

Delivery via email to: ed@mansionatwaterfordslc.com

April 5, 2023

License Number: AL5591

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

Survey Event ID: UWFB11

Dear Ms. Flowers:

On **March 23, 2023**, 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.

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

INVESTIGATIVE REPORT

Facility: The Mansion at Waterford
Address: 6110 N Penn Ave
City, State, Zip: OKC, OK 73112
Provider #: AL5591
Complaint #: OK00060029
Investigation Date(s): 03/02/23, 03/15/23-03/16/23, 03/20/23, and 03/22/23-03/23/23

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to follow nursing standards of practice, policies, and procedures by not monitoring residents every two hours and provided incontinent care in the floor after a fall.	S
2. The center failed to ensure residents were assessed post-fall.	S
3. The center failed to ensure residents/residents' representatives were notified of a change in condition.	S

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

An unannounced on-site investigation was initiated 03/02/2023 at 3:00 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1512 and C1304 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1512 for details.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1512 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1-#3. The facility will be required to submit a plan of correction (POC). The survey team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read "M Swaim RN", is written over a horizontal line.

Melissa Swaim RN

Date report completed: 03/29/2023

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS Complaint investigation (#OK00060029) was conducted 03/02/23, 03/15/23 and 03/16/23, 03/20/23, 03/22/23 and 03/23/23. The following abbreviations will be used throughout this document: ACMA-advanced certified medication aide A-fib-atrial fibrillation CNA-certified nurse aide ED-emergency department EMAR-electronic medication administration record eval-evaluation HTN-hypertension L-left LLE-left lower extremity LLL-left lower leg LPN-licensed practical nurse MAR-medication administration record mg-milligram ODH-Oklahoma State Department of Health PO-by mouth POA-power of attorney RN-registered nurse tx-treatment	C 000		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to coordinate all assessments with a signature by a registered nurse or the resident's	C 542		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 542	Continued From page 1 personal physician for two (#1 and #7) of two sampled residents whose comprehensive assessments were completed by an LPN. Findings: A "Job Description," dated January 2017, read in part, "...responsible for assessment of resident health status for both new and existing residents...the development of the care or service plan..." Resident #1's "Recommended Assisted Living Resident Assessment Form," dated 06/12/22 was signed by former LPN #4. Resident #7's "Recommended Assisted Living Resident Assessment Form, " dated 01/19/23 was signed by former LPN #4. On 03/16/23 at 5:16 p.m., LPN #2 stated there was no RN during gaps of employment from 01/15/23 through 01/30/23. An RN was not available to ensure resident and staff oversight. On 03/23/23 at 1:43 p.m., during (Res #7) record review, LPN #2 stated the comprehensive assessment form should have been completed and signed by an RN or the resident's physician. On 03/23/23 at 2:57 p.m., during (Res #1) record review, LPN #2 stated the annual comprehensive assessment form should have been completed and signed by an RN or the resident's physician.	C 542		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all	C1304		

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C1304	Continued From page 2 services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure all services specified in the resident's current service contract were provided for one (#1) of three sampled residents. A "residency agreement," dated 06/06/20, read in part, "...assistance with personal care...scheduled cueing for toileting...periodic checks during the night...observation...We welcome You as a new resident and want You to know that Your safety, happiness, and personal rights are of the utmost importance to us..." Resident #1 admitted to the center 06/06/20 with diagnoses to include chronic atrial fibrillation, atherosclerotic heart disease, aphasia, and abnormalities of gait. An annual "comprehensive assessment," dated 06/16/22, read in part, "...alert, oriented x 2 (person, place), forgetful with good judgement...Resident mobility fair with wheelchair until left heel improves...full range of motion...not	C1304		

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C1304	Continued From page 3 weight bearing due to history of stroke...ambulatory with staff assistance: wheelchair...one person assist bathing, dressing, transferring, toileting...toileting ability: assist with adult briefs...good ability to communicate...interviewable..." A "service plan," dated 07/21/22, read in part, "...effective date: 06/08/20...Alerts: Fall Risk...Safety Checks...Resident may not have a sense of what is safe. Check frequently and re-direct if needed...Supervision: Requires...Recent stroke history. will require supervision...Night Care: Periodically...check for safety, General well-being. Toilet if necessary...effective date: 07/21/21...Toileting: Total incontinence...incontinent of bowel and bladder...one person assist with changing depends, soiled clothes and linens..." A "Service Checkoff List," dated October 2022, read in part, "...Safety checks...resident may not have a sense of what is safe. Check frequently and re-direct if needed..." There were no initials to indicate safety checks were provided during the 3-11 shift 10/15/22. On 03/16/23 at 4:46 p.m., during record review, LPN #2 stated if it's not documented it didn't get done.	C1304		
C1505 SS=H	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B	C1505		

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C1505	Continued From page 4 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: On 03/22/23, an Immediate Jeopardy (IJ) situation was determined to exist related to the center's failure to ensure the pharmacy and the center verified anticoagulant medication and monitor resident received physician ordered medication.	C1505		

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C1505	Continued From page 5 At 2:49 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. At 3:12 p.m., LPN #1 and LPN #2 were notified of the IJ situation. On 03/23/23 at 10:37 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented: "Process for medication review to ensure resident received physicians ordered medications: 1. Center notified alleged pharmacy and demanded they come do a medication audit. This was completed 02/24/23. 2. Center contracted with 3rd party pharmacy to conduct an independent mediation audit. This was completed 02/23/23. 3. All items identified in the pharmacy audit were corrected by 03/06/23. no medication errors identified in audit resulted in negative resident outcome. 4. Center gave formal notice to alleged pharmacy to terminate pharmacy agreement due to cause. 5. Center contracted with new pharmacy to provide medications to community. Residents and family notified of pharmacy change. 6. Executive Director will implement a secondary clinical review to medication admission orders/start up orders. a) There will be two clinicians that will utilize the three-way process/stamp. This is an ongoing visual safety check of medication review before the medication(s) are entered into the EMAR/Physician Orders. Process to notify center's RN for assessments:	C1505		

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C1505	Continued From page 6 1. Executive Director and/or designee will notify RN via phone call and/or email when assessments need review and signature. 2. A designated file has been established in the health and wellness office for RN signatures. 3. Center nurse will monitor file to ensure documents needing signature are reviewed and signed monthly with monthly physician orders. Process for hospice client to be sent to hospital in timely manner: 1. Center will collaborate with hospice provider, resident and family to ensure if resident needs hospital attention, resident is sent out. Center will advocate on behalf resident if there is an urgent need for medical attention. b) A timely manner is dependent on several factors including but not limited to: EMSA response time, family choice, resident choice. In this case, when hospice refused to send resident out, center nurse and/or clinical designee will advocate on resident behalf for evaluation and treatment at the hospital." The IJ was lifted, effective 03/23/23 at 11:59 a.m., when all components of the plan of removal had been completed. The deficiency remained at a level of actual harm at a pattern. Based on record review and interview, the center failed to ensure the pharmacy and the center verified anticoagulant medication and monitor resident received physician ordered medication for one (#7) of one sampled residents who missed 16 doses of anticoagulant therapy and received a left above the knee amputation. Findings:	C1505		

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C1505	Continued From page 7 A "residency agreement," dated 01/19/23, read in part, "...We welcome You as a new resident and want You to know that Your safety, happiness, and personal rights are of the utmost importance to us. The Community has a Resident's Bill of Rights...Appendix B...Every resident shall have the right receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community..." Resident #7 admitted to the center 01/19/23 with diagnoses to include Factor V Leiden (a mutation of one of the clotting factors in the blood. This mutation can increase your chance of developing abnormal blood clots, most commonly in your legs or lungs. Most people with factor V Leiden never develop abnormal clots.) sinus sick syndrome (a type of heart rhythm disorder), pacemaker, and coronary artery disease. An admission "comprehensive assessment," dated 01/19/23, read in part, "... (Resident #7) was alert, oriented x 3 (person, place, time.) Resident #7 was confused at times with good judgement..." A "move-in" assessment, dated 01/19/23, read in part, "...Does the resident have history of circulatory disorders? Yes..." A "medication self administration" assessment, dated 01/19/23, read in part, "...does resident self-administer medication? No..." A "healthcare practitioner move-in orders," dated 01/19/23, read in part, "...resident requires assistance with medications by qualified employees..."	C1505		

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C1505	Continued From page 8 An "assisted living admission order form," dated 01/19/23, read in part, "...Xarelto 15 mg, PO daily, anticoagulant..." Xarelto 15 mg, PO daily was not documented on the January or February 2023 MAR. A "hospice certification and plan of care," read in part, "...state of care date: 01/20/23..." A "sign in" sheet, dated 02/04/23, read in part, "... (hospice) LPN...time in 11:15 (p.m.)...time out 12:39 (a.m.)...comments...Sore to LLL (left lower leg), increased bruising..." A "visit note report," dated 02/04/23, read in part, "...patient unable to verbalize...mental/cognitive assessment performed...lethargic...decreased strength...upper and lower bilateral extremities...patient care due to unexpected status change...LLL is badly bruised, cool to touch...continue to monitor left lower leg..." A "sign in" sheet, dated 02/05/23, read in part, "... (hospice) RN...time in 9:32 (a.m.)...time out 10:20 (a.m.)...L(left) leg swollen, discolored, sent to (hospital)..." A "visit note report," dated 02/05/23, read in part, "...uncomfortable because of pain...pain score: 7...left leg...stabbing...constant...transitional movement...left leg discolored, painful...cardiovascular assessment performed...transfers bed to chair with maximal assistance...discharge initiated by family...Narrative: prn visit for leg changes. Upon arrival, pt in bed, restless, occasionally moaning, c/o left leg pain. Left leg dark. Discolored, cool to touch, unable to palpate pedal pulse. Blistering noted, two open areas noted..."	C1505		

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C1505	Continued From page 9 A "coordination of care third party form," dated 02/05/23, read in part, "...L lower leg discoloration, cool to touch, painful. Sent resident to (hospital) for eval and tx..." An Emergency Medical Services Authority (EMSA), dated 02/05/23, read in part, "...primary impression: generalized weakness...secondary impression: fatigue...chief complaint: left leg discoloration...discolored and cold on left leg below knee..." A "hospital record," dated 02/05/23 at 10:30 a.m., read in part, "... (Resident #7) ED arrival...presents with cold and insensate (lacking physical sensation) left lower extremity, with reported bilateral lower extremity pain...left worse than right over the last 4 days...it appears his Xarelto was discontinued inadvertently...reportedly has been off Xarelto since Jan 19th..." A "hospital record," dated 02/06/23, read in part, "...vascular surgery...critical limb ischemia (a condition in which blood flow (and thus oxygen) is restricted or reduced in a part of the body) of left lower extremity...left above knee amputation..." On 03/16/23 at 3:48 p.m., LPN #2 stated the missing medication resulted in a DVT (deep vein thrombosis-a medical condition that occurs when a blood clot forms in a deep vein.)	C1505		
C1512 SS=E	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be	C1512		

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C1512	Continued From page 10 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own	C1512		

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 03/23/2023
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C1512	Continued From page 11 interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed protect one vulnerable adult (#1) of one sampled resident from neglect and/or mental abuse/mental anguish post fall. Findings: An "Internal Incident Reports and State Reports," policy and procedure, dated 07/19, read in part, "...The Internal Incident Report is to be completed for all unusual occurrences...and incidents. The staff member involved in...the incident will complete the Internal Incident Report...Notify the Director of Health and Wellness or Executive Director of the incident as soon as possible following the incident. The Director of Health and Wellness or designee will notify the appropriate parties...The Director of Health and Wellness and Executive Director will investigate the incident...Incidents are reported to the resident's family/responsible party. Document the date and time the report was made to the	C1512		

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C1512	Continued From page 12 family/responsible party in the narrative charting section of the resident's chart..." Resident #1 A "Resident Incident Report," dated 10/16/22, read in part, "...slid to floor...bedroom...didn't remember what happened...no vital signs documented...Staff had to get more assistance to get resident back in bed. Vital signs were not taken at time of incident...manager on duty (former LPN #3)...no other notifications documented at the time of the incident..." An "ODH Form 283," dated 10/16/22, read in part, "...Allegations of Abuse/Mistreatment...Resident was lying on the floor with his bedding. Resident had experienced an incontinent episode. While the resident was on the floor, (former) CNA (#1) provided incontinent care. (former) CNA (#1) then sought assistance to return resident to bed. Resident was assisted back to bed..." No staff obtained vital signs at the time of the incident. There was no documentation by a nurse an assessment was completed post fall. A "progress note," dated 10/21/22, read in part, "...Incident report was not done at the time of incident, and vitals were not taken...based on statements made by family and staff..." The center did not notify the family of the fall. On 03/16/23 at 4:46 p.m., during record review, LPN #2 stated if it's not documented it didn't get done.	C1512		

Oklahoma State Department of Health

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C1512	Continued From page 13 On 03/20/23 at 3:55 p.m., the Administrator stated during her investigation (former LPN #3) did not delegate vital signs or obtain vital signs, and did not assess the resident for injury or pain. They just got another employee (total of three) to help assist the resident back to bed.	C1512		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		

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C1911	Continued From page 14 This Rule is not met as evidenced by: Based on record review and interview, the center failed to report within one Department business day of the reportable incident's discovery for an allegation of abuse/mistreatment for one resident (#1) of three residents sampled with reportable events. Findings: An "Incident Reports and State Reports," policy and procedure, dated 07/19, read in part, "...Oklahoma...All report to the Department shall be made via facsimile or by telephone within one Department business day of the reportable incident's discovery..." An incident report for resident #1, read in part, "...Incident Date, 10/16/22 (Sunday)...Allegations of Abuse/Mistreatment...lying on floor with bedding...incontinent care provided...assistance to return resident to bed..." The initial report was sent to OSDH, via facsimile (fax) on 10/19/22, three business days after the incident. On 03/16/23 at 3:54 p.m., during review, LPN #2 stated the intital incident form was dated (Sunday) 10/16/22, but was not faxed to the Department until (Wednesday) 10/19/22 outside the twenty-four hour parameter.	C1911		

REPORT REVISED NOTICE

Delivery via email to: ed@mansionatwaterfordslc.com

April 10, 2023

Survey Event ID: UWFB11

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

Dear Ms. Flowers:

On **March 23, 2023**, agents from our office concluded an investigation at your facility. You were advised of the findings of that investigation in our notice of **April 5, 2023**.

The original 2567 report has been revised during a review of this case. A copy of the corrected 2567 report is included to correct the deficient practice/tag reference. Deficiencies identified during the investigation are not affected by these corrections and a new plan of correction is not required. The corrected investigation report is being provided for your records and no additional action on your part is required at this time.

If we can be of any further assistance, please contact us at 405-426-8200.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS Complaint investigation (#OK00060029) was conducted 03/02/23, 03/15/23 and 03/16/23, 03/20/23, 03/22/23 and 03/23/23. The following abbreviations will be used throughout this document: ACMA-advanced certified medication aide A-fib-atrial fibrillation CNA-certified nurse aide ED-emergency department EMAR-electronic medication administration record eval-evaluation HTN-hypertension L-left LLE-left lower extremity LLL-left lower leg LPN-licensed practical nurse MAR-medication administration record mg-milligram ODH-Oklahoma State Department of Health PO-by mouth POA-power of attorney RN-registered nurse tx-treatment	C 000		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to coordinate all assessments with a signature by a registered nurse or the resident's	C 542		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 542	Continued From page 1 personal physician for two (#1 and #7) of two sampled residents whose comprehensive assessments were completed by an LPN. Findings: A "Job Description," dated January 2017, read in part, "...responsible for assessment of resident health status for both new and existing residents...the development of the care or service plan..." Resident #1's "Recommended Assisted Living Resident Assessment Form," dated 06/12/22 was signed by former LPN #4. Resident #7's "Recommended Assisted Living Resident Assessment Form," dated 01/19/23 was signed by former LPN #4. On 03/16/23 at 5:16 p.m., LPN #2 stated there was no RN during gaps of employment from 01/15/23 through 01/30/23. An RN was not available to ensure resident and staff oversight. On 03/23/23 at 1:43 p.m., during (Res #7) record review, LPN #2 stated the comprehensive assessment form should have been completed and signed by an RN or the resident's physician. On 03/23/23 at 2:57 p.m., during (Res #1) record review, LPN #2 stated the annual comprehensive assessment form should have been completed and signed by an RN or the resident's physician.	C 542		
C1304 SS=E	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 2 services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure all services specified in the resident's current service contract were provided for one (#1) of three sampled residents. A "residency agreement," dated 06/06/20, read in part, "...assistance with personal care...scheduled cueing for toileting...periodic checks during the night...observation...We welcome You as a new resident and want You to know that Your safety, happiness, and personal rights are of the utmost importance to us..." Resident #1 admitted to the center 06/06/20 with diagnoses to include chronic atrial fibrillation, atherosclerotic heart disease, aphasia, and abnormalities of gait. An annual "comprehensive assessment," dated 06/16/22, read in part, "...alert, oriented x 2 (person, place), forgetful with good judgement...Resident mobility fair with wheelchair until left heel improves...full range of motion...not	C1304		

Oklahoma State Department of Health

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C1304	Continued From page 3 weight bearing due to history of stroke...ambulatory with staff assistance: wheelchair...one person assist bathing, dressing, transferring, toileting...toileting ability: assist with adult briefs...good ability to communicate...interviewable..." A "service plan," dated 07/21/22, read in part, "...effective date: 06/08/20...Alerts: Fall Risk...Safety Checks...Resident may not have a sense of what is safe. Check frequently and re-direct if needed...Supervision: Requires...Recent stroke history. will require supervision...Night Care: Periodically...check for safety, General well-being. Toilet if necessary...effective date: 07/21/21...Toileting: Total incontinence...incontinent of bowel and bladder...one person assist with changing depends, soiled clothes and linens..." A "Service Checkoff List," dated October 2022, read in part, "...Safety checks...resident may not have a sense of what is safe. Check frequently and re-direct if needed..." There were no initials to indicate safety checks were provided during the 3-11 shift 10/15/22. On 03/16/23 at 4:46 p.m., during record review, LPN #2 stated if it's not documented it didn't get done.	C1304		
C1505 SS=J	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B	C1505		

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C1505	Continued From page 4 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: On 03/22/23, an Immediate Jeopardy (IJ) situation was determined to exist related to the center's failure to ensure the pharmacy and the center verified anticoagulant medication and monitor resident received physician ordered medication.	C1505		

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C1505	Continued From page 5 At 2:49 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation. At 3:12 p.m., LPN #1 and LPN #2 were notified of the IJ situation. On 03/23/23 at 10:37 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented: "Process for medication review to ensure resident received physicians ordered medications: 1. Center notified alleged pharmacy and demanded they come do a medication audit. This was completed 02/24/23. 2. Center contracted with 3rd party pharmacy to conduct an independent mediation audit. This was completed 02/23/23. 3. All items identified in the pharmacy audit were corrected by 03/06/23. no medication errors identified in audit resulted in negative resident outcome. 4. Center gave formal notice to alleged pharmacy to terminate pharmacy agreement due to cause. 5. Center contracted with new pharmacy to provide medications to community. Residents and family notified of pharmacy change. 6. Executive Director will implement a secondary clinical review to medication admission orders/start up orders. a) There will be two clinicians that will utilize the three-way process/stamp. This is an ongoing visual safety check of medication review before the medication(s) are entered into the EMAR/Physician Orders. Process to notify center's RN for assessments:	C1505		

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C1505	Continued From page 6 1. Executive Director and/or designee will notify RN via phone call and/or email when assessments need review and signature. 2. A designated file has been established in the health and wellness office for RN signatures. 3. Center nurse will monitor file to ensure documents needing signature are reviewed and signed monthly with monthly physician orders. Process for hospice client to be sent to hospital in timely manner: 1. Center will collaborate with hospice provider, resident and family to ensure if resident needs hospital attention, resident is sent out. Center will advocate on behalf resident if there is an urgent need for medical attention. b) A timely manner is dependent on several factors including but not limited to: EMSA response time, family choice, resident choice. In this case, when hospice refused to send resident out, center nurse and/or clinical designee will advocate on resident behalf for evaluation and treatment at the hospital." The IJ was lifted, effective 03/23/23 at 11:59 a.m., when all components of the plan of removal had been completed. The deficiency remained at a level of actual harm at a pattern. Based on record review and interview, the center failed to ensure the pharmacy and the center verified anticoagulant medication and monitor resident received physician ordered medication for one (#7) of one sampled residents who missed 16 doses of anticoagulant therapy and received a left above the knee amputation. Findings:	C1505		

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C1505	Continued From page 7 A "residency agreement," dated 01/19/23, read in part, "...We welcome You as a new resident and want You to know that Your safety, happiness, and personal rights are of the utmost importance to us. The Community has a Resident's Bill of Rights...Appendix B...Every resident shall have the right receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community..." Resident #7 admitted to the center 01/19/23 with diagnoses to include Factor V Leiden (a mutation of one of the clotting factors in the blood. This mutation can increase your chance of developing abnormal blood clots, most commonly in your legs or lungs. Most people with factor V Leiden never develop abnormal clots.) sinus sick syndrome (a type of heart rhythm disorder), pacemaker, and coronary artery disease. An admission "comprehensive assessment," dated 01/19/23, read in part, "... (Resident #7) was alert, oriented x 3 (person, place, time.) Resident #7 was confused at times with good judgement..." A "move-in" assessment, dated 01/19/23, read in part, "...Does the resident have history of circulatory disorders? Yes..." A "medication self administration" assessment, dated 01/19/23, read in part, "...does resident self-administer medication? No..." A "healthcare practitioner move-in orders," dated 01/19/23, read in part, "...resident requires assistance with medications by qualified employees..."	C1505		

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C1505	Continued From page 8 An "assisted living admission order form," dated 01/19/23, read in part, "...Xarelto 15 mg, PO daily, anticoagulant..." Xarelto 15 mg, PO daily was not documented on the January or February 2023 MAR. A "hospice certification and plan of care," read in part, "...state of care date: 01/20/23..." A "sign in" sheet, dated 02/04/23, read in part, "... (hospice) LPN...time in 11:15 (p.m.)...time out 12:39 (a.m.)...comments...Sore to LLL (left lower leg), increased bruising..." A "visit note report," dated 02/04/23, read in part, "...patient unable to verbalize...mental/cognitive assessment performed...lethargic...decreased strength...upper and lower bilateral extremities...patient care due to unexpected status change...LLL is badly bruised, cool to touch...continue to monitor left lower leg..." A "sign in" sheet, dated 02/05/23, read in part, "... (hospice) RN...time in 9:32 (a.m.)...time out 10:20 (a.m.)...L(left) leg swollen, discolored, sent to (hospital)..." A "visit note report," dated 02/05/23, read in part, "...uncomfortable because of pain...pain score: 7...left leg...stabbing...constant...transitional movement...left leg discolored, painful...cardiovascular assessment performed...transfers bed to chair with maximal assistance...discharge initiated by family...Narrative: prn visit for leg changes. Upon arrival, pt in bed, restless, occasionally moaning, c/o left leg pain. Left leg dark. Discolored, cool to touch, unable to palpate pedal pulse. Blistering noted, two open areas noted..."	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 03/23/2023
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
C1505	Continued From page 9 A "coordination of care third party form," dated 02/05/23, read in part, "...L lower leg discoloration, cool to touch, painful. Sent resident to (hospital) for eval and tx..." An Emergency Medical Services Authority (EMSA), dated 02/05/23, read in part, "...primary impression: generalized weakness...secondary impression: fatigue...chief complaint: left leg discoloration...discolored and cold on left leg below knee..." A "hospital record," dated 02/05/23 at 10:30 a.m., read in part, "... (Resident #7) ED arrival...presents with cold and insensate (lacking physical sensation) left lower extremity, with reported bilateral lower extremity pain...left worse than right over the last 4 days...it appears his Xarelto was discontinued inadvertently...reportedly has been off Xarelto since Jan 19th..." A "hospital record," dated 02/06/23, read in part, "...vascular surgery...critical limb ischemia (a condition in which blood flow (and thus oxygen) is restricted or reduced in a part of the body) of left lower extremity...left above knee amputation..." On 03/16/23 at 3:48 p.m., LPN #2 stated the missing medication resulted in a DVT (deep vein thrombosis-a medical condition that occurs when a blood clot forms in a deep vein.)	C1505		
C1512 SS=E	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be	C1512		

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C1512	Continued From page 10 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own	C1512		

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C1512	Continued From page 11 interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed protect one vulnerable adult (#1) of one sampled resident from neglect and/or mental abuse/mental anguish post fall. Findings: An "Internal Incident Reports and State Reports," policy and procedure, dated 07/19, read in part, "...The Internal Incident Report is to be completed for all unusual occurrences...and incidents. The staff member involved in...the incident will complete the Internal Incident Report...Notify the Director of Health and Wellness or Executive Director of the incident as soon as possible following the incident. The Director of Health and Wellness or designee will notify the appropriate parties...The Director of Health and Wellness and Executive Director will investigate the incident...Incidents are reported to the resident's family/responsible party. Document the date and time the report was made to the	C1512		

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C1512	Continued From page 12 family/responsible party in the narrative charting section of the resident's chart..." Resident #1 A "Resident Incident Report," dated 10/16/22, read in part, "...slid to floor...bedroom...didn't remember what happened...no vital signs documented...Staff had to get more assistance to get resident back in bed. Vital signs were not taken at time of incident...manager on duty (former LPN #3)...no other notifications documented at the time of the incident..." An "ODH Form 283," dated 10/16/22, read in part, "...Allegations of Abuse/Mistreatment...Resident was lying on the floor with his bedding. Resident had experienced an incontinent episode. While the resident was on the floor, (former) CNA (#1) provided incontinent care. (former) CNA (#1) then sought assistance to return resident to bed. Resident was assisted back to bed..." No staff obtained vital signs at the time of the incident. There was no documentation by a nurse an assessment was completed post fall. A "progress note," dated 10/21/22, read in part, "...Incident report was not done at the time of incident, and vitals were not taken...based on statements made by family and staff..." The center did not notify the family of the fall. On 03/16/23 at 4:46 p.m., during record review, LPN #2 stated if it's not documented it didn't get done.	C1512		

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C1512	Continued From page 13 On 03/20/23 at 3:55 p.m., the Administrator stated during her investigation (former LPN #3) did not delegate vital signs or obtain vital signs, and did not assess the resident for injury or pain. They just got another employee (total of three) to help assist the resident back to bed.	C1512		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery.	C1911		

Oklahoma State Department of Health

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C1911	Continued From page 14 This Rule is not met as evidenced by: Based on record review and interview, the center failed to report within one Department business day of the reportable incident's discovery for an allegation of abuse/mistreatment for one resident (#1) of three residents sampled with reportable events. Findings: An "Incident Reports and State Reports," policy and procedure, dated 07/19, read in part, "...Oklahoma...All report to the Department shall be made via facsimile or by telephone within one Department business day of the reportable incident's discovery..." An incident report for resident #1, read in part, "...Incident Date, 10/16/22 (Sunday)...Allegations of Abuse/Mistreatment...lying on floor with bedding...incontinent care provided...assistance to return resident to bed..." The initial report was sent to OSDH, via facsimile (fax) on 10/19/22, three business days after the incident. On 03/16/23 at 3:54 p.m., during review, LPN #2 stated the intital incident form was dated (Sunday) 10/16/22, but was not faxed to the Department until (Wednesday) 10/19/22 outside the twenty-four hour parameter.	C1911		

Delivery via email to: ed@mansionatwaterfordslc.com

April 18, 2023

License Number: AL5591

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

Survey Event ID: UWFB11

Dear Ms. Flowers:

On **March 23, 2023**, 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 **April 14, 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: 2023.04.18 14:04:39 -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: 4/11/2023

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: UWFB11

Date Survey Completed: 3/23/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C542

Based on: record review and interview, the center failed to coordinate all assessments with a signature by registered nurse or the resident's personal physician

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 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.

OAC 310:663-25-4(F)

Date 4/13/2023

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 Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE	
	Current Date: 4/11/2023	
	Facility Name: The Mansion at Waterford	
	License Number: AL5591	
	Survey Event ID: UWFB11	
Date Survey Completed: 3/23/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: 1304	Based on: The center failed to ensure all services specified in the resident's current service contract were provided	
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		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?		Resident #1 no longer resides in the community.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		A. Director of Health and Wellness and/or designee will review service plans of residents to ensure ADLs are listed for service delivery in electronic medical record for each residents.
OSDH Response: Element accepted Yes ☐ No ☐		
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		A. Director of Health and Wellness and/or designee will train staff on documenting ADL tasks in the Resident electronic medical record.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		A. Executive Director and/or designee will monitor performance by reviewing electronic medical records to ensure ADL service delivery. B. Executive Director and/or designee will conduct random review of electronic medical record of residents to ensure ADLs are being completed. C. Adjustment to resident ADL needs will be reviewed at daily stand-up with service delivery issues addressed in the quality assurance process. D. Director of Health and Wellness and/or designee will train staff on documenting ADL tasks in the Resident electronic medical record.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		4/14/2023
OSDH Response: Element accepted Yes ☐ No ☐		