

Delivery via email to: ExecutiveDirector@MansionAtWaterfordSLC.com

August 17, 2022

License Number: AL5591

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

Survey Event ID: 7P1T11

Dear Ms. Flowers:

On **August 2, 2022**, 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, Ok
Provider #: AL5591
Complaint #: OK000059266
Investigation Date(s): 08/01 and 08/02/2022

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The facility failed to ensure they had effective infection control program to prevent the transmission of infection. (Covid)	US
2. The center failed to meet the nutritional needs of the residents in accordance with the recommended dietary allowances.	US
3. The center failed to meet the resident's nutritional status and maintain acceptable parameters of body weight.	US
4. The center failed to have adequate staff in the resident care areas.	US

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

An unannounced on-site investigation was initiated 08/01/2022 at 12:20 p.m.

A sample of 10 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 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 unsubstantiated related to this allegation.

Observations were made of staff through the survey entering and leaving Resident rooms identified as isolation rooms, including those with COVID-19. Staff were observed donning and doffing proper PPE including N-95 masks, gowns, gloves and eye protection. Observations were also made of staff washing their hands and using hand sanitizer. Each isolation room was observed with accessible PPE outside the room for staff to utilize.

Interviews were conducted with direct care staff including licensed nurses. All staff was knowledgeable on the proper PPE to use when a resident was in isolation for COVID-19 and other infectious disease. Staff identified the carts in the hallways with PPE as their source and stated the bins were filled before each shift. The employees also stated if at any time during the shift the bins ran out there were plenty of PPE in the supply room to restock them.

Resident interviews were conducted throughout the facility including Residents in isolation. Residents stated staff would wear gloves, gowns and eye protection if they had contracted COVID-19 and was in isolation. The residents stated they were encouraged to wear masks outside the room and wash and use hand sanitizer. There were no complaints from the residents regarding staff not wearing the proper PPE

At the time of the survey no deficient practice was found regarding PPE use and infection control practices.

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

An investigation specific to therapeutic diets and nutrition was conducted.

Observations were made during meal services. Dietary staff was observed serving residents the correct diets at the correct portions based on the menus. Diets being provided included regular, ground and pureed. The dietary staff had records of each diet order and was observed providing meals according to the diet orders.

A sample of four residents were reviewed for diet orders and nutritional parameters. Two had documented orders for pureed meals and two for regular. The sampled residents' weights were reviewed. All four residents had a weight gain over the past four months. Residents had interventions in place such as shakes for a nutritional supplement.

The sampled residents were observed during two meal services. The residents each received the correct diet ordered for them with each meal. Residents were observed throughout the survey receiving their nutritional supplement.

Interviews were conducted with three of the four sampled residents plus additional residents throughout the facility. All residents stated they received their meals as ordered from the doctor. There were no complaints from the resident regarding their meals and all stated the food was good. No residents complained of weight loss.

Interviews were conducted with direct care staff and kitchen staff regarding resident diet orders. Each staff member was able to identify the sampled residents with their correct diet order.

At the time of the survey there were no deficient practices related to nutrition and therapeutic diets.

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

An investigation specific to therapeutic diets and nutrition was conducted.

Observations were made during meal services. Dietary staff was observed serving residents the correct diets at the correct portions based on the menus. Diets being provided included regular, ground and pureed. The dietary staff had records of each diet order and was observed providing meals according to the diet orders.

A sample of four residents were reviewed for diet orders and nutritional parameters. Two had documented orders for pureed meals and two for regular. The sampled residents' weights were reviewed. All four residents had a weight gain over the past four months. Residents had interventions in place such as shakes for a nutritional supplement.

The sampled residents were observed during two meal services. The residents each received the correct diet ordered for them with each meal. Residents were observed throughout the survey receiving their nutritional supplement.

Interviews were conducted with three of the four sampled residents plus additional residents throughout the facility. All residents stated they received their meals as ordered from the doctor. There were no complaints from the resident regarding their meals and all stated the food was good. No residents complained of weight loss.

