

Delivery via email to: ExecutiveDirector@MansionAtWaterfordSLC.com

January 10, 2022

License Number: AL5591

Ms. Sharon Flowers, Administrator
The Mansion At Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

Survey Event ID: 6WYQ11

Dear Ms. Flowers:

On **December 22, 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
LICENSURE**

Facility: The Mansion at Waterford
Address: 6110 North Penn Ave
City, State, Zip: Oklahoma City, OK 73112
Provider #: AL5591
Complaint #: OK00057941
Investigation Date(s): 12/15/21 – 12/17/21 and 12/20/21 - 12/22/21

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The center failed to ensure residents' narcotics were not misappropriated.	US
2. The center failed to provide adequate medical care and failed to treat residents with dignity and respect.	US

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

An unannounced on-site investigation was initiated on 12/15/2021 at 4:00 p.m.

A sample of three residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

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

An investigation specific to misappropriation of narcotics was conducted.

Upon entry and throughout the survey, the medication staff was observed preparing medications for administration to residents.

During the survey, narcotics were counted and correct.

Cognitive residents were asked about receiving Ativan and Norco medications. They all stated they received what they needed.

Clinical records were reviewed and documented Ativan and Norco medications were administered according to the physician's order.

At the time of the investigation, there was no deficient practice related to misappropriation of narcotics.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to adequate medical care and treating residents with dignity and respect was conducted.

Upon entry and throughout the survey, the staff was observed interacting with residents appropriately and with care, repositioning and changing residents. The residents of the memory care and assisted living were observed clean with no unpleasant odors.

Cognitive residents were asked about staff. No resident complained of staff yelling.

Clinical records were reviewed and documented the wound treatment orders were completed by a nurse according to the physician's order.

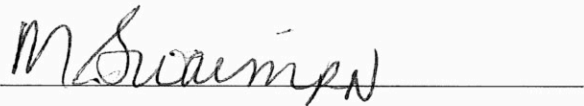
At the time of the investigation, there was no deficient practice related to skin breakdown or abuse.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. No further action is required.

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

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script, appearing to read 'M. Swaim', is written over a horizontal line.

Melissa Swaim RN

Date report completed: 12/29/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: The Mansion at Waterford
Address: 6110 North Penn Ave
City, State, Zip: Oklahoma City, OK 73112
Provider #: AL5591
Complaint #: OK00057969
Investigation Date(s): 12/15/21 – 12/17/21 and 12/20/21 – 12/22/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to administer medications as ordered.	S
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☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 12/15/2021 at 4:00 p.m.

A sample of three residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

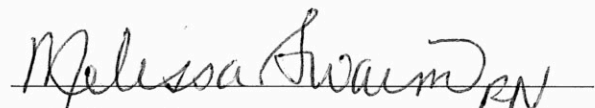
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

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 surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

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

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, reading "Melissa Swaim RN". The signature is written in a cursive style with a horizontal line underneath.

Melissa Swaim RN

Date report completed: 12/29/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: The Mansion at Waterford
Address: 6110 North Penn Ave
City, State, Zip: Oklahoma City, OK 73112
Provider #: AL5591
Complaint #: OK00058088
Investigation Date(s): 12/15/21 – 12/17/21 and 12/21/21 – 12/22/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to allow residents visitors, and failed to allow hospice staff to make visits.	S
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 12/15/2021 at 4:00 p.m.

A sample of three residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1502 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 surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

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

Thank you for bringing these concerns to our attention.

A handwritten signature in cursive script that reads "Melissa Swaim RN". The signature is written in black ink and is positioned above the printed name.

Melissa Swaim RN

Date report completed: 12/29/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: The Mansion at Waterford
Address: 6110 North Penn Ave
City, State, Zip: Oklahoma City, OK 73112
Provider #: AL5591
Complaint #: OK00058109
Investigation Date(s): 12/15/21 – 12/17/21 and 12/20/21 – 12/22/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to ensure the resident's right to access medical records, visitors of choice and failed to provide care according to the contract.	US
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 12/15/2021 at 4:00 p.m.

A sample of three residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

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

An investigation specific to access to medical records, visitors of choice and care according to the contract was conducted.

Upon entry and throughout the survey, visitors were observed being screened in at the front desk upon entering the center and when they exited.

Cognitive residents were asked about visitors of their choice. They all stated they had visitors of their choice.

Direct care staff were asked their job duties. They stated incontinent care, bathing, and other activities of daily living.

The licensed practical nurse (LPN) described the procedure to access medical records.

No resident or resident representative complained about not having access to medical records, choice of visitors or care according to the contract.

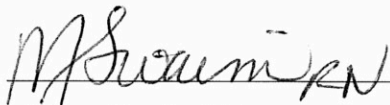
At the time of the investigation, there was no deficient practice related to access to medical records, choice of visitors or care according to the contract.

Determination Summary and Follow-Up Action:

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

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

Thank you for bringing these concerns to our attention.


Melissa Swaim RN

Date report completed: 12/29/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: The Mansion at Waterford
Address: 6110 North Penn Ave
City, State, Zip: Oklahoma City, OK 73112
Provider #: AL5591
Complaint #: OK00058167
Investigation Date(s): 12/15/21 – 12/17/21 and 12/20/21 - 12/22/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to provide services according to residents' contracts.	S
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☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 12/15/2021 at 4:00 p.m.

A sample of three residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 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 surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

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

Thank you for bringing these concerns to our attention.


Melissa Swaim RN

Date report completed: 12/29/2021

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 12/22/2021
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 (#OK00057941, OK00057969, OK00058088, OK00058109, and #OK00058167) were conducted on 12/15/21-12/17/21 and 12/20/21-12/22/21. Licensed practical nurse (LPN) #1 identified 76 residents resided in the center. Listed below are abbreviations used throughout this document. CDC (Centers for Disease Control and Prevention) eMAR (electronic medication administration record) ER (emergency department) LPN (licensed practical nurse) LTCA (long term care aide) mg (milligrams) OSDH (Oklahoma State Department of Health)	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.	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 12/22/2021
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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the center failed to provide all services specified in the resident's current service contract for an effective pest control program and weekly housekeeping for one (#1) of three sampled residents reviewed for pest control services. LPN #1 identified 76 residents resided in the center. Findings: The center's residency agreement, read in part, "...The community will provide weekly housekeeping...will offer regular routine apartment maintenance..." Resident #1 had diagnoses which included almost blind. The resident's "Comprehensive Assessment," dated 08/20/20, read in part, "...alert and oriented (person and place), confused at times with fair judgement and was almost blind..." The resident's "Care Plan," dated 10/01/21, read in part, "...hoh (hard of hearing) and difficulty with vision..." A weekly apartment cleaning schedule, dated October 18-22, 2021, read in part, "...[resident #1's room # deleted] roaches mess was cleaned up and sanitized..." The weekly apartment cleaning schedule did not identify the resident's room as being cleaned the week of October 24-30 and November 23-27,	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 12/22/2021
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 2021. A pest problem document with [exterminator company #1 name deleted], dated 11/03/21, read in part, "...roaches, [resident #1's room # deleted], kitchen..." A receipt with [exterminator company #2 name deleted], dated 11/11/21, did not identify the resident's room as being treated for cockroaches. A receipt with [exterminator company #2 name deleted], dated 12/09/21, did not identify the resident's room as being treated for cockroaches. On 12/16/21 at 11:20 a.m., during observation of resident #1's room, employee #5 was asked about pest control. Employee #5 stated, "We had a problem in this room with bugs (cockroaches)." There was dead cockroaches observed in the resident's shower, sink, in a bathroom drawer, in the bathroom cabinet and one next to the toilet. Employee #5 was asked about the dark debris between the refrigerator and kitchen cabinet in the resident's room. He stated, "It could be eggs or poop. They (cockroaches) poop a lot." There were also two dead cockroaches observed in the debris. Employee #5 stated, "She [resident #1] is blind." Employee #5 was asked about housekeeping. He stated housekeeping was provided once a week. On 12/21/21 at 4:30 p.m., LPN #1 and Administrator #2 were asked about housekeeping services provided when a resident was out of the center for any length of time. They both stated the resident's room should be cleaned the day 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 12/22/2021
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 resident left the center, even if it was not the resident's cleaning day, and then again upon the resident's return to the center.	C1304		
C1502 SS=E	310:663-15-1 & 63 OS 1-1918(B)(2) RESIDENT RIGHTS - Communications/Mail 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)(2) (2) Every resident shall have the right to have private communications, including telephonic communications and visits and consultations with a physician or an attorney, and meetings of family and resident groups or any other person or persons of the resident's choice, and may send and promptly receive, unopened, the resident's personal mail; This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the center failed to allow families entrance into the facility for visitation in the past three months for one (#8) of	C1502		

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 12/22/2021
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
C1502	Continued From page 4 three sampled residents reviewed for visitation. LPN #1 identified 76 residents resided in the center. Findings: During a combined provider call conducted by the OSDH on 03/17/21, visitation grids had been updated for non-nursing home centers. The provider calls were essential for non-nursing home centers to stay informed about the requirements for resident centered visitation. Provider calls were conducted bi-weekly during 2021. On 12/21/21 at 12:02 p.m., resident #8's representative was asked if they had ever been denied entrance into the center. They stated, "Yes, two times the middle of October and the next time was the beginning of November." They stated, after Thanksgiving they called the facility and were notified the visitation ban was not going to be lifted until 12/06/21. At 3:00 p.m., LPN #1 was asked when no visitation was allowed in the center. She stated, "Twice that I remember." She was asked which dates. She stated, they did not allow visitation 10/07/21 to 10/17/21 and 11/16/21 to 11/29/21. The corporate staff explained the center was following their company policy rather than the grid or information in the provider calls released by the OSDH and the CDC.	C1502		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care	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 12/22/2021
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
C1505	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the center failed to discontinue a blood pressure medication	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 12/22/2021
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
C1505	Continued From page 6 as ordered by the physician in a timely manner for one (#3) of three resident's whose medications were reviewed. LPN #1 identified 76 residents resided in the center. Findings: Resident #3 had diagnoses which included hypertension. On 11/24/21 at 8:46 a.m., the center received a fax from the resident's hospice to discontinue amlodipine (a medication used for hypertension) 2.5 mg, one tablet daily for hypertension. The eMAR documented the resident continued to be administered amlodipine 2.5 mg daily 11/24/21 through 11/26/21. On 12/21/21 at 11:35 a.m., LPN #1 was asked about the fax received on 11/24/21. She stated she did not see the fax until 11/25/21 and amlodipine was not removed from the eMAR until 11/27/21.	C1505		

Delivery via email to: ExecutiveDirector@MansionAtWaterfordSLC.com

January 25, 2022

License Number: AL5591

Ms. Sharon Flowers, Administrator
The Mansion at Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

Survey Event ID: 6WYQ11

Dear Ms. Flowers:

On **December 22, 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 **February 1, 2022**.

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

Sincerely,

Tempal Killman
Digitally signed by Tempal Killman
Date: 2022.01.25 10:49:53 -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@health.ok.gov

Fax:

From: Sharon Gowers

Resident:

Date: 1/24/2022

Number of pages: 7

Comments: Optional Plan of Correction
Survey Completed 12/22/2021



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/19/2022

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: 6WYQ11

Date Survey Completed: 12/22/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1304

Based on: observations, record reviews and interviews the facility failed to provide all services specified in the residents current service contract for an effective pest control program and weekly housekeeping. 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?

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

A. Residents #1 room was inspected by a pest control company and no live pests found. Resident room was placed on housekeeping schedule to monitor for pests.
B. Community has pest control contract in place that will service all areas of the community.

A. All residents have the potential to be affected by the deficient practice identified.
B. Maintenance Director and/or Housekeeping Supervisor will review with housekeepers how to identify pest issues in resident apartments and procedure for notification.
C. Residents will have routine weekly apartment cleaning, whether room is occupied or unoccupied.

A. Maintenance Director will conduct tour of resident apartments and community to identify other potential housekeeping issues and monitor for pest issues.
C. Residents will have routine weekly apartment cleaning, whether room is occupied or unoccupied.

Executive Director will monitor performance by conducting random room inspections for cleanliness and pest issues. Executive Director will discuss any concerns in standup with the Maintenance Director.

A. Executive Director will evaluate effectiveness of pest control and housekeeping by random survey of residents.

B. identified pest control issues will be reviewed at daily stand-up with service delivery issues addressed in the quality assurance process.

C. Pest Control contracts will be kept active and remain in the state book and available for viewing when asked. Houskeeping grievance issues will be maintained in the grievance binder.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

2/1/2022

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature Administrator signature required.
OAC 310:663-25-4(F)

Date Enter a date of signature.

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: 1/17/2022

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: 6WYQ11

Date Survey Completed: 12/22/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1502

Based on: interview and record reviews the center failed to allow families entrance into the facility for visitation in the past three months.

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

Administrator signature required.

Date Enter a date of signature.

OAC 310:663-25-4(F)

Sharon Brown

1/24/2022

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

Addendum Date

Enter a date of addendum.

Submitted by

Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.

Facility in Compliance by: Click here to enter a date.



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/17/2022

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: 6WYQ11

Date Survey Completed: 12/22/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: interview and record reviews the center failed to discontinue a blood pressure medication as ordered by the physician 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?

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

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

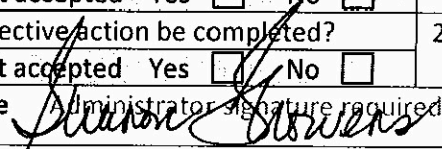
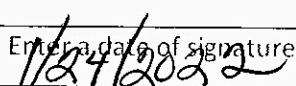
Current residents residing in the community had the potential to be affected by deficient practice. To date, no resident has experienced a negative outcome pertaining to the listed findings. Staff training completed on 11/16/2021 to provide education on medication administration, missed medication protocol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

- 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.
- Director of Health and Wellness and/or Resident Care Director will review electronic medication administration record to ensure compliance with medication ordering.

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?		2/1/2022	
OSDH Response: Element accepted Yes ☒ No ☐			
Administrator's Signature OAC 310:663-25-4(F)		Date Enter a date of signature.	
			
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.			

Delivery via email to: ExecutiveDirector@MansionAtWaterfordSLC.com

August 16, 2022

License Number: AL5591

Ms. Sharon Flowers, Administrator
The Mansion At Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

RE: Survey Event 6WYQ12

Dear Ms. Flowers:

Enclosed is the Assisted Living Center Licensure inspection deficiency report form, showing the summary of deficiencies noted during the revisit at your facility on **August 2, 2022**. These deficiencies remain uncorrected since your survey of **December 22, 2021**.

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 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 and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance.

However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

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

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

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

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

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;

- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

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

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

Sincerely,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 08/02/2022
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 A revisit was conducted from 08/01/22 through 08/02/22.	{C 000}		
{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

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 R-C 08/02/2022
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
{C1505}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed ensure an antibiotic therapy was discontinued after the stop date for one (#1) of one sampled residents reviewed for medications. Findings: Resident #1 had diagnoses which included urinary tract infection (UTI). A physician's order for Resident #1, dated 05/27/22, read in parts, "...Ciprofloxacin tab [tablet] 500 mg [milligrams] (CIPRO) 1 tablet by mouth every twelve hours for 7 days for UTI..." The end date on the physician's order was 06/02/22. A review of the medication administration records for May, June, and July 2022, documented the resident received the Cipro 05/27/22 through 07/23/22. The medication was administered an additional 51 days past the stop date of 06/02/22. There was no documentation to indicate why the resident continued to receive the antibiotic past the stop date. On 08/02/22 at 9:10 am, the DON stated "the antibiotics sometimes falls off & sometimes it doesn't. Staff has to let me know so that I can call the pharmacy. It should have stopped on the 7th day."	{C1505}		

Delivery via email to: ed@mansionatwaterfordslc.com

September 26, 2022

License Number: AL5591

Ms. Sharon Flowers, Administrator
The Mansion at Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

RE: Survey Event 6WYQ12

Dear Ms. Flowers:

On **August 2, 2022**, a Licensure follow-up inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **August 5, 2022**.

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

Respectfully,

Tempal Killman

Digitally signed by Tempal
Killman
Date: 2022.09.26 14:01:50 -05'00'

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

enc



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 8/29/2022

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: 6WYQ12

Date Survey Completed: 8/2/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: Based on record review and interview, it was determined the facility failed ensure an antibiotic therapy was discontinued after the stop date for one (#1) of one sampled residents reviewed for medications.

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

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

- Staff were in-serviced 8/5/2022 on resident rights with specific focus on medication administration.
- Staff were in-serviced 8/5/2022 on medication ordering/refill/stop date protocol.

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 8/5/2022 to provide education on medication administration, medication protocol, medication ordering protocol and medication stop date protocol and follow-up.

- Director of Health and Wellness and/or his designee will review electronic medication administration dashboard during daily routine to ensure compliance and medication administration.
- Director of Health and Wellness and/or his designee will review electronic medication administration record to ensure compliance with medication orders/administration.

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

ED and/or Director of Health and Wellness will maintain documentation of completed inservice that was conducted on 8/5/2022 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?		Click here to enter a date when corrective action will be completed.	
OSDH Response: Element accepted Yes ☐ No ☒			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature. 8/30/2022	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			



Oklahoma State Department of Health

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 R 02/23/2023
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 A revisit was conducted 02/23/23. All deficiencies from the 08/05/22 survey were cleared.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Delivery via email to: ed@mansionatwaterfordslc.com

February 28, 2023

USPS Tracking # 7021 2720 0002 0354 1525

FINAL DETERMINATION & CORRECTION NOTICE

License Number: AL5591

Ms. Sharon Flowers, E.D./Administrator
The Mansion At Waterford
6110 North Penn Avenue
Oklahoma City, OK 73112

Survey Event ID: 6WYQ13

Dear Ms. Flowers:

This letter corrects and replaces the FINAL NOTICE sent this morning dated February **28, 2023**. A revisit conducted **February 23, 2023**, revealed that your facility corrected deficiencies effective **August 5, 2022**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me 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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure:

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/23/2023
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 A revisit was conducted 02/23/23. All deficiencies from the 08/05/22 survey were cleared.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE