OKLAHOMA
State Department
of Health

Delivery via email to: ed@mansionatwaterfordslc.com

December 30, 2022

License Number: AL5591

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

Survey Event ID: ZPTB11

Dear Ms. Flowers:

On **December 20, 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,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **The Mansion at Waterford**
Address: **6110 North Penn Avenue**
City, State, Zip: **Oklahoma City, OK, 73112**
Provider #: **AL5591**
Complaint #: **OK00059922**
Investigation Date(s): **12/19/22 and 12/20/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to establish and maintain an Infection Control Program to provide a safe, sanitary environment and to help prevent the development and transmission of dieseas and infection.	**US**

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

An unannounced on-site investigation was initiated on 12/19/2022 at 12:30 pm.

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

The investigation was conducted following standards set by the 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 infection control was conducted.

Observations were made of staff wearing mask, screening in when coming of shift, and performing hand hygiene throughout the investigation. No staff were observed to be coughing or having congestion.

Residents stated that they had been notified, as required by guidance of any positive person in the building.

Staff stated they notify residents/families of positive covid exposure. Staff stated last covid positive was July 2022

Record review did not document any recent confirmed covid positive cases.

Determination Summary and Follow-Up Action:

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.

Sherry McKee

_____

Sherry McKee, LPN Clinical Health Facility Surveyor

Date report completed: 12/20/2022

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **The Mansion At Waterford**
Address: **6110 North Penn Avenue**
City, State, Zip: **Oklahoma City, OK, 73112**
Provider #: **AL5591**
Complaint #: **OK00059906**
Investigation Date(s): **12/19/22 and 12/20/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have an effective program for ensuring medications were re-ordered in a timely manner, and medication reconciliations were performed according to standards of practice.	S

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

An unannounced on-site investigation was initiated on 12/19/2022 at 1230:p.m.

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

The investigation was conducted following standards set by the 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.

Theresa Williams

Theresa Williams, RN, Clinical Health Facility Surveyor

Date report completed: 12/20/2022

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS Complaint investigations (#OK00059906 and #OK00059922) was conducted from 12/19/22 through 12/20/22. The following abbrevations will be used through out this document: A-fib - atrial fibratlation DON - director of nursing eMAR - electronic medication administratiion 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.	C1505		

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C1505	Continued From page 1 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 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,	C1505		

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

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

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C1505	Continued From page 2	C1505		

depression, A-fib, GERD, HTN, venous 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..."

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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		

OKLAHOMA
State Department
of Health

Delivery via email to: ed@mansionatwaterfordslc.com

January 9, 2023

License Number: AL5591

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

Survey Event ID: ZPTB11

Dear Ms. Flowers:

On **December 20, 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 **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: 2023.01.09 15:36:11 -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 Creating a State of Health 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:** ZPTB11 **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	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	1. Staff will be in-serviced by Director of Health and Wellness and/or his designee on resident rights with specific focus on medication administration. 2. Staff will be in-serviced by Director of Health and Wellness and/or his designee on medication ordering/refill/stop date protocol.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Current residents residing in the community had the potential to be affected. 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, mediation ordering protocol and medication stop date protocol and follow-up.
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 and mediation administration. 2. Dirrector of Health and Wellness and/or his designee will review electronic medication administration record to ensure compliance with medication orders/administration.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and	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.

OKLAHOMA
State Department of Health

Delivery via email to: ed@mansionatwaterfordslc.com

February 28, 2023

License Number: AL5591

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

Survey Event ID: ZPTB12

Dear Ms. Flowers:

On **February 23, 2023,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 20, 2022,** have now been corrected effective **January 6, 2023.**

If you have any questions concerning the information in this letter, please contact me at (405) 426-8200.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5591	A. BUILDING: _____ B. WING _____	R-C 02/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS A 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