

Delivery via email to: ed@mansionatwaterfordslc.com

December 21, 2023

License Number: AL5591

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

RE: Survey Event ID: 0P6V11

Dear Ms. Henderson:

On **November 22, 2023**, agents from our office concluded a State Licensure survey along with complaint investigations at your facility. 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 (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

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

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

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

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

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

The IDR request must be submitted within 10 calendar from receipt of the State Form deficiency statement. 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, conducted in a face-to-face, or virtual 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.

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

INVESTIGATIVE REPORT

Facility: The Mansions at Waterford
Address: 6110 North Penn Avenue
City, State, Zip: Oklahoma City, OK, 73112
Provider #: AL5591
Complaint #: OK00060483
Investigation Date(s): 11/20/23 through 11/22/23

ALLEGATION(S)

- | |
|---|
| 1. The center failed to ensure medications were administered according to physician's orders. |
| 2. The center failed to prevent new or worsening pressure wounds. |
| 3. The center failed to provide timely incontinent care for dependent residents. |

An unannounced on-site investigation was initiated 11/20/2023 at 7:45 a.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls and rooms were observed for smells and incontinent care.

Resident records were reviewed including assessments, physician orders, nursing notes, service plans, wound care notes, hospital records, and treatment records. Facility policy and procedures were reviewed. Grievances were reviewed.

Residents were interviewed related to medication administration, wound care needs, and incontinent care needs being provided.

Staff members were interviewed regarding incontinent care, wound care, and medication administration.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health

Long Term Care Service

Date report completed: 11/27/2023

INVESTIGATIVE REPORT

Facility: The Mansion at Waterford
Address: 6110 North Penn Avenue
City, State, Zip: Oklahoma City, OK 73112
Provider #: AL5591
Complaint #: OK00060694
Investigation Date(s): November 20th-22nd, 2023

ALLEGATIONS

The facility failed to have and or implement an effective method of entering newly ordered medications into the electronic medication administration system.
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The facility failed to ensure residents received medications as ordered by the physician.

An unannounced on-site investigation was initiated 11/20/2023 at 11:45 a.m.

A sample of seven residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the 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 Summary of Complaint Investigation:

The allegations referenced on this complaint were investigated as part of a complaint survey completed on 03/23/23.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/27/2023

INVESTIGATIVE REPORT

Facility: The Mansions at Waterford
Address: 6110 North Penn Avenue
City, State, Zip: Oklahoma City, OK, 73112
Provider #: AL5591
Complaint #: OK00060483
Investigation Date(s): 11/20/23 through 11/22/23

ALLEGATION(S)

- | |
|---|
| 1. The center failed to ensure medications were administered according to physician's orders. |
| 2. The center failed to prevent new or worsening pressure wounds. |
| 3. The center failed to provide timely incontinent care for dependent residents. |

An unannounced on-site investigation was initiated 11/20/2023 at 7:45 a.m.

A sample of 3 residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls and rooms were observed for smells and

Resident records were reviewed including assessments, physician orders, nursing notes, and treatment records. Facility policy and procedures were reviewed. Grievances were reviewed. Pest control logs were reviewed.

Residents were interviewed related to the provision of pest in the facility.

Staff members were interviewed regarding the facility policy on pest control.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/27/2023

INVESTIGATIVE REPORT

Facility: The Mansions at Waterford
Address: 6110 North Penn Avenue
City, State, Zip: Oklahoma City, OK, 73112
Provider #: AL5591
Complaint #: OK00061851
Investigation Date(s): 11/20/23 through 11/22/23

ALLEGATION(S)

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|---|
| 1. The center failed to ensure a clean, safe, and homelike environment and failed to have and/or implement an effective pest control program. |
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An unannounced on-site investigation was initiated 11/20/2023 at 7:45 a.m.

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

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

A Summary of Complaint Investigation:

A tour of the facility was conducted upon entrance and at other various times throughout the survey. Resident halls, common areas, the kitchen, and rooms were observed pest and environmental concerns.

Resident records were reviewed including assessments, physician orders, nursing notes, service plans, wound care notes, hospital records, and treatment records. Facility policy and procedures, remodeling plans, pest management records, and Grievances were reviewed.

Residents were interviewed related to pest management and any environmental concerns.