Interviews were conducted with direct care staff and kitchen staff regarding resident diet orders. Each staff member was able to identify the sampled residents with their correct diet order.

At the time of the survey there were no deficient practices related to nutrition and therapeutic diets.

Allegation #4 : Deficient practice was unsubstantiated related to this allegation.

Observations were made upon entrance to the facility and throughout the facility of staff responding to residents call for assistance. Staff was observed passing medications, providing meal assistance, and providing assistance with bathing and showering.

Record review of staff schedules and assignments were made. Staffing was documented in sufficient numbers to be adequate to care for residents in all areas.

Resident interviews were conducted with alert and oriented residents. There were no complaints of staffing and residents all stated they received care as needed and had no complaints.

Interviews were conducted with the direct care staff. All staff stated no complaints had been received from family and residents regarding care not being provided. The facility staff all stated they had no concerns with being able to provide care and services and stated they were always able to get their assignments completed and respond to residents call for assistance.

At the time of the survey there were no deficient practices related to adequate staffing.

Determination Summary and Follow-Up Action:

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.

Deficient practice was unsubstantiated for allegations 1-4. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read 'Ed Roth', with a horizontal line underneath it.

Ed Roth Preventative Medical Consultant

Date report completed: 08/03/2022

INVESTIGATIVE REPORT

Facility: The Mansion at Waterford
Address: 6110 North Penn Avenue
City, State, Zip: Oklahoma City, Ok
Provider #: AL5591
Complaint #: OK000059282
Investigation Date(s): 08/01/22 and 08/02/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to have and/or implement COVID-19 infection control procedures.	US
2. The center failed to ensure CPR was performed on a resident who had a full-code designation.	US
3. The center failed to ensure residents' medications were not misappropriated.	US
4. The center failed to ensure residents were free of medication errors	S
5. The center failed to have and or implement a pest control problem.	US
6. The center failed to provide qualified staff to administer treatments.	S

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

An unannounced on-site investigation was initiated 08/01/2022 at 12:20 p.m.

A sample of 10 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 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 unsubstantiated related to this allegation.

Observations were made of staff through the survey entering and leaving Resident rooms identified as isolation rooms, including those with COVID-19. Staff were observed donning and doffing proper PPE including N-95 masks, gowns, gloves and eye protection. Observations were also made of staff washing their hands and using hand sanitizer. Each isolation room was observed with accessible PPE outside the room for staff to utilize.

Interviews were conducted with direct care staff including licensed nurses. All staff was knowledgeable on the proper PPE to use when a resident was in isolation for COVID-19 and other infectious disease. Staff identified the carts in the hallways with PPE as their source and stated the bins were filled before each shift. The employees also stated if at any time during the shift the bins ran out there were plenty of PPE in the supply room to restock them.

Resident interviews were conducted throughout the facility including Residents in isolation. Residents stated staff would wear gloves, gowns and eye protection if they had contracted COVID-19 and was in isolation. The residents stated they were encouraged to wear masks outside the room and wash and use hand sanitizer. There were no complaints from the residents regarding staff not wearing the proper PPE

At the time of the survey no deficient practice was found regarding PPE use and infection control practices.

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

An investigation related to residents' code status and CPR was conducted.

A review of the sample residents' clinical records, was conducted. All residents code status was accurately documented in the chart. There was documentation for the sampled residents if they were found unresponsive that their code status was honored such as DNR or full code.

A review of the facility incident reports contained only one documented incident of a resident being unresponsive and CPR not being formed. There was additional documentation the resident had a DNR on file within a week of the even occurring.

Interviews were conducted with facility staff. All staff were knowledgeable of the residents' code status and the proper procedure for each status. When asked about the sampled residents they accurately identified the resident's ad DNR or full code. They also identified one sampled resident who had changed their code status to DNR just days prior to them being unresponsive.

Interviews were conducted with alert and oriented residents. All residents were able to identify their current code status and stated they were able to change it at any time if they wanted.

At the time of the survey, there was no deficient practice related to code status and CPR.

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

An investigation was conducted related to misappropriation of medications.

A review of the sample residents' clinical records, was conducted. There was no documentation to support misappropriation of medication. The surveyor completed four random narc counts and watched medications being passed with no errors were found.

Interviews were conducted with residents and there were no complaints of not receiving medications.

The employee listed in the allegation is no longer working at the facility.

Allegation #4 : Deficient practice was unsubstantiated related to this allegation.

Please see the Statement of Deficiencies 2567, L-tag 1505.

Allegation #5 : Deficient practice was unsubstantiated related to this allegation.

An investigation related to the presence and treatment of vermin was conducted. Observations were made in the kitchen, dining room, resident rooms, and other areas were made throughout the duration of the survey. No active signs of mice, cockroaches, and bedbugs were observed.

Record reviews showed receipts for monthly pest control, including roaches, mice, and bedbugs, along with other pests.

Staff and residents were interviewed and stated they had no complaints or seen any problems with pests in the facility.

At the time of this investigation no deficient practice was found related to pest control.

Allegation #6: Deficient practice was unsubstantiated related to this allegation.

Please see the Statement of Deficiencies 2567, N-tag 1437.

Determination Summary and Follow-Up Action:

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.

Deficient practice was unsubstantiated for allegations 1-4. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.



Ed Roth Preventive Medical Consultant

Date report completed: 08/10/2022

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 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
N 000	Initial Comments Complaint investigations (#OK00059282 and #OK00059266) was conducted on 08/01/22 and 08/02/22. Listed below are the abbreviations that will be used throughout this document: CMA Certified Med Aide	N 000		
N1437 SS=E	310:677-13-7 (b) (8) Skills And Functions Limitations. A certified medication aide shall not: (8) Administer medications or nutrition via nasogastric or gastrostomy tubes, or administer oral metered dose inhalers or nebulizers, unless the CMA has completed a Department-approved advanced training program and has demonstrated competency for such services; or This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure respiratory treatments were administered by a certified medication aide with advacned training in repirtatory treatments for two (#9 and #10) of two sampled residents reviewed for respiratory treatments.	N1437		

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 08/02/2022
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N1437	Continued From page 1 Findings: A facility policy titled "Med 27-Nebulizer use and cleaning" dated: 05/18/2022, read in part, " ... Any administration of nebulizer treatments must be done by a licensed professional or as allowed per state regulations". 1. Resident #9 had diagnosis which included shortness of breath. A physician's order for Resident #9, dated 07/07/22, read in parts, "...Ipratropium/Albuterol inh [inhalation] sol [solution] (duoneb) 1 vial via nebulizer four times a day for shortness of breath..." A review of the medication administration records (MAR) for Resident #9 documented the resident had received breathing treatments nine times in the Month of July 2022 by CMA #1. 2. Resident #10 had diagnosis which included chronic obstructive pulmonary disease (COPD). A physician's order for Resident #10, dated 11/22/21, read in parts, "...Symbicort inhaler 160/4.5 MCG [micrograms] (Budesonide-Formoterol Fumarate) 2 puffs by mouth 2 times a day long-term INH [inhalation] steroid use..." A review of the medication administration records (MAR) for Resident #10 documented the resident had received Symbicort inhaler 13 times in the Month of July 2022 by CMA #1. A review of the employee file for CMA #?? contained no documentation to indicate the CMA had advanced training to perform the nebulizer	N1437		

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 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
N1437	Continued From page 2 treatment to Resident #9 and the inhaler to Resident #10. On 08/02/22 at 10:30 a.m., the DON stated "the CMA #1 was allowed to administer nebulizer treatments per state regulations." On 08/02/22 at 10:48 a.m., the BOM stated "CMA #1 was not an ACMA."	N1437		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/02/2022
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C1505	Continued From page 3 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.	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 08/02/2022
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C1505	Continued From page 4 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: ExecutiveDirector@MansionAtWaterfordSLC.com

September 14, 2022

License Number: AL5591

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

Survey Event ID: 7P1T11

Dear Ms. Flowers:

On **August 2, 2022**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1437:** The plan of correction for C-1437 does not address how they will ensure that the CMA has the proper advanced training to provide the treatment and how they will monitor to ensure the certification and training remain current.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 8/29/2022

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: 7P1T11

Date Survey Completed: 8/2/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1437

Based on: Based on record review and interview it was determined the facility failed to ensure respiratory treatments were administered by a certified medication aide with advanced training in respiratory treatments for two (#9 and #10) of two sampled residents reviewed for respiratory treatments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to 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. CMA #1 was in-serviced on 8/2/2022 on facility policy and state regulation for administration of nebulizer treatments.
2. All CMA/ACMA staff were in-serviced on 8/5/2022 on facility policy and state regulation for administration of nebulizer treatments.

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 with orders for nebulizer treatments 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 8/2/2022 and 8/5/2022 to provide education on facility policy and state regulation for administration of nebulizer treatments.

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 his designee will review electronic medication administration dashboard during daily routine to ensure compliance with nebulizer treatment administration by qualified staff.

OSDH Response: Element accepted Yes ☐ No ☐

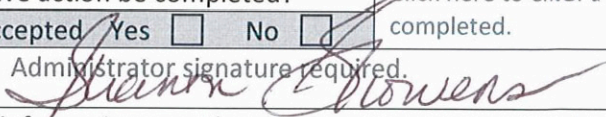
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- 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 inservices that were conducted on 8/2/2022 and 8/5/2022 in community in-service binder.

Tracking and trending of future nebulizer treatment administration will be reported and reviewed during the QA meeting.

		Monitoring records will be attached to the QA meeting minutes and maintained by ED 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 OAC 310:663-25-4(F)		Administrator signature required. 	Date 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
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: 7P1T11

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, revised medication protocol, medication ordering protocol and medication stop date protocol and follow-up.

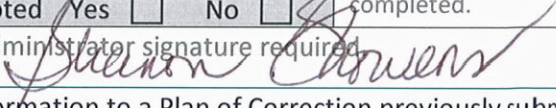
- Director of Health and Wellness and/or his designee will review electronic medication administration dashboard during daily routine to ensure compliance and medication administration.
- Director of Health and Wellness and/or his designee will review electronic medication administration record to ensure 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 OAC 310:663-25-4(F)	Administrator signature required 	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: ed@mansionatwaterfordslc.com

September 16, 2022

License Number: AL5591

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

Survey Event ID: 7P1T11

Dear Ms. Flowers:

On **August 2, 2022**, 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 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: 2022.09.16 11:21:59 -05'00'

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

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Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 8/29/2022

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: 7P1T11

Date Survey Completed: 8/2/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1437

Based on: Based on record review and interview it was determined the facility failed to ensure respiratory treatments were administered by a certified medication aide with advanced training in respiratory treatments for two (#9 and #10) of two sampled residents reviewed for respiratory treatments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to 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 ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

1. CMA #1 is no longer employed with the community.
2. All CMA/ACMA staff were in-serviced on 8/5/2022 on facility policy and state regulation for administration of nebulizer treatments.

1. Upon review, no current residents were affected by the deficient practice of employee #1.
2. Employee #1 is no longer employed with the community.
3. Residents requiring respiratory treatment are identified within their EHR/EMR and only staff licensed to as ACMA with respiratory qualifications will provide respiratory care.
4. Staff training completed on 8/2/2022 and 8/5/2022 to provide education on facility policy and state regulation for administration of nebulizer treatments.

1. An audit was completed of all care staff and information on licensing, advanced training and expiration dates was placed on a tickler file that the BOM will maintain.
2. BOM will review employee tickler file with credentials with the clinical team to ensure certifications and advanced training are kept up to date.
3. Advanced CMA's identified in audit will be reviewed to ensure they have the proper designated training for nebulizer treatments.
4. Director of Health and Wellness and/or his designee will perform random skill audit of Advanced CMA's and CMA's to ensure compliance with certifications.

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.		ED and/or Director of Health and Wellness will be responsible for sustained compliance. ED and/or designee will maintain documentation of completed inservices that were conducted on 8/2/2022 and 8/5/2022 in community in-service binder. Tracking and trending of future nebulizer treatment administration will be reported and reviewed during the QA meeting. Monitoring records will be attached to the QA meeting minutes and maintained by ED to ensure compliance.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		8/5/2022	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required OAC 310:663-25-4(F)		Date 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 9/15/2022		Submitted by Sharon Flowers	
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: ed@mansionatwaterfordslc.com

December 23, 2022

License Number: AI5591
Survey Event ID: 7P1T12

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

Dear Ms. Flowers:

Enclosed is the summary of deficiencies identified during the complaint investigation revisit conducted at your facility on **December 20, 2022**.

Please note the items listed in the deficiency column of the report. Your plan of correction and anticipated date of completion must be typed in the spaces provided. If additional space is needed, a supplemental sheet may be attached.

The criteria for an acceptable plan of correction are:

- A statement of exactly how the facility has or intends to correct each deficiency.
- The method of correction. This includes who is responsible for the correction.
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This is part of your quality assurance plan. At the revisit, the quality assurance plan shall be reviewed to determine the earliest date of compliance. If there is no finding of continuing non-compliance, **evidence of quality assurance being implemented will be required to establish a correction date earlier than the date of the revisit.**
- A reasonable date of correction, which will normally be within 60 days of this notice.

NOTE: Please avoid naming individuals, business firms or brand names on the enclosed form since it is a public disclosure form.

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **Failure to submit an acceptable Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process.** Please retain a copy of this completed form for your files.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/20/2022
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
{N 000}	Initial Comments	{N 000}		

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 12/20/2022
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 re-visit was conducted on 12/19/22 and 12/20/22. The following abbreviations will be used throughout this document: A-fib - atrial fibrillation DON - director of nursing eMAR - electronic medication administration record GERD - gastroesophageal reflux disease HTN - hypertension LPN - licensed practical nurse MAR - medication administration record mg - milligrams	C 000		
{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 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	{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 12/20/2022
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 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 record review and interview the facility failed to ensure medications were administered according to physician's orders for two (#6 and #11) of three sampled residents reviewed for medication administration. The DON identified 87 residents resided in the facility. Findings: The facility's "Medication Administration" policy, dated 02/2019, read in part, "...The Community staff will comply with resident's practitioner orders, state laws and regulations may be applicable. If medication is omitted or not given, the MAR/eMAR is circled and an explanation for omission is documented on the MAR/eMAR. 1. Resident #11 had diagnoses which included dementia with behavioral disturbance, depression, A-fib, GERD, HTN, venous	{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 R 12/20/2022
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 2 thrombosis, edema, and allergies. Resident #11's initial admit assessment, dated 05/31/22, read in parts, "... Medication Management...Staff re-orders medication...and Oral medications administered by staff...Mental Status: Orientation not determined or disoriented occasionally..." Resident #11's MAR, dated 06/03/22 through 06/08/22, documented the following medications were circled: Donepezil 10mg two times a day for dementia, Eliquis 5mg two times a day for venous thrombosis, Prozac 10mg to take with 20mg one time a day, Flonase twice a day for allergies, Lasix 20mg one time a day for edema, Metoprolol Succ ER tab 50mg two times a day for HTN, and Protonix 40mg one time a day for GERD. Resident #11's medication notes, dated 06/03/22 through 06/08/22, documented the circled medications were "On hold until medication is available." Resident #11's MAR, dated 06/23/22, documented donepezil was last administered on 06/23/22. Resident #11's "Progress Note," dated 11/30/22, read in part, "...[resident's family] asked facility why and how the medication [donepezil] was stopped on June 23, 2022, ED voiced to [resident's family] that a investigation would be started ..." Resident #11's "Progress Note," dated 11/30/22, read in part, "... Physician notified...pharmacy mistakenly stopping resident's [donepezil]...medication order..."	{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 R 12/20/2022
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 3 Resident #11's "Progress Note," late entry dated 12/03/22, documented a new order for donepezil. On 12/20/22 at 9:30 a.m., the DON and LPN #1 were asked how they ensured medications were available. The DON stated they signed for the medications. They were asked how they ensured the medications were administered as ordered. The DON stated they followed the MAR. The DON and LPN #1 were asked what the circles on the MAR indicated. LPN #1 stated it could indicate the medications were missed or refused. On 12/20/22 at 11:55 a.m., LPN #1 was asked if there was documentation Resident #11's donepezil had been administered from 06/23/22 to 12/04/22. They stated they were not aware of any documentation. 2. Resident #6 had diagnoses which included Parkinson's disease, GERD, constipation, ear wax build up, anemia, and urinary retention. Resident #6's "Medication List," documented the resident had physician orders for the following: ferrous sulfate, Finasteride, Nuplazid, Pantoprazole, stool softner, and ear drops solution. Resident #6's assessment, dated 08/29/22, the resident had "major forgetfulness and confusion." It documented the staff re-ordered medications, and oral medications were administered by staff. Resident #6's MAR, dated 12/13/22, documented blanks for the morning doses of Nuplazid, Pantoprazole, stool softner, ferrous sulfate, finasteride, and ear drops.	{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 R 12/20/2022
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 4 On 12/20/22 at 9:30 a.m., the DON and LPN #1 were asked what blanks on the MAR indicated. The DON stated the medication was not due or wasn't administered. On 12/20/22 at 10:23 a.m., LPN #1 was asked if Resident #6 received their medications on 12/13/22. They stated they didn't see the medications had been given.	{C1505}		

Delivery via email to: ed@mansionatwaterfordslc.com

January 4, 2023

License Number: AL5591

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

RE: Survey Event 7P1T12

Dear Ms. Flowers:

On **December 20, 2022**, a Licensure revisit 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 will be corrected and you will be in substantial compliance by **January 6, 2023**.

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: 2023.01.04 16:09:03 -06'00'

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

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Oklahoma State
Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/4/2023

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: 7P1T12

Date Survey Completed: 12/20/2022

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: Based on record review and interview the facility failed to ensure medications were administered according to physician's orders for two (#6 and #11) of three sampled residents reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to cited deficiencies do not constitute an admission or agreement by the provider of the truth or facts alleged or the 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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

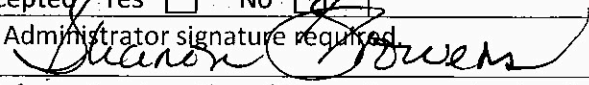
- Staff will be in-serviced by Director of Health and Wellness and/or his designee on resident rights with specific focus on medication administration.
- Staff will be in-serviced by Director of Health and Wellness and/or his designee on medication ordering/refill/stop date protocol.

Current residents residing in the community had the potential to be affected. To date, no resident has experienced a negative outcome pertaining to the the listed findings. Staff training completed by Director of Health and Wellness and/or his designee, to provide education on medication administration, missed 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 inservices that were conducted.

c. How monitoring records will be kept to evidence the correction.		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?		1/6/2023	
OSDH Response: Element accepted Yes ☒ No ☐			
Administrator's Signature Administrator signature required OAC 310:663-25-4(F) 		Date 1/4/2023	
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If 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: ed@mansionatwaterfordslc.com

USPS Tracking #7021 2720 0002 0354 1471

FINAL DETERMINATION

February 28, 2023

License Number: AL5591

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

Survey Event ID: 7P1T13

Dear Ms. Flowers:

A revisit conducted **February 23, 2023**, revealed that your facility corrected deficiencies effective **January 6, 2023**.

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-C 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
{N 000}	Initial Comments	{N 000}		
{C 000}	INITIAL COMMENTS A revisit was conducted 02/23/23. All deficiencies from the 12/20/22 survey were cleared.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE