to the investigation and resolution of the medication error.	C1923		
C1971 SS=E	310:663-19-4(b) POLICIES (b) The administrator of the assisted living center who becomes aware of abuse or neglect of a resident or misappropriation of a resident's property shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to investigate and report an allegation of abuse for one (#2) of four sampled residents reviewed for allegations of abuse. The administrator identified 90 residents resided in the facility. Findings:	C1971		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/28/2021
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C1971	Continued From page 13 The "Resident Protection and Abuse Prevention" policy, dated 03/2020, read in part, "...Employee Reporting Requirements...Employees are mandated reporters and upon knowledge of an abuse allegation has a duty to report to required regulatory agencies, law enforcement and the Executive Director/Designee...The Executive Director/Designee will initiate and direct investigations for abuse allegations and ensure residents are maintained in a safe environment..." Resident #2 had diagnoses which included pyelonephritis, osteoporosis, and congestive heart failure. An "Annual Assessment," dated 12/10/19, documented the resident was alert, confused at times, forgetful, and had good judgement. The "Progress Notes," dated 05/18/20, read in part, "...The resident had a vagal event on the 15th of the month. There were 2 aides present when this happened she did not fall then. Only outward appearance was a swelling in the right side of her neck with the red/purple color. This morning her arms are edematous (swollen) with the same red/purple color. Her sides, back and breasts are also covered with the same kind of red/purple color She was given a norco routine this am. Weekend records checked for additional falls there are none recorded. Cognitively she is searching for the right words which isn't like her...Sent to [hospital name deleted]..." The "Progress Notes," dated 05/22/20, read in part, "...Spoke with [resident name deleted] about incidents prior to leaving community...Someone was mean to her, she could not remember who...When asked what happened she said they	C1971		

Oklahoma State Department of Health

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C1971	Continued From page 14 took her to the bathroom and were mean to her...could not verbalize how they were mean to her..." The "Progress Notes," dated 07/04/20, read in part, "...Received email from [family member title deleted] stating that [resident name deleted] was "afraid" of a nightshift worker. Called [family member name deleted] and left a message requesting more information. Spoke with [resident name deleted], she stated that this certain "helper" was not nice to her one morning. Never stating she was afraid of her but did not want her coming back into her room. I informed [resident name deleted] that we would speak with the caregiver but at this time I could not guarantee this specific caregiver would not have to assist her int [sic] time..." The State Reportable incidents were reviewed. There was no documentation the three incidents had been investigated or reported to the Oklahoma State Department of Health. On 10/28/21 at 9:00 a.m., the administrator was asked what the facility's process was when a resident's family reported the resident was afraid of a staff member. She stated she would start an investigation immediately. She stated she would interview the resident, the staff member, and get statements from everyone. She stated she would suspend the worker until the investigation was completed. She was asked what the facility's process was when unknown bruising was found on a resident. She stated they would do the same investigation as previously discussed. The progress notes were reviewed with the administrator of the incidents involving resident #2. She was asked to provide documentation the incidents had been investigated and reported.	C1971		

Oklahoma State Department of Health

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C1971	Continued From page 15 At 12:00 p.m., the administrator was asked if they had documentation the three incidents had been investigated and reported. She stated she could not find any documentation.	C1971		



OKLAHOMA
State Department
of Health

Delivery via email to: ExecutiveDirector@MansionAtWaterfordSLC.com

November 23, 2021

License Number: AL5591

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

Survey Event ID: XPRU11

Dear Mr. Baggs:

On **October 28, 2021**, a complaint investigation was 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 **December 21, 2021**.

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.

Sincerely,

Tempal Killman

Digitally signed by Tempal

Killman

Date: 2021.11.23 10:18:11 -06'00'

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

enc



6110 N. Pennsylvania Avenue

Oklahoma City, OK 73112

Phone: 405.848.1817

Fax: 405.607.0006

To: LTC Enforcement@health.ok.gov

Fax:

From: Sharon Groves, Executive Director

Resident:

Date: 11/22/2021

Number of pages: 9

Comments: POC for survey conducted on
10-28-2021



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/13/2021

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: XPRU11

Date Survey Completed: 10/28/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304

Based on: observations, record reviews and interviews the facility failed to provide services according to the contract regarding activities of daily living, maintenance of air conditioner unit and the grievance process.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: *Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law*

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

- A. Residents 3, 4, 5 and 6 no longer reside in the community. Resident #9's ADL service delivery will be scheduled in the electronic medical record to be completed and documented by Staff.
- B. Residents 8, 10, 11 and 12 have been placed on a maintenance schedule for their air conditioner units.
- C. Resident #3 no longer resides in the community.

OSDH Response: Element accepted: Yes ☐ No ☐

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

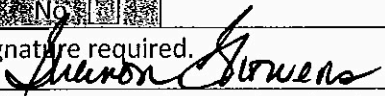
- A. Director of Health and Wellness and/or Assistant Director of Health and Wellness will review service plans to ensure ADLs are listed for service delivery in electronic medical record for residents.
- B. Maintenance Director and/or Houskeeping Supervisor will conduct tour of resident apartments to determine air conditioner units maintenance needs.
- C. Executive Director will notify residents of grievance process.

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. Director of Health and Wellness and/or Resident Care Director will train staff on documenting ADL tasks in the Resident electronic medical record.
- B. Maintenance Director and/or Houskeeping Supervisor will place resident apartment air conditioner units on a maintenance schedule.
- C. Executive Director will implement grievance procedure and maintain binder in Executive Director office.

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.	Executive Director will monitor performance by reviewing electronic medical record to ensure ADL service delivery. Executive Director will conduct rounds of resident living quarters to inspect housekeeping effectiveness and air conditioner unit maintenance and weekly 1:1 meetings with the Maintenance Director. A. Executive Director will conduct random review of electronic medical record of residents to ensure ADLs are being completed. Regional Director of Operations will review grievance log upon visit to community quarterly to ensure follow up. B. Adjustment to resident ADL needs will be reviewed at daily stand-up with service delivery issues addressed in the quality assurance process. C. Director of Health and Wellness and/or Resident Care Director will train staff on documenting ADL tasks in the Resident electronic medical record. Executive Director will maintain grievance binder in office for monitoring and review by Regional Director.		
OSDH Response: Element accepted: Yes ☒ No ☐			
5. On what date will corrective action be completed?	12/21/2021		
OSDH Response: Element accepted: Yes ☒ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)			Date Enter a date of signature. 11/22/2021
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: 11/13/2021

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: XPRU11

Date Survey Completed: 10/28/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: observations, record reviews, and interviews the facility failed to ensure medications were administered according to the physician's order and a prescription was obtained in a timely manner.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: *Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law*

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. Staff were in-serviced 11/16/2021 on resident rights with specific focus on medication administration.
2. Staff were in-serviced 11/16/2021 on medication ordering/refill protocol.

OSDH Response: Element accepted Yes ☐ No ☐

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

Current residents residing in the community had the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings. Staff training completed on 11/16/2021 to provide education on medication administration, missed medication protocol and medication ordering protocol.

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?

1. Director of Health and Wellness and/or Assistant Director of Health and Wellness will review electronic medication administration dashboard during daily routine to ensure compliance with medication administration.
2. Director of Health and Wellness and/or Resident Care Director will review electronic medication administration record to ensure compliance with medication ordering.

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.

ED and/or Director of Health and Wellness will be responsible for sustained compliance.

ED and/or designee will maintain documentation of completed inservice that was conducted on 11/16/2021 in community in-service binder.

Tracking and trending of future medication management compliance will be reported and reviewed during the QA meeting.

		Monitoring records will be attached to the QA meeting and maintained by the Executive Director to ensure compliance.	
OSDH Response: Element accepted: Yes ☒ No ☐			
5. On what date will corrective action be completed?		12/21/2021	
OSDH Response: Element accepted: Yes ☒ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. <i>Duane Elverson</i>	Date Enter a date of signature. <i>11/22/2021</i>	
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			
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Oklahoma State
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 11/13/2021

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: XPRU11

Date Survey Completed: 10/28/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923

Based on: observations, record reviews, and interviews the facility failed to complete a medication error report.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: *Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law*

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

1. Resident #1 no longer resides at the community.

Residents currently residing in the community had the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings. Staff were inserviced on 11/16/2021 to educate them on medication administration, missed medication protocol and medication error Incident reporting.

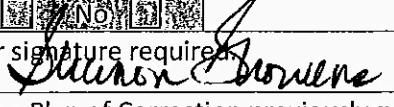
- Director of Health and Wellness and/or Assistant Director of Health and Wellness will review electronic medication administration dashboard to ensure compliance with medication administration.
- Director of Health and Wellness and/or Resident Care Director will ensure missed medications are reported following missed medication protocol.

ED and/or Director of Health and Wellness will be responsible for sustained compliance.

ED and/or designee will maintain documentation of completed inservice that was conducted on 11/16/2021 in community in-service binder.

Tracking and trending of future medication incident reports will be reported and reviewed during the QA meeting.

Monitoring records will be attached to the QA meeting and maintained by the Executive Director to ensure compliance.

OSDH Response: Element accepted: Yes ☐ No ☒		
5. On what date will corrective action be completed?		12/21/2021
OSDH Response: Element accepted: Yes ☐ No ☒		
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required 	Date Enter a date of signature. 11/22/2021
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: 11/13/2021

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: XPRU11

Date Survey Completed: 10/28/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1971

Based on: observations, record reviews, and interviews the facility failed to investigate and report an allegation of abuse.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: *Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law*

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 *[Signature]*

Administrator signature required

Date Enter a date of *11/22/2021*

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. Resident #2 no longer resides at the community.

Residents currently residing in the community had the potential to be affected by deficient practice. The community takes allegations of abuse seriously. Staff were inserviced on 11/16/2021 to educate them on reporting allegations of abuse and Incident Reporting.

1. Director of Health and Wellness and/or Executive Director will investigate allegations of abuse.
2. Executive Director and/or Director of Health and Wellness will report allegations of abuse to the appropriate parties and comply with OSDH 283 Incident Report Form.

ED and/or Director of Health and Wellness will be responsible for sustained compliance.
ED and/or designee will maintain documentation of completed inservice that was conducted on 11/16/2021 in community in-service binder.

Tracking and trending of future abuse allegation incidents will be reported and reviewed during the QA meeting.

OSDH 283 records will be maintained in the Community State Reportable Binder with investigation documents to ensure compliance.