Staff members were interviewed regarding pest concerns and pest management.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/27/2023

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 11/22/2023
NAME OF PROVIDER OR SUPPLIER THE MANSION AT WATERFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 6110 NORTH PENN AVENUE OKLAHOMA CITY, OK 73112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted from 11/20/23 through 11/22/23. Complaint investigations (#OK00060483, OK00060694, OK00060987, and #OK00061851) were conducted in conjunction with the survey. Facility Census: 92 Listed below are abbreviations that will be used throughout this document. > - greater than < - less than approx - approximately BIL - bilateral cm - centimeter CMA - certified medication aide CNA - certified nursing assistant Consult. - consultant Corp. - corporate CPR - cardiopulmonary resuscitation DTI - deep tissue injury EMSA - emergency medical services authority L - left MAR - medication administration record MD - medical doctor Meds - medications mg - milligram NS - normal saline q - every R - right RN - registered nurse tab/tabs - tablet (s)	C 000		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed 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

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 11/22/2023
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C 542	Continued From page 1 personal physician. This Rule is not met as evidenced by: Based on record review and interview, the center failed to obtain a physician or registered nurse signature on the annual assessments for three (#2, 4, and #8) of ten sampled residents whose annual assessments were reviewed. The "Assisted Living Resident Condition and Care Overview", dated 11/20/23, documented 92 residents resided in the facility. Findings: 1. Resident #2 had diagnoses that included diabetes type II and hypertension. The annual assessment for Resident #2, dated 10/07/22, was not signed by a physician or registered nurse. 2. Resident #4 had diagnoses that included multiple sclerosis and depression. The annual assessment for Resident #4, dated 01/21/21, was not signed by a physician or registered nurse. 3. Resident #8 had diagnoses that included Parkinson's disease and depression. The annual assessment for Resident #8, dated 12/24/22, was not signed by a physician or registered nurse. On 11/22/23 at 3:30 p.m., the Corp. Nurse	C 542		

Oklahoma State Department of Health

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C 542	Continued From page 2 Consult. #1 was asked to review the resident assessments referenced above and acknowledged they did not contain the required RN or MD signatures.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to obtain the signature of the resident or resident representative interviewed when completing the annual assessments for four (#2, 4, 6, and #8) of ten sampled residents whose annual assessments were reviewed. The "Assisted Living Resident Condition and Care Overview", dated 11/20/23, documented 92 residents resided in the facility. Findings: 1. Resident #2 had diagnoses that included diabetes type II and hypertension. The annual assessments for Resident #2, dated 10/07/21 and 10/07/22, did not contain the signature of the resident or the resident	C 543		

Oklahoma State Department of Health

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C 543	Continued From page 3 representative interviewed at the time of the assessments. 2. Resident #4 had diagnoses that included multiple sclerosis and Alzheimer's disease. The annual assessments for Resident #4, dated 01/21/21, 01/22/22, and 09/27/23, did not contain the signature of the resident or the resident representative interviewed at the time of the assessments. 3. Resident #6 had diagnoses that included dementia and depression. The annual assessments for Resident #6, dated 01/19/21, 01/19/22, and 01/19/23, did not contain the signature of the resident or the resident representative interviewed at the time of the assessments. 4. Resident #8 had diagnoses that included Parkinson's disease and depression. The annual assessments for Resident #8, dated 12/14/21 and 12/24/22, did not contain the signature of the resident or the resident representative interviewed at the time of the assessments. On 11/22/23 at 3:30 p.m., the Corp. Nurse Consult. #1 was asked to review the resident assessments referenced above and acknowledged they did not contain the required signatures for the resident or resident representative interviewed at the time the assessments were completed.	C 543		

Oklahoma State Department of Health

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C 954	Continued From page 4	C 954		
C 954 SS=E	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on interview and record review, the center failed to ensure four (CMA #2, Dietary Aide #1, Cook #1, and CNA #4) of five sampled employees received training in CPR and first aid. Findings: CMA #2's date of hire was documented as 11/08/23. Dietary Aide #1's date of hire was documented as 11/14/23. Cook #1's date of hire was documented as 10/26/23. CNA #4's date of hire was documented as 10/11/23. On 11/21/23 at 1:42 p.m., employee records were reviewed and documentation of CPR and first aid training for the employees named above was requested. On 11/22/23 at 3:00 p.m., the Corp. Nurse Consult. #1 reported there was no documentation CMA #2, Dietary Aide #1, Cook #1, or CNA #4 had received CPR and first aid training.	C 954		

Oklahoma State Department of Health

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C1505 SS=G	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. This REQUIREMENT is not met as evidenced	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 6 by: Based on record review and interview, the center failed to: a. administer medications as ordered by the physician for one (#3) of seven sampled residents reviewed for medication administration. This deficient practice resulted in harm to Resident #3 who was admitted to the hospital with a discharging diagnosis of accidental methotrexate overdose and toxicity, and b. assess, monitor, and coordinate care with third party providers for one (#3) of one sampled resident who developed a stage II pressure ulcer and received three separate skin grafts. The "Assisted Living Resident Condition and Care Overview" form, dated 11/20/23, documented 92 residents resided in the facility. Findings: 1. Resident #3 had diagnoses that included metabolic encephalopathy and dermatomyositis. A "Medication Administration" policy, issued 02/2019, read in parts, "...AM will be administered between the hours of 6am - 11am...PM or afternoon will be administered between the hours of 4pm - 7pm..." An admission physician order for Resident #3, dated 06/08/2022, documented Methotrexate tabs 2.5mg, 3 tabs twice a day on Thursdays. The September 2022 MAR documented Methotrexate tab 2.5mg 3 tablets (7.5mg) was given on Thursday 09/08/22 at AM Meds and at PM Meds.	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 7 A physician order, dated 09/09/22, documented Methotrexate was increased to 5 tabs twice a day on Thursdays. The September 2022 MAR documented Methotrexate tab 2.5mg 5 tablets (12.5mg) was given on Saturday 09/10/22 at AM Meds and PM Meds, Sunday 09/11/22 at AM Meds and PM Meds, and again on Monday 09/12/22 at AM Meds. A nurse progress note, dated 09/16/22 at 1:45 p.m., documented Resident #3 had stool with blood in it, appeared pale, had increased confusion, and was sent out to hospital via EMSA per family request. An emergency room report for Resident #3, dated 09/16/22, read in part, "...patient was noted to be pan cytopenic...When speaking to the husband, he mentions that the patient was accidentally given 50 mg of methotrexate this past week instead of her scheduled 15 mg per week...This does seem to explain the patient's pan cytopenia...Impression...Gastrointestinal hemorrhage...Pancytopenia..." A hospital discharge summary for Resident #3, dated 10/14/2022, read in part, "...Discharge Diagnoses...methotrexate accidental overdose and toxicity..." On 11/21/23 at 3:24 p.m., the Corp. Nurse Consult. #1 reviewed the September 2022 MAR and corresponding physician orders for Resident #3's Methotrexate and acknowledged the medication had not been given according to the physician's order.	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 8 2. A "Move-In & Routine Skin Assessment", dated 06/08/2022, documented Resident #3 had no current decubitus and no interventions were implemented to reduce risk of developing pressure ulcers. A "Physician's Progress Note", dated 06/21/2022, documented Resident #3 had no new rashes or ulcers. A "Physician's Progress Note", dated 06/28/2022, read in part, "...Rash to perineum region. No other new rashes or ulcers...Nystatin cream/powder alternating. Reflex to Diflucan if needed..." No order for nystatin cream alternating with nystatin powder was transcribed to physician's orders nor to the June 2023 MAR. No updates were made to Resident #3's Service Plan. No documentation was found in the nurse's notes referencing the new rash to perineum region nor new treatment order. A "Physician's Progress Note", dated 08/16/2022, read in part, "...She does have irritation to the coccygeal region with wounds being treated by home health...Dressing in place..." A third-party "Wound Care Progress Note", dated 08/19/2022, read in part, "...Wound: coccyx sacral area Measurements 1.4cm x 1.0cm x <0.1cm...cleanse with NS, apply allevyn Non-adhesive dressing for protection ..." A third-party "Wound Care Progress Note", dated 08/26/2022, read in parts, "...Wound: coccyx area measures 1.0cm x 1.0cm x <0.1cm...cleanse with NS apply allevyn adhesive bandage for protection...will get graft preauthorized...Facility	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 11/22/2023
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 staff/caregivers to monitor and notify with concerns or changes. Keep patient repositioned q 2 hours..." No order for treatment to coccyx-sacral wound was transcribed to physician's orders nor to the August 2023 MAR. No updates were made to Resident #3's Service Plan. A third-party "Wound Care Progress Note", dated 08/31/2022, read in part, "...Wound: measurement on Coccyx 1.0cm x 1.3cm x <0.1cm Graft application #1...Wound monitoring by facility staff/caregivers..." No documentation of wound monitoring by facility staff was found in the nurse's notes. No updates were made to Resident #3's Service Plan. A "Physician's Progress Note", dated 09/06/2022, read in parts, "...Today the patient is being seen for a follow up on a recent graft placement to her buttock...Also a leg ulceration with rash as described...Red rash to the inguinal region and inferior left breast...Rash: Will use nystatin cream...Leg ulcer: Will continue to be treated by [third-party] in regard to graft placement..." A third-party "Wound Care Progress Note", dated 09/07/2022, read in parts, "...Wound: Sacral area measurements 1.5cm x 2.0cm x 0.2cm Graft application #2...Wound monitoring by facility staff/caregivers..." A third-party "Wound Care Progress Note", dated 09/14/2022, read in parts, "...Wound: Coccyx/Sacral Area measurements 1.5cm x 2.0cm x 0.1cm Graft application #3... BIL heels	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 11/22/2023
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 10 spongy...Wound monitoring by facility staff/caregivers...Turn q 2, offload heels order booties to prevent skin breakdown..." No documentation of wound monitoring by facility staff was found in the nurse's notes. No updates were made to Resident #3's Service Plan. A "[Hospital] Wound Consult", dated 09/17/2022, read in part, "...wound to sacral area...Upon exam, pt has a large area of deeply reddened, denuded, weeping, ragged-edge, what appears to be partial thickness tissue loss measuring approx. 5cm x 4cm...there may be areas that are deeper than partial thickness...this is most likely damage as a result of not-fully-or-sufficiently relieved pressure over the bone...dark discoloration to both heels...Definitely DTI to both, R>L..." On 11/22/23 at 3:24 p.m., the Corp. Nurse Consult. reported Resident #3 had no wounds on admission and they were not aware of when they developed. The Corp. Nurse Consult. stated the home health agency would have been responsible for residents wound care. There was no Home Health Certification Plan of Care (485) in Resident #3's record nor documentation of home health nurse visits having been done. The Corp. Nurse Consult. acknowledged these findings.	C1505		

Delivery via email to: alex.baggs@milestoneretirement.com

January 8, 2024

License Number: AL5591

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

Survey Event ID: 0P6V11

Dear Mr. Baggs:

On **November 22, 2023**, a Relicensure survey with a Complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 15, 2024**.

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, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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: 12/28/2023

Facility Name: The Mansion At Waterford

License Number: AL5591

Survey Event ID: OP6V11

Date Survey Completed: 11/22/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 542

Based on: record review and interview, the center failed to obtain a physician or registered nurse signature on the annual assessments for three (#2, 4, and #8) of ten sampled residents whose annual assessments were reviewed.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

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

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

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

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

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

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The Director of Health and Wellness and/or designee will coordinate a review of assessments for residents 2, 4, and 8. DHW to collaborate with PCP and/or RN for review and signature.

The DHW and/or designee will conduct audit of assessments and notify Regional team of results.

The DHW and/or designee will monitor for completion of RN or PCP signatures on assessments.

The DHW and/or designee will monitor signatures on assessments to make sure they are signed per regulations.

An assessment log will be implemented by the DHW and/or designee and reviewed weekly. Regional Team to conduct audit of assessment to ensure compliance with regulation.

Director of Health and Wellness, Executive Director and/or designee will maintain documentation of assessments signed by RN or Physician.

Assessments completed will be reported and reviewed during QA meeting.

Administrator's Signature Dee Henderson, ED

OAC 310:663-25-4(F)

Date 12/28/2023

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: 12/28/2023	
	Facility Name: The Mansion At Waterford	
	License Number: AL5591	
	Survey Event ID: 0P6V11	
Date Survey Completed: 11/22/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 543	Based on: Based on observation, record review and interview, it was determined the facility failed to ensure the signature of the resident or resident's representative interviewed when completing the annual assessments for residents #2,4 & 8.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: <i>Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law</i>		
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?	The Director of Health and Wellness and/or designee will coordinate review of assessments for residents 2,4,and 8. DHW and/or designee to collaborate with resident and or resident representative for review and signature.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The DHW and/or designee will conduct audit for resident or resident's representative signatures on assessments and will report findings to regional team.	
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?	The DHW and/or designee will monitor for completion of resident and/or resident's representative signatures on assessments.	
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.	The DHW and/or designee will monitor signatures on assessments to make sure they are signed per regulations. An assessment log will be implemented by the DHW and/or designee and reviewed weekly. Regional Team to conduct audit of assessment to ensure compliance with regulation. Director of Health and Wellness, Executive Director and/or designee will maintain documentation of assessments signed by resident or resident's representative. Assessments completed will be reported and reviewed during QA meeting.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	1/15/2024	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Dee Henderson, ED		Date 12/28/2023

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.
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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: 12/29/2023	
	Facility Name: The Mansion At Waterford	
	License Number: AL5591	
	Survey Event ID: 0P6V11	
Date Survey Completed: 11/22/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C954	Based on: Based on observation, record review and interview, it was determined the facility failed to ensure employees received training in CPR and first aid,	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: <i>Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law</i>		
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?		CMA #2, Dietary Aide #1, Cook #1, CNA #4 will be inserviced on CPR and First Aid training.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Business Office Manager and/or designee will communicate new hire start date. CPR and First aid training will be completed according to regulations upon hire and thereafter.
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?		Business Office Manager and/or designee will run monthly reports to ensure staff continuing education in CPR and First Aid is completed in a timely manner, according to regulation. BOM to communicate report to Director of Health and Wellness.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		Executive Director and/or designee will monitor for completion of staff continuing education. Business Officer Manager and/or designee will review continuing education reports frequently and report findings to ED. ED and/or designee will maintain documentation of education through Relias and/or inservice. Staff will be educated on continuing education. Records will be reported and reviewed during the QA meeting.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		1/15/2024
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Dee Henderson		Date 12/29/2023
OAC 310:663-25-4(F)		

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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: 12/29/2023

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: OP6V11

Date Survey Completed: 11/22/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: record review and interview, the center failed to: a) administer medications as ordered by the physician for resident #3 and b) facility failed to assess, monitor, and coordinate care with third party providers for resident #3.

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 ☐

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

The facility will administer medications as ordered by the physician. DHW and/or designee to assess, monitor, and coordinate care with third party providers. Resident #3 no longer resides at the community.

The DHW and/or designee will monitor new orders received from 3rd party providers and/or collaborate care with 3rd party providers weekly. . No residents have been effected since survey completed.

The DHW and/or designee will monitor new orders received from 3rd party providers, weekly.

New medication orders will continue to be verified by 3 way check process. Wounds will be communicated in writing from 3rd party providers and DHW and/or designee will assess, monitor and coordinate care with 3rd party provider, weekly. New pharmacy provider was put into place 04/01/23.

Execuative Director, Clinical Team, and/or designee to review during weekly clinical meeting.

Director of Health and Wellness, Execuative Director and/or designee will monitor new orders received from 3rd party providers, weekly.

Regional Team will conduct a audit to ensure new orders are entered into EHR occuring to physician orders.

		DHW and ED and/or designee to review during weekly clinical meeting.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		1/15/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Dee Henderson, ED OAC 310:663-25-4(F)		Date 12/29/2023	
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.			
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Facility in Compliance by: Click here to enter a date.			

Delivery via email to: alex.baggs@milestoneretirement.com

January 8, 2024

License Number: AL5591

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

Survey Event ID: 0P6V11

Dear Mr. Baggs:

On **November 22, 2023**, a Relicensure survey with a Complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **January 15, 2024**.

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, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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: 12/28/2023	
	Facility Name: The Mansion At Waterford	
	License Number: AL5591	
	Survey Event ID: OP6V11	
Date Survey Completed: 11/22/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 542	Based on: record review and interview, the center failed to obtain a physician or registered nurse signature on the annual assessments for three (#2, 4, and #8) of ten sampled residents whose annual assessments were reviewed.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: <i>Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law</i>		
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?		The Director of Health and Wellness and/or designee will coordinate a review of assessments for residents 2,4,and 8. DHW to collaborate with PCP and/or RN for review and signature.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		The DHW and/or designee will conduct audit of assessments and notify Regional team of results.
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?		The DHW and/or designee will monitor for completion of RN or PCP signatures on assessments.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		The DHW and/or designee will monitor signatures on assessments to make sure they are signed per regulations. An assessment log will be implemented by the DHW and/or designee and reviewed weekly. Regional Team to conduct audit of assessment to ensure compliance with regulation. Director of Health and Wellness, Executive Director and/or designee will maintain documentation of assessments signed by RN or Physician. Assessments completed will be reported and reviewed during QA meeting.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		1/15/2024
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Dee Henderson, ED OAC 310:663-25-4(F)		Date 12/28/2023
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.		

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	License Number: AL5591	
	Survey Event ID: 0P6V11	
Date Survey Completed: 11/22/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C 543	Based on: Based on observation, record review and interview, it was determined the facility failed to ensure the signature of the resident or resident's representative interviewed when completing the annual assessments for residents #2,4 & 8.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: <i>Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law</i>		
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?	The Director of Health and Wellness and/or designee will coordinate review of assessments for residents 2,4,and 8. DHW and/or designee to collaborate with resident and or resident representative for review and signature.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The DHW and/or designee will conduct audit for resident or resident's representative signatures on assessments and will report findings to regional team.	
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?	The DHW and/or designee will monitor for completion of resident and/or resident's representative signatures on assessments.	
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.	The DHW and/or designee will monitor signatures on assessments to make sure they are signed per regulations. An assessment log will be implemented by the DHW and/or designee and reviewed weekly. Regional Team to conduct audit of assessment to ensure compliance with regulation. Director of Health and Wellness, Executive Director and/or designee will maintain documentation of assessments signed by resident or resident's representative. Assessments completed will be reported and reviewed during QA meeting.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	1/15/2024	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Dee Henderson, ED		Date 12/28/2023

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.
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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: 12/29/2023	
	Facility Name: The Mansion At Waterford	
	License Number: AL5591	
	Survey Event ID: 0P6V11	
Date Survey Completed: 11/22/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C954	Based on: Based on observation, record review and interview, it was determined the facility failed to ensure employees received training in CPR and first aid,	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION		
Assisted Living Center's Comments: <i>Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law</i>		
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?		CMA #2, Dietary Aide #1, Cook #1, CNA #4 will be inserviced on CPR and First Aid training.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Business Office Manager and/or designee will communicate new hire start date. CPR and First aid training will be completed according to regulations upon hire and thereafter.
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?		Business Office Manager and/or designee will run monthly reports to ensure staff continuing education in CPR and First Aid is completed in a timely manner, according to regulation. BOM to communicate report to Director of Health and Wellness.
OSDH Response: Element accepted Yes ☐ No ☐		
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.		Executive Director and/or designee will monitor for completion of staff continuing education. Business Officer Manager and/or designee will review continuing education reports frequently and report findings to ED. ED and/or designee will maintain documentation of education through Relias and/or inservice. Staff will be educated on continuing education. Records will be reported and reviewed during the QA meeting.
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?		1/15/2024
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Dee Henderson		Date 12/29/2023
OAC 310:663-25-4(F)		

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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: 12/29/2023

Facility Name: The Mansion at Waterford

License Number: AL5591

Survey Event ID: OP6V11

Date Survey Completed: 11/22/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: record review and interview, the center failed to: a) administer medications as ordered by the physician for resident #3 and b) facility failed to assess, monitor, and coordinate care with third party providers for resident #3.

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 ☐

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

The facility will administer medications as ordered by the physician. DHW and/or designee to assess, monitor, and coordinate care with third party providers. Resident #3 no longer resides at the community.

The DHW and/or designee will monitor new orders received from 3rd party providers and/or collaborate care with 3rd party providers weekly. . No residents have been effected since survey completed.

The DHW and/or designee will monitor new orders received from 3rd party providers, weekly.

New medication orders will continue to be verified by 3 way check process. Wounds will be communicated in writing from 3rd party providers and DHW and/or designee will assess, monitor and coordinate care with 3rd party provider, weekly. New pharmacy provider was put into place 04/01/23.

Execuative Director, Clinical Team, and/or designee to review during weekly clinical meeting.

Director of Health and Wellness, Execuative Director and/or designee will monitor new orders received from 3rd party providers, weekly.

Regional Team will conduct a audit to ensure new orders are entered into EHR occuring to physician orders.

		DHW and ED and/or designee to review during weekly clinical meeting.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		1/15/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Dee Henderson, ED OAC 310:663-25-4(F)		Date 12/29/2023	
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.			

FINAL DETERMINATION NOTICE
USPS Tracking #7021 2720 0002 0354 1761

Delivery via email to: alex.baggs@milestoneretirement.com

February 1, 2024

License Number: AL5591

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

Survey Event ID: 0P6V12

Dear Mr. Baggs:

A revisit conducted **January 24, 2024**, revealed that your facility corrected deficiencies effective **January 15, 2024**.

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

Respectfully,



Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure: