OKLAHOMA
State Department
of Health

Delivery via email to: jsorum@ireg.us

December 2, 2022

License Number: AL5595

Mr. Jason Sorum, Administrator
Town Village Assisted Living
13000 North May Avenue
Nichols Hills, OK 73120

Survey Event ID: OE4H11

Dear Mr. Sorum:

On **November 16, 2022,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

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

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

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

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

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

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

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Town Village Assisted Living
Address: 13000 North May Avenue
City, State, Zip: Nichols Hills, OK., 73120
Provider #: AL5595
Complaint #: OK00059697
Investigation Dates: 11/15/22 and 11/16/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were administered according to physician's orders, and according to medication administration standard practice guidelines, policies and procedures.	**S**
2. The center failed to ensure quality of care according to standard practice to prevent urinary tract infections.	**US**

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 11/15/2022 at 8:45 a.m..

A sample of 5 residents including any identified residents were selected for the investigation based on the concerns relevant to the allegations.

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 C1505 for details.

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

An investigation specific to concerns related to the facility failed to ensure quality of care according to standard practices to prevent urinary tract infections was conducted.

Residents' medical records were reviewed for concern related to UTI's. Medical records documented the facility responded to lab reports and physician orders in a timely manner.

Tours were conducted throughout the facility. Staff was observed to interact with residents. Resident appeared clean and well kept. No visible sign of dehydration was observed. Staff was observed to be washing and/or sanitizing hands between resident care. Residents had free access to fluids as needed.

Resident rooms contained kitchen and refrigerators with access to fluids for hydration as needed.

Residents were observed to be offered sufficient fluids during scheduled dining times.

Interviews were conducted with residents in regards to urinary tract infection risk and treatment. One resident did report concerns, the facility responded with the resident's concern and notified the physician immediately.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation # 1. The facility will be required to submit a plan of correction (POC). The 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.

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

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

Thank you for bringing these concerns to our attention.

Rick Atkinson Health Facility Surveyor III

Enter name and title

Date report completed: 11/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5595	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWN VILLAGE ASSISTED LIVING	13000 NORTH MAY AVENUE NICHOLS HILLS, OK 73120

(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 complaint investigation #OK00059697 was conducted on 11/15/22 and 11/16/22. Listed below are the abbreviations that will be used throughout this document: # - number Admin - Administrator CMA - Certified Medication Aide CNA - Certified Nursing Assistant CQK - Quick DISS - Dissolvable DON - Director of Nursing d/t - Due to ETC - Etcetera HSM - Health Services Manager ie - Example Mag Ox - Magnesium Oxide MAR - Medication Administration Record MCG - Microgram Med - Medication MEQ - Milli Equivalent MG - Milligram PCP - primary Care Physician POC - Plan of Correction POT - Potassium P&P - Policy and Procedure Res. - Resident SUBL - Sublingual TABs - Tablets TAR - Treatment Administration Record VS - Vital Signs WNL - Within Normal Limits	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following:	C 522		

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C 522	Continued From page 1 (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure an annual assessment had been completed for one (#1) of four sampled residents reviewed for annual assessments. The HSM identified 17 residents resided in the center. Findings: Res #1 had diagnoses which included high blood pressure and high cholesterol. Res #1's last annual assessment in the clinical health record was dated 08/01/21. On 11/15/22 at 2:57 p.m., the HSM was asked for an annual assessment for Res #1. The HSM stated, "We are behind on that one." The HSM was asked if the resident's annual assessment had not been completed for this year. They stated, "Yes."	C 522		
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights	C1505		

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C1505	Continued From page 2 and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the center failed to ensure medications were administered according to physician orders for two (#2 and #3) of 8 residents reviewed for medications.	C1505		

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C1505	Continued From page 3 The HSM identified 17 residents resided in the center. Findings: 1. Resident #3 had diagnoses which included, edema and high blood pressure. A physician order, dated 11/02/22, read in parts, "...Furosemide Oral Tablet 40 MG...1 Tablet by mouth per day Every day at 8:00 a.m....Potassium Chloride ER Oral Tablet Extended Release 20 MEQ...1 Tablet Extended Release by mouth One time per day Every day at 8:00 a.m..." Res #3's medication cards, read in parts,"...TAKE ONE TABLET BY MOUTH EACH DAY...POT CHLORIDE 10 MEQ ER...TAKE ONE TABLET BY MOUTH ONCE A DAY...FUROSEMIDE 20 MG..." A semi annual six month assessment, dated 11/16/22, documented Res #3 was alert to person, place, time, and situation. On 11/16/22 at 7:59 a.m., CMA #1 was observed to prepare Res #3's medications: Tylenol 500 mg one tablet, Furosemide 20 mg one tablet, Mag Ox 40 mg one tablet, Metoprolol 50 mg one tablet, and Potassium 10 meq one tablet. CMA #1 was then observed to obtain the residents blood pressure and give Res #3's medications to them. On 11/16/22 at 8:52 a.m., CMA #1 was asked to review the Furosemide medication card, and was asked how many tablets did they administer. CMA #1 stated, "One.". CMA #1 was asked to review the Potassium medication card and was asked	C1505		

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C1505	Continued From page 4 how many tablets had they administered. CMA #1 stated, "One, [the residents] counts [their] pills, [the resident] gets one." CMA #1 was then asked to review the physician orders for the potassium 20 meq and was asked how many tablets were given. They stated two. The physician order for Furosemide 40 mg was reviewed and CMA #1 was asked if the resident was given the right dose. CMA #1 stated, yes and was asked again how many tablets were administered. They stated, "Two." On 11/16/22 at 9:51 a.m., Res #3 was asked how many pills had they been administered this morning. Res #3 stated, "I took five pills this morning." On 11/16/22 at 10:00 a.m., the HSM was asked if Res #3 was alert and oriented. They stated, yes. The HSM was asked to review the medication pass observation sheet documenting the resident was administered five medication tablets. The HSM was asked if Res #3 had been administered two pills of the potassium and the furosemide should Res #3 have gotten seven tablets during the medication pass. The HSM stated "Yes". 2. Res. #2 had diagnoses which included vitamin deficiency and high blood pressure. An undated P&P titled, "Documentation Reminders", read in part, "....If you ever circle your initials with a med , you ALWAYS need to document reason on back of MAR or TAR (i.e. resident refused, med held due to....., resident out of the facility, med out of stock, etc)..." Res #2's "eMAR", dated 11/01/22 through	C1505		

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C1505	Continued From page 5 11/16/22, read in part, "...Biotin QCK DISS 5000 MCG Sublingual tablet 3 TABs BY Mouth EVERY DAY..." Res #2's "eMAR" was reviewed and Biotin QCK DISS 5000 MCG had blanks on 11/04/22 and 11/05/22. On 11/06/22 CMA #2 documented the medication was unavailable. On 11/16/22 at 1:30 p.m., the HSM was asked if Res #2 received Biotin on 11/4/22, 11/5/22, and 11/6/22. They replied, "No, not one idea why they would do that." The HSM was asked if the center has a medication dispensing problem. They replied, "I didn't, but I have told {Admin.}. We are retraining everyone straight away."	C1505		
C1951 SS=D	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a complete/accurate clinical medical record for one (#2) of four sampled residents reviewed for medical records. Findings: Resident # 2 had diagnoses which included vitamin deficiency and high blood pressure.	C1951		

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C1951	Continued From page 6 A "Nursing Note", dated 11/07/22 at 7:58 p.m., read in parts, "...Res sent to ER last evening d/t confusion. Res was scared, weakened and stated [the resident] thought [they] "may be having a stroke." Res VS were WNL, all stroke checks were negative; has symmetry of face, no [sic]dropped [sic] extremeties. Res sent to [name of] Hosp-and is still there presently. Family and PCP notified..." On 11/15/22 at 4:00 p.m., the HSM was asked to review the progress note dated 11/07/22. The HSM stated, it was on 11/06/22 the resident was confused, thought they were having a stroke. The DON was asked how did the CMA know how to assess the resident. The HSM stated, I told the CMA over the phone. The HSM was asked when the CMA had contacted them. The HSM reviewed their cell phone and stated, on 11/06/22 at 7:13 p.m., the resident said they were scared. I had the CMA assess the resident. The HSM was asked when was the last text from the CMA they stated at 7:42 p.m.. The resident was then transferred to the hospital. On 11/16/22 at 12:30 p.m., the HSM was asked if there was any documentation when Res #2 had been picked up and transported by the ambulance, or any documentation of Res #2's vital signs. The HSM stated, "No."	C1951		

OKLAHOMA
State Department
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Delivery via email to: JSorum@ireg.us

December 22, 2022

License Number: AL5595

Mr. Jason Sorum, Administrator
Town Village Assisted Living
13000 North May Avenue
Nichols Hills, OK 73120

Survey Event ID: OE4H11

Dear Mr. Sorum:

On **November 16, 2022,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **November 25, 2022**.

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

Respectfully,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2022.12.22 14:31:43 -06'00'

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

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Oklahoma State Department of Health

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C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following:	C 522	1. It is the policy of Town Village, to follow the assessment timeframe policy and procedures, all assessments shall be completed within the following timeframe at a	11/25/22

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C 522	Continued From page 1 (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure an annual assessment had been completed for one (#1) of four sampled residents reviewed for annual assessments. The HSM identified 17 residents resided in the center. Findings: Res #1 had diagnoses which included high blood pressure and high cholesterol. Res #1's last annual assessment in the clinical health record was dated 08/01/21. On 11/15/22 at 2:57 p.m., the HSM was asked for an annual assessment for Res #1. The HSM stated, "We are behind on that one." The HSM was asked if the resident's annual assessment had not been completed for this year. They stated, "Yes."	C 522	minimum; within 14 days after admission of the resident; once every twelve months; promptly after a significant change of condition. 2. Residents in assisted living had the potential to be affected. 3. To enhance current compliant operations under the Executive Director, the Director of Health Services was re-educated, on 11/23/22, regarding assessment timeframe policy and procedures. Resident #1 assessments were completed, signed and placed into the resident's chart on 11/18/22. 4. To enhance current complaint operations, the Director of Health Services and/or designee will audit compliance with assessment timeframe policy and procedures three times a week for four weeks, twice a week for four weeks, then once a week for four weeks. The Executive Director and/or designee will present results of the audit to the QA/PI Committee monthly. Audit results and system components will be reviewed, identifying any trends, by the Performance Improvement Team with subsequent plans of correction developed and implemented as deemed necessary, to ensure compliance is maintained.	
C1505 SS=D	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights	C1505	1. It is the policy of Town Village, to ensure that all staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under	11/25/22

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	AL5595	A. BUILDING: _____ B. WING _____	11/16/2022

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TOWN VILLAGE ASSISTED LIVING	13000 NORTH MAY AVENUE NICHOLS HILLS, OK 73120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 2 and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the center failed to ensure medications were administered according to physician orders for two (#2 and #3) of 8 residents reviewed for medications.	C1505	Title 63 O.S. Supp 1997, Section 1-1918B. 2. All residents had the potential to be affected. 3. To enhance current compliant operations under the Executive Director, the Director of Health Services and Certified Medication Aides were re-educated on medication administration policy and procedures on 11/18/22. Competency checks were performed on the Certified Medication Aides with only positive results by the Director of Health Services on 11/18/22 to 11/22/22. Residents #2 and #3 were assessed with no adverse affects noted. 4. To enhance current compliant operations under the Director of Health Services, an audit compliance with medication administration policy and procedures will be completed three times a week for four weeks, twice a week for four weeks, then once a week for four weeks by the Director of Health Services and/or designee. The Director of Health Services or designee will present results of the audit to the QA/PI Committee monthly. Audit results and system components will be reviewed, identifying any trends, by the Performance Improvement Team with subsequent plans of correction developed and implemented as deemed necessary, to ensure compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 3 The HSM identified 17 residents resided in the center. Findings: 1. Resident #3 had diagnoses which included, edema and high blood pressure. A physician order, dated 11/02/22, read in parts, "...Furosemide Oral Tablet 40 MG...1 Tablet by mouth per day Every day at 8:00 a.m....Potassium Chloride ER Oral Tablet Extended Release 20 MEQ...1 Tablet Extended Release by mouth One time per day Every day at 8:00 a.m..." Res #3's medication cards, read in parts,"...TAKE ONE TABLET BY MOUTH EACH DAY...POT CHLORIDE 10 MEQ ER...TAKE ONE TABLET BY MOUTH ONCE A DAY...FUROSEMIDE 20 MG..." A semi annual six month assessment, dated 11/16/22, documented Res #3 was alert to person, place, time, and situation. On 11/16/22 at 7:59 a.m., CMA #1 was observed to prepare Res #3's medications: Tylenol 500 mg one tablet, Furosemide 20 mg one tablet, Mag Ox 40 mg one tablet, Metoprolol 50 mg one tablet, and Potassium 10 meq one tablet. CMA #1 was then observed to obtain the residents blood pressure and give Res #3's medications to them. On 11/16/22 at 8:52 a.m., CMA #1 was asked to review the Furosemide medication card, and was asked how many tablets did they administer. CMA #1 stated, "One.". CMA #1 was asked to review the Potassium medication card and was asked	C1505		

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C1505	Continued From page 4 how many tablets had they administered. CMA #1 stated, "One, [the residents] counts [their] pills, [the resident] gets one." CMA #1 was then asked to review the physician orders for the potassium 20 meq and was asked how many tablets were given. They stated two. The physician order for Furosemide 40 mg was reviewed and CMA #1 was asked if the resident was given the right dose. CMA #1 stated, yes and was asked again how many tablets were administered. They stated, "Two." On 11/16/22 at 9:51 a.m., Res #3 was asked how many pills had they been administered this morning. Res #3 stated, "I took five pills this morning." On 11/16/22 at 10:00 a.m., the HSM was asked if Res #3 was alert and oriented. They stated, yes. The HSM was asked to review the medication pass observation sheet documenting the resident was administered five medication tablets. The HSM was asked if Res #3 had been administered two pills of the potassium and the furosemide should Res #3 have gotten seven tablets during the medication pass. The HSM stated "Yes". 2. Res. #2 had diagnoses which included vitamin deficiency and high blood pressure. An undated P&P titled, "Documentation Reminders", read in part, "....If you ever circle your initials with a med , you ALWAYS need to document reason on back of MAR or TAR (i.e. resident refused, med held due to....., resident out of the facility, med out of stock, etc)..." Res #2's "eMAR", dated 11/01/22 through	C1505		

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C1505	Continued From page 5 11/16/22, read in part, "...Biotin QCK DISS 5000 MCG Sublingual tablet 3 TABs BY Mouth EVERY DAY..." Res #2's "eMAR" was reviewed and Biotin QCK DISS 5000 MCG had blanks on 11/04/22 and 11/05/22. On 11/06/22 CMA #2 documented the medication was unavailable. On 11/16/22 at 1:30 p.m., the HSM was asked if Res #2 received Biotin on 11/4/22, 11/5/22, and 11/6/22. They replied, "No, not one idea why they would do that." The HSM was asked if the center has a medication dispensing problem. They replied, "I didn't, but I have told {Admin.}. We are retraining everyone straight away."	C1505		
C1951 SS=D	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a complete/accurate clinical medical record for one (#2) of four sampled residents reviewed for medical records. Findings: Resident # 2 had diagnoses which included vitamin deficiency and high blood pressure.	C1951	1. It is the policy of Town Village to ensure proper maintenance of records, there shall be an organized, accurate clinical record for each resident admitted. The record shall document all services provided under the direction of a licensed health care professional. 2. All resident had the potential to be affected. 3. To enhance current compliant operations under the Executive Director, the Director of Health Services and Certified Medication Aides were re-educated on maintenance of records policy and procedures by the Regional Director of Health Services on 11/23/22. 4. To enhance current compliant operations, the Director of Health Services and/or designee will audit	11/25/22

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C1951	Continued From page 6 A "Nursing Note", dated 11/07/22 at 7:58 p.m., read in parts, "...Res sent to ER last evening d/t confusion. Res was scared, weakened and stated [the resident] thought [they] "may be having a stroke." Res VS were WNL, all stroke checks were negative; has symmetry of face, no [sic]dropped [sic] extremeties. Res sent to [name of] Hosp-and is still there presently. Family and PCP notified..." On 11/15/22 at 4:00 p.m., the HSM was asked to review the progress note dated 11/07/22. The HSM stated, it was on 11/06/22 the resident was confused, thought they were having a stroke. The DON was asked how did the CMA know how to assess the resident. The HSM stated, I told the CMA over the phone. The HSM was asked when the CMA had contacted them. The HSM reviewed their cell phone and stated, on 11/06/22 at 7:13 p.m., the resident said they were scared. I had the CMA assess the resident. The HSM was asked when was the last text from the CMA they stated at 7:42 p.m.. The resident was then transferred to the hospital. On 11/16/22 at 12:30 p.m., the HSM was asked if there was any documentation when Res #2 had been picked up and transported by the ambulance, or any documentation of Res #2's vital signs. The HSM stated, "No."	C1951	compliance with maintenance of records policy and procedures three times a week for four weeks, twice a week for four weeks, then once a week for four weeks. The Director of Health Services and/or designee will present results of the audit to the QA/PI Committee monthly. Audit results and system components will be reviewed, identifying any trends, by the Performance Improvement Team with subsequent plans of correction developed and implemented as deemed necessary, to ensure compliance is maintained.	

OKLAHOMA
State Department
of Health

Delivery via email to: JSorum@ireg.us

February 13, 2023

License Number: AL5595

Mr. Jason Sorum, Administrator
Town Village Assisted Living
13000 North May Avenue
Nichols Hills, OK 73120

Survey Event ID: OE4H12

Dear Mr. Sorum:

On **February 9, 2023,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 16, 2022,** have now been corrected effective **November 25, 2022.**

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

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{C 000}	INITIAL COMMENTS A revisit was conducted 02/09/23. All deficiencies from the 11/16/22 survey were cleared.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE