OKLAHOMA
State Department
of Health

Delivery via email to: JSorum@ireg.us

March 5, 2024

License Number: AL5595

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

Survey Event ID: JYX211

Dear Mr. Sorum:

On **February 28, 2024,** 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 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 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 calendar days 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 a 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

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Town Village Assisted Living**
Address: **13000 North May Avenue**
City, State, Zip: **Nichols Hills, Okla. 73120**
Provider #: **AL5595**
Complaint #: **OK00062539**
Investigation Dates: **02/27/24 and 02/28/24**

INVESTIGATION

The center failed to prevent new or worsening pressure wounds.
The center failed to ensure residents were provided timely incontinent care.

An unannounced on-site investigation was initiated 02/27/2024 at 09:05 a.m.

A sample of four 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 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 Summary of Complaint Investigation:

Observations were made throughout the investigation of residents and staff interacting and providing assistance, resident's cleanliness and hygiene.

Resident records reviewed included, physician orders, home health and hospice record, service plans, resident contracts, medication administration records, and progress notes.

Residents and resident representative were interviewed regarding staff assistance as needed for assistance with activities of daily living, provision of wound care, worsening of wounds and staff assessments of wounds.

Staff were interviewed regarding provision of care with activities of daily living, documentation of activities of daily living, prevention and treatment of wounds and the process for coordinating care with third party providers.

The attached CMS 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: Click to Enter a Date

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 _____	C 02/28/2024

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 (#OK00062539) was conducted on 02/27/24 and 02/28/24. Facility Census: 21 The following abbreviations will be used throughout this document: Ca. - calcium vs. - versus x - time	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure:

a. a physician order for daily wound care was implemented for one (#2) and,
b. weekly skin assessments were completed for residents with wound care treatments for two (#1 and #2) of two sampled residents reviewed for wound care.

The Executive Director identified 21 residents resided in the facility.

Findings:

A policy titled, "SKIN CARE AND PRESSURE SORE PREVENTION", dated 02/0/12, read in part, "...to outline a process for the care of the resident's skin, the prevention of pressure sores and the treatment of skin issues...The goals of the Skin Assessment are" (1) to identify residents at risk for developing skin breakdowns who are not currently receiving some type of preventative skin care program and (2) to ensure that a treatment plan is in place for residents with skin breakdowns...A skin assessment for pressure

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C1505	Continued From page 2	C1505		

sores will be completed upon admission...The Admission skin risk assessment should be completed within 24 hours of admission...A Wound/Skin Issue form should be completed weekly to document the characteristics of the pressure sore/wound, determine the status of healing and identify the presence of any complications..."

1. Resident #1's initial service plan, dated 02/12/24, documented a gluteal fold abrasion, two scabbed areas on the lower extremities, but no active wound. Resident #1 had no cognitive impairment and was independent with activities of daily living.

An "Assisted Living Residency Agreement", dated 02/15/24, read in part, "...All outside providers providing care or services at [name of facility] must agree and abide by the Oklahoma State Department of Health regulations regarding third party providers...Attending Physician....we will work with this professional to collaborate and execute services and care that best meets your needs..."

Resident #1 admitted to the facility on 02/15/24 and had diagnoses which included type two diabetes mellitus, non-pressure chronic ulcer of buttock limited to breakdown skin, and chronic kidney disease.

A "Home Health Clarification and Plan of Care" dated 02/17/24 through 04/16/24, read in part, "...Assess wounds to left buttock. Instructed patient to apply buttpaste to areas's 3 x's daily and as needed, monitor for worsening vs healing..."

The clinical health record contained no

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C1505	Continued From page 3 documentation weekly skin assessment had been completed since admission. On 02/27/24 at 1:20 p.m., Resident #1 was asked if they had any open wound or sores. They stated they did not have any at this time, but have been using "buttpaste" about three times a week. They were asked if the facility staff had completed a skin check. They stated "No." Resident #1 was asked if they notified the facility staff they were using the buttpaste. They stated they had not notified anyone from the facility. On 02/28/24 at 12:40 p.m., the corporate nurse was asked if they were aware of the home health plan of care that documented wounds to buttock. They stated they had not seen the plan of care. They stated they had not gone back and assessed the client after admission and had not implemented weekly skin assessments. 2. Client #2 had diagnoses which included debility, dementia, and type two diabetes mellitus. A preadmission "Resident Assessment Form", dated 09/07/23, documented Resident #2 needed assistance of one staff for bathing, dressing, transferring, toileting, ambulation and was incontinent of bladder and incontinent of bowel at times. A nurse progress note, dated 01/15/24, read in part, "Sent fax for wound care to [name of wound care] per physicians order..." A home health "Start of Care", dated 01/17/24, documented Resident #1 was at risk for pressure ulcers, and had two stage two pressure ulcers, one on the right buttock and one on the left buttock. Resident #1 would require dressing	C1505		

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C1505	Continued From page 4 changes two times per week. A wound care "Progress Note Details", dated 01/31/24, read in part, "...Wound #1 buttock is Stage 2 Pressure Injury Pressure Ulcer and had received a status of Not Healed...Plan...1. cleanse wound with cleanser 2. Ca. Alginate and silicone dressing, 3. daily wound care. We will see [client] every 2 weeks..." The clinical health record did not contain the start of care, or home health wound care notes. The executive director requested the information on 02/27/24. The home health start of care documentation was provided to this surveyor on 02/28/24. Resident #2 had been discharged from home health services on 02/01/24. The executive director was shown the home health start of care and asked who provided the daily dressing changes as ordered on 01/31/24 if home health discharged the client on 02/01/24. They were not sure. They stated Resident #2 was on hospice and home health at the same time and home health discharged the client due to being on hospice. The clinical health record did not contain documentation a weekly wound/skin issue form had been completed or daily dressing changes had been completed as ordered from 01/31/24 through 02/09/24 when Resident #2 was admitted to the hospital. On 02/28/24 at 12:40 p.m., the corporate nurse was asked if the physician order for daily dressings had been followed. They stated no they did not believe the wound care had been completed.	C1505		

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C5010	Continued From page 5	C5010		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on record review and interview, the center	C5010		

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C5010	Continued From page 6 failed to ensure coordination of care with a third party provider for two (#1 and #2) of two sampled residents reviewed for coordination of care. The Executive Director identified 21 clients resided in the facility and five clients received home health services. Findings: 1. Resident #1's "Assisted Living Residency Agreement", dated 02/15/24, read in part, "...All outside providers providing care or services at [name of facility] must agree and abide by the Oklahoma State Department of Health regulations regarding third party providers..."Attending Physician....we will work with this professional to collaborate and execute services and care that best meets your needs..." Resident #1 admitted to the facility on 02/15/24 and had diagnoses which included type two diabetes mellitus, neuromuscular disease, and high blood pressure. A "Home Health Clarification and Plan of Care" dated 02/17/24 through 04/16/24, read in part, "Non-pressure chronic ulcer of buttock limited to brkdwn skin...Assess wounds to left buttock. Instructed patient to apply buttpaste to areas's 3 x's daily and as needed, monitor for worsening vs healing..." The clinical health record did not contain a weekly skin assessment had been completed since admission. On 02/27/24 at 1:20 p.m., Resident #1 was asked if they had any open wound or sores. They stated they did not have any at this time but have been	C5010		

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C5010	Continued From page 7	C5010		

using "buttpaste" about three times a week. They were asked if the facility staff had completed a skin check. They stated "No." Resident #1 was asked if they notified the facility staff they were using the buttpaste. They stated they had not notified anyone from the facility.

On 02/28/24 at 12:40 p.m., the corporate nurse was asked if they were aware of the home health plan of care that documented wounds to buttock. They stated they had not seen the plan of care.

2. Client #2 had diagnoses which included debility, dementia, and type two diabetes mellitus.

Resident #1's "Assisted Living Residency Agreement", dated 09/30/23, read in part, "...All outside providers providing care or services at [name of facility] must agree and abide by the Oklahoma State Department of Health regulations regarding third party providers..."Attending Physician....we will work with this professional to collaborate and execute services and care that best meets your needs..."

A preadmission "Resident Assessment Form", dated 09/07/23, documented Resident #2 needed assistance of one staff for bathing, dressing, transferring, toileting, ambulation and was incontinent of bladder and incontinent of bowel at times.

A nurse progress note, dated 01/15/24, read in part, "Sent fax for wound care to [name of wound care] per physicians order..."

A home health "Start of Care", dated 01/17/24, documented Resident #1 was at risk for pressure ulcers, and had two stage two pressure ulcers, one on the right buttock and left buttock. Resident

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C5010	Continued From page 8 #1 would require dressing changes two times per week..." A wound care "Progress Note Details", dated 01/31/24, read in part, "...Wound #1 buttock is Stage 2 Pressure Injury Pressure Ulcer and had received a status of Not Healed...Plan...1. cleanse wound with cleanser 2. Ca. Alginate and silicone dressing, 3. daily wound care. We will see [client] every 2 weeks..." The clinical health record did not contain the start of care, or home health wound care notes. The executive director requested the information on 02/27/24. The home health start of care documentation was provided to this surveyor on 02/28/24. Resident #2 was discharged from home health services on 02/01/24. The executive director was shown the home health start of care and asked who provided the daily dressing changes as ordered on 01/31/24 if home health discharged the client on 02/01/24. They were not sure. They stated Resident #2 was on hospice and home health at the same time and home health discharged the client due to being on hospice. The clinical health record did not contain hospice documentation of the start of care or any nurses notes. On 02/28/24 at 12:40 p.m., the corporate nurse was asked how the center coordinated care when Resident #2 had been discharged from home health on 02/01/24. They stated the nurse should have contacted another home health to start services. They were asked if the physician order for daily dressings had been followed. They stated no they did not believe the wound care had	C5010		

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C5010	Continued From page 9 been completed. They stated it was up to the facility to coordinate third party provider services.	C5010		

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Delivery via email to: JSorum@ireg.us

March 21, 2024

License Number: AL5595

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

Survey Event ID: JYX211

Dear Mr. Sorum:

On **February 28, 2024,** 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 **March 13, 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,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A complaint investigation (#OK00062539) was conducted on 02/27/24 and 02/28/24. Facility Census: 21 The following abbreviations will be used throughout this document: Ca. - calcium vs. - versus x - time	C 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.	
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505	1) It is the policy of Town Village under the direction of the Executive Director that the center and its staff shall be familiar with and observe all resident rights and responsibilities. 2) All residents have the potential to be affected. 3) Resident records were audited for physician wound care orders. Physician wound care orders were verified for accuracy and implementation. A skin assessment was conducted on residents with wounds. New Director of Health Services (DHS) started on 3-6-2024. Director of Health Services was educated on 3-13-2024 regarding policies and procedures related to physician wound care orders and skin assessments on residents with wounds and/or at risk for breakdown.	3-13-2024

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3/15/24

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 _____	C 02/28/2024

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

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C1505	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure: a. a physician order for daily wound care was implemented for one (#2) and, b. weekly skin assessments were completed for residents with wound care treatments for two (#1 and #2) of two sampled residents reviewed for wound care. The Executive Director identified 21 residents resided in the facility. Findings: A policy titled, "SKIN CARE AND PRESSURE SORE PREVENTION", dated 02/0/12, read in part, "...to outline a process for the care of the resident's skin, the prevention of pressure sores and the treatment of skin issues...The goals of the Skin Assessment are" (1) to identify residents at risk for developing skin breakdowns who are not currently receiving some type of preventative skin care program and (2) to ensure that a treatment plan is in place for residents with skin breakdowns...A skin assessment for pressure	C1505	4) Weekly skin assessments will be completed on all residents with noted wounds and/or at risk by the DHS and documented within the EHR. Caregivers will report any noted skin changes during care to the DHS.. Audits on implementation of physician wound orders and skin assessments will be completed by the Executive Director and/or designee monthly. The results will be presented 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.	

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C1505	Continued From page 2 sores will be completed upon admission...The Admission skin risk assessment should be completed within 24 hours of admission...A Wound/Skin Issue form should be completed weekly to document the characteristics of the pressure sore/wound, determine the status of healing and identify the presence of any complications..." 1. Resident #1's initial service plan, dated 02/12/24, documented a gluteal fold abrasion, two scabbed areas on the lower extremities, but no active wound. Resident #1 had no cognitive impairment and was independent with activities of daily living. An "Assisted Living Residency Agreement", dated 02/15/24, read in part, "...All outside providers providing care or services at [name of facility] must agree and abide by the Oklahoma State Department of Health regulations regarding third party providers...Attending Physician....we will work with this professional to collaborate and execute services and care that best meets your needs..." Resident #1 admitted to the facility on 02/15/24 and had diagnoses which included type two diabetes mellitus, non-pressure chronic ulcer of buttock limited to breakdown skin, and chronic kidney disease. A "Home Health Clarification and Plan of Care" dated 02/17/24 through 04/16/24, read in part, "...Assess wounds to left buttock. Instructed patient to apply buttpaste to areas's 3 x's daily and as needed, monitor for worsening vs healing..." The clinical health record contained no	C1505		

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C1505	Continued From page 3 documentation weekly skin assessment had been completed since admission. On 02/27/24 at 1:20 p.m., Resident #1 was asked if they had any open wound or sores. They stated they did not have any at this time, but have been using "buttpaste" about three times a week. They were asked if the facility staff had completed a skin check. They stated "No." Resident #1 was asked if they notified the facility staff they were using the buttpaste. They stated they had not notified anyone from the facility. On 02/28/24 at 12:40 p.m., the corporate nurse was asked if they were aware of the home health plan of care that documented wounds to buttock. They stated they had not seen the plan of care. They stated they had not gone back and assessed the client after admission and had not implemented weekly skin assessments. 2. Client #2 had diagnoses which included debility, dementia, and type two diabetes mellitus. A preadmission "Resident Assessment Form", dated 09/07/23, documented Resident #2 needed assistance of one staff for bathing, dressing, transferring, toileting, ambulation and was incontinent of bladder and incontinent of bowel at times. A nurse progress note, dated 01/15/24, read in part, "Sent fax for wound care to [name of wound care] per physicians order..." A home health "Start of Care", dated 01/17/24, documented Resident #1 was at risk for pressure ulcers, and had two stage two pressure ulcers, one on the right buttock and one on the left buttock. Resident #1 would require dressing	C1505		

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C1505	Continued From page 4 changes two times per week. A wound care "Progress Note Details", dated 01/31/24, read in part, "...Wound #1 buttock is Stage 2 Pressure Injury Pressure Ulcer and had received a status of Not Healed...Plan...1. cleanse wound with cleanser 2. Ca. Alginate and silicone dressing, 3. daily wound care. We will see [client] every 2 weeks..." The clinical health record did not contain the start of care, or home health wound care notes. The executive director requested the information on 02/27/24. The home health start of care documentation was provided to this surveyor on 02/28/24. Resident #2 had been discharged from home health services on 02/01/24. The executive director was shown the home health start of care and asked who provided the daily dressing changes as ordered on 01/31/24 if home health discharged the client on 02/01/24. They were not sure. They stated Resident #2 was on hospice and home health at the same time and home health discharged the client due to being on hospice. The clinical health record did not contain documentation a weekly wound/skin issue form had been completed or daily dressing changes had been completed as ordered from 01/31/24 through 02/09/24 when Resident #2 was admitted to the hospital. On 02/28/24 at 12:40 p.m., the corporate nurse was asked if the physician order for daily dressings had been followed. They stated no they did not believe the wound care had been completed.	C1505		

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C5010	Continued From page 5	C5010		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on record review and interview, the center	C5010	1) It is the policy of Town Village under the direction of the Executive Director, to follow OSDH Care and Service Policy, ensuring home care services are delivered in accordance with the written orders of the physician. 2) Residents receiving Home Health services had the potential to be affected. 3) Care plan meeting was held with resident #1 and resident #2, respective responsible parties, respective physician, and facility to ensure coordination of care. New Director of Health Services, (DHS) started on 3-6-2024. DHS was educated on policies and procedures related to continuity of care with outside agencies. Communication form is completed by the outside vendor and given to the DHS and/or designee for review. 4) Audits on continuity of care with Home Health will be completed by the Executive Director or designee weekly. The results will be presented 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	3-13-2024

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C5010	Continued From page 6 failed to ensure coordination of care with a third party provider for two (#1 and #2) of two sampled residents reviewed for coordination of care. The Executive Director identified 21 clients resided in the facility and five clients received home health services. Findings: 1. Resident #1's "Assisted Living Residency Agreement", dated 02/15/24, read in part, "...All outside providers providing care or services at [name of facility] must agree and abide by the Oklahoma State Department of Health regulations regarding third party providers..."Attending Physician....we will work with this professional to collaborate and execute services and care that best meets your needs..." Resident #1 admitted to the facility on 02/15/24 and had diagnoses which included type two diabetes mellitus, neuromuscular disease, and high blood pressure. A "Home Health Clarification and Plan of Care" dated 02/17/24 through 04/16/24, read in part, "Non-pressure chronic ulcer of buttock limited to brkdwn skin...Assess wounds to left buttock. Instructed patient to apply buttpaste to areas's 3 x's daily and as needed, monitor for worsening vs healing..." The clinical health record did not contain a weekly skin assessment had been completed since admission. On 02/27/24 at 1:20 p.m., Resident #1 was asked if they had any open wound or sores. They stated they did not have any at this time but have been	C5010		

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C5010	Continued From page 7 using "buttpaste" about three times a week. They were asked if the facility staff had completed a skin check. They stated "No." Resident #1 was asked if they notified the facility staff they were using the buttpaste. They stated they had not notified anyone from the facility. On 02/28/24 at 12:40 p.m., the corporate nurse was asked if they were aware of the home health plan of care that documented wounds to buttock. They stated they had not seen the plan of care. 2. Client #2 had diagnoses which included debility, dementia, and type two diabetes mellitus. Resident #1's "Assisted Living Residency Agreement", dated 09/30/23, read in part, "...All outside providers providing care or services at [name of facility] must agree and abide by the Oklahoma State Department of Health regulations regarding third party providers..."Attending Physician....we will work with this professional to collaborate and execute services and care that best meets your needs..." A preadmission "Resident Assessment Form", dated 09/07/23, documented Resident #2 needed assistance of one staff for bathing, dressing, transferring, toileting, ambulation and was incontinent of bladder and incontinent of bowel at times. A nurse progress note, dated 01/15/24, read in part, "Sent fax for wound care to [name of wound care] per physicians order..." A home health "Start of Care", dated 01/17/24, documented Resident #1 was at risk for pressure ulcers, and had two stage two pressure ulcers, one on the right buttock and left buttock. Resident	C5010		

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C5010	Continued From page 8 #1 would require dressing changes two times per week..." A wound care "Progress Note Details", dated 01/31/24, read in part, "...Wound #1 buttock is Stage 2 Pressure Injury Pressure Ulcer and had received a status of Not Healed...Plan...1. cleanse wound with cleanser 2. Ca. Alginate and silicone dressing, 3. daily wound care. We will see [client] every 2 weeks..." The clinical health record did not contain the start of care, or home health wound care notes. The executive director requested the information on 02/27/24. The home health start of care documentation was provided to this surveyor on 02/28/24. Resident #2 was discharged from home health services on 02/01/24. The executive director was shown the home health start of care and asked who provided the daily dressing changes as ordered on 01/31/24 if home health discharged the client on 02/01/24. They were not sure. They stated Resident #2 was on hospice and home health at the same time and home health discharged the client due to being on hospice. The clinical health record did not contain hospice documentation of the start of care or any nurses notes. On 02/28/24 at 12:40 p.m., the corporate nurse was asked how the center coordinated care when Resident #2 had been discharged from home health on 02/01/24. They stated the nurse should have contacted another home health to start services. They were asked if the physician order for daily dressings had been followed. They stated no they did not believe the wound care had	C5010		

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C5010	Continued From page 9 been completed. They stated it was up to the facility to coordinate third party provider services.	C5010		

OKLAHOMA
State Department
of Health

Delivery via email to: dajohnson@ireg.us

May 1, 2024

License Number: AL5595

Ms. Danna Johnson, Administrator
Town Village Assisted Living
13000 North May Avenue
Nichols Hills, OK 73120

Survey Event ID: JYX212

Dear Ms. Johnson:

On **April 26, 2024,** an offsite/paper complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **February 28, 2024,** have now been corrected effective **March 13, 2024.**

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

Respectfully,

Lisa Calvin

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

Enclosure

Oklahoma State Department of Health

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{C 000}	INITIAL COMMENTS An offsite/paper visit was conducted on 04/26/24. The facility was in substantial compliance.	{C 000}		

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