Oklahoma State Department of Health
Creating a State of Health

December 6, 2019

License Number: AL6904

Ms. Jessica Garvin, Administrator
West Wind Assisted Living
111 North 9th Street
Marlow, OK 73055

RE: Survey Event ID: DHG511

Dear Ms. Garvin:

On **October 31, 2019,** agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on October 31, 2019.

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 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 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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6904	A. BUILDING _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST WIND ASSISTED LIVING	111 NORTH 9TH STREET MARLOW, OK 73055

(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
N 000	Initial Comments On 10/30/19 through 10/31/19 a re-licensure survey was conducted. Census was 28. The following deficient practice was cited.	N 000		
N1429 SS=F	310:677-13-7 (b) (5) Skills And Functions Limitations. A certified medication aide shall not: (5) Administer PRN medication without a documented assessment unless authorization is obtained from a licensed nurse on duty or on call, and unless fully documented by the certified medication aide; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the center failed to ensure CMA's (certified medication aides) did not administer (as needed) PRN medications prior to notifying a licensed nurse for 1 (#5) of 1 sampled resident that had medications that required assessment prior to administering. This failed practice had the isolated potential for more than minimal harm. Findings. On 10/30/19 at 9:27 a.m., resident #5 had a	N1429		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N1429	Continued From page 1 physician's order dated 09/18/2019 check daily for swelling to lower legs, if swelling is observed give PRN (as needed) Lasix along with PRN potassium as ordered under PRN medications. CMA #1 observed resident #5's lower legs for swelling, she determined his swelling was a two (a two millimeter depression in the skin when pressure applied by the finger). Lasix 40 (milligrams) MG one tablet and potassium 20 (millequivalents) MEQ one tablet was administered to resident #5. She did not notify a licensed nurse prior to administering the medication. At 12:30 p.m., the (licensed practical nurse/director of nursing) LPN/DON stated if CMA's give a PRN medication they are to notify the LPN on duty prior to administering the medication. The LPN/DON stated she was not notified that a prn medication was given by CMA #1 this day. West Wind Policy CMA The CMA works under the direct supervision and perform duties assigned by the Registered Nurse or Licensed Practical Nurse.	N1429		
C 000	INITIAL COMMENTS On 10/30/19 through 10/31/19 a re-licensure survey was conducted. Census was 28. The following deficient practice was cited.	C 000		
C 911 SS=F	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with	C 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6904	A BUILDING _____ B WING _____	10/31/2019

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C 911	Continued From page 2 each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to ensure registered nurse supervision of the skilled nursing intervention of assessment for 1 (#5) of 1 sampled resident was completed by a licensed nurse prior to the administration of PRN (as needed) medications that required assessment. This deficient practice had the isolated potential for more than minimal harm. Findings: On 10/30/19 at 9:27 a.m., Resident #5's (Medication Administration Record) MAR documented check daily for edema (swelling) to both lower legs. If edema is observed give (as needed) PRN Lasix along with PRN potassium as ordered under PRN medications. (Certified Medication Aide) CMA #1 observed resident #5's lower legs for edema and when asked what she determined his edema was, she stated a two (a two millimeter depression in the skin when pressure applied by the finger). Lasix 40 (milligrams) MG one tablet and potassium 20 (millequivalents) MEQ one tablet was administered to resident #5 by CMA #1. CMA #1 did not notify a licensed nurse prior to giving resident #5 his medication. At 12:30 p.m., the (licensed practical nurse/director of nursing) LPN/DON stated if CMA's give a PRN medication they are to notify	C 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 911	Continued From page 3 the LPN on duty prior to administering the medication. The LPN/DON stated she was not notified that a prn medication was given by CMA #1 this day. At 1:50 p.m. The LPN/DON stated CMA #1 was qualified and it was in her scope of practice to assess swelling because the center had given an inservice to CMAs about swelling. On 10/31/2019 at 11:25 a.m., LPN #1 was asked if a CMA was able to perform an assessment. She stated no. LPN #1 was asked if she considered checking or observing for edema an assessment. She stated yes. West Wind Policy CMA The CMA works under the direct supervision and perform duties assigned by the Registered Nurse or Licensed Practical Nurse.	C 911		
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	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6904	A BUILDING _____ B WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1505	Continued From page 4 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 observation, interview and record review, it was determined the center failed to provide Eliquis (a blood thinner medication) for 1 (#1) of 1 sampled resident with a physician's order for Eliquis 2.5 mg (milligrams) twice a day for hardening of the arteries. This deficient practice resulted in the potential for more than minimal harm at a pattern. Findings: On 10/30/19 at 9:22 a.m., a medication pass was observed with certified medication aide (CMA) #2 and resident #1. Resident #1's morning dose of Eliquis was not available for administration. CMA #2 stated she would need to check on it. Resident #1 had ran out of Eliquis on the evening of October 26, 2019. Resident #1 missed a total of eight doses of Eliquis. On 10/31/19 at 10.45 a.m., resident #1 was asked if she had ran out of medications before. She stated no, but she had received a medication late last night (10/30/19). The resident was not aware she had missed any doses of medications. The licensed practical nurse/assistant director of nurses (LPN/ADON) was asked if resident #1 received her Eliquis late last night (10/30/19). She stated yes.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6904	A. BUILDING: _____ B. WING _____	10/31/2019

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C1505	Continued From page 5 Policy Emergency pharmacy services are available on a 24-hour basis from the contract pharmacy provider. Residents who obtain medications from their own pharmacy must provide for emergency pharmacy services, which is documented in the resident's file.	C1505		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL6904	WEST WIND ASSISTED LIVING

Type of Survey (select all that apply)

2								

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A								

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30875	10/30/2019	10/31/2019	0.50	0.00	14.25	0.00	4.00	2.50
2. 41872	10/30/2019	10/31/2019	0.50	0.00	14.25	0.00	3.50	3.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

DEC 11 2019

~~DEC 11 2019~~

Oklahoma State Department of Health
Creating a State of Health

January 6, 2020

License Number: AL6904

Ms. Jessica Garvin,
West Wind Assisted Living
111 North 9th Street
Marlow, OK 73055

RE: Survey Event DHG511

Dear Ms. Garvin:

On October 31, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. 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, 2020**.

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) 271-6868.

Sincerely,

Katie Stagner

for Sue V. Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/18/2019** **Facility Name:** West Wind Assisted Living **License Number:** AL6904 **Survey Event ID:** DHG511 **Date Survey Completed: 10/31/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: N1429	Based on: Based on observation, interview and record review it was determined the center failed to ensure CMAs did not administer PRN medicaitons prior to notifying a licensed nurse for 1 of 1 sampled residents that had medications that required assessment prior to administering.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The facility policy has been changed to reflect that residents who are able to voice their concern or symptoms will continue to do so, as no assessment is needed if the resident is able to voice their needs and state the reason for asking for a PRN medication to be given. Medicaiton aides will continue to follow physicians orders written for specific symptoms (such as giving Tylenol for a headache if a resident is able to voice that they have a headache) without having to notify a nurse, as no assessment is needed if a resident is able to identify their concerns and notify nursing staff of symptoms.

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?	For residents who are not able to voice their concerns, the nurse on duty or on call will be notified prior to a PRN medication being given. PRN diuretic medications will be given based on weight changes and per the attached policy.
OSDH Response: Element accepted Yes No	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DON has audited resident roster and determined which residents are not able to voice their needs for PRN medications or those that have PRN diuretic medications; those residents
OSDH Response: Element accepted Yes No	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	DON will alert staff via secure messaging system immediately if a resident becomes unable to voice their needs in regard to PRN medication dosing. Staff will alert nurse on call or on duty if a resident appears to need a PRN medication but is unable to communicate the need for medication, such as pain medication or breathing treatment.
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	RN Consultant and/or physician will assess residents who are prescribed PRN medications and evaluate their ability to identify symptoms that might require PRN medicaitons to be delivered. QA Committee to monitor for effectiveness by working with pharmacist to ensure no unnecessary medications were given each quarter.

correction.	QA Committee will review pharmacy consultant report to check for unnecessary PRN medicaitons given to residents. This process will be documented in the QA meetings until the issue is resolved.
OSDH Response: Element accepted: Yes No	
5. On what date will corrective action be completed?	1/15/2019
OSDH Response: Element accepted: Yes No	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.	**Date** Enter a date of signature. 12/18/19

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: 12/18/2019** **Facility Name:** West Wind Assisted Living **License Number:** AL6904 **Survey Event ID:** DHG511 **Date Survey Completed: 10/31/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C911	Based on: Based on observation, interview and record review it was determined the center failed to ensure CMAs did not administer PRN medicaitons prior to notifying a licensed nurse for 1 of 1 sampled residents that had medications that required assessment prior to administering.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: The facility policy has been changed to reflect that residents who are able to voice their concern or symptoms will continue to do so, as no assessment is needed if the resident is able to voice their needs and state the reason for asking for a PRN medication to be given. Medicaiton aides will continue to follow physicians orders written for specific symptoms (such as giving Tylenol for a headache if a resident is able to voice that they have a headache) without having to notify a nurse, as no assessment is needed if a resident is able to identify their concerns and notify nursing staff of symptoms.

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?	For residents who are not able to voice their concerns, the nurse on duty or on call will be notified prior to a PRN medication being given. PRN diuretic medications will be given based on weight changes and per the attached policy.
OSDH Response: Element accepted Yes No	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DON has audited resident roster and determined which residents are not able to voice their needs for PRN medications or those that have PRN diuretic medications; those residents
OSDH Response: Element accepted Yes No	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	DON will alert staff via secure messaging system immediately if a resident becomes unable to voice their needs in regard to PRN medication dosing. Staff will alert nurse on call or on duty if a resident appears to need a PRN medication but is unable to communicate the need for medication, such as pain medication or breathing treatment.
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	RN Consultant and/or physician will assess residents who are prescribed PRN medications and evaluate their ability to identify symptoms that might require PRN medicaitons to be delivered. QA Committee to monitor for effectiveness by working with pharmacist to ensure no unnecessary medications were given each quarter.

correction.	QA Committee will review pharmacy consultant report to check for unnecessary PRN medicaitons given to residents. This process will be documented in the QA meetings until the issue is resolved.
OSDH Response: Element accepted: Yes No	
5. On what date will corrective action be completed?	1/15/2019
OSDH Response: Element accepted: Yes No	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 12/18/19

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.

PRN Diuretic Medication Administration

If a prn diuretic medication is prescribed to a resident, the order must reflect that the medication is to be given as needed according to if a 2lbs or greater weight gain in 24 hours is observed.

If the prn diuretic medication prescribed does not reflect when the medication is to be given or if it reflects to be given for swelling/edema, a licensed nurse must clarify the order notifying the prescribing physician of West Wind Assisted Living policy on administration of prn diuretic(s).

The qualified staff administering the prn diuretic must obtain and document the resident's weight in the resident's electronic chart daily. The qualified staff must obtain the resident's weight at approximately the same time each day, which shall be before breakfast every morning.

Medical Director: _____

Director of Nursing: _____

Executive Director: _____

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 12/18/2019** **Facility Name:** West Wind Assisted Living **License Number:** AL6904 **Survey Event ID:** DHG511 **Date Survey Completed: 10/31/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: observation, interview and record review, it was determined the center failed to provide Eliquis for one of one sampled resident with a physician's order for Eliquis 2.5mg twice a day...

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This particular situation occurred because the midlevel provider (Reggie Pennypacker, NP) had not been properly educated on assisted living policy and procedures regarding timeliness of medication refill requests.

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?	Staff responsible for medication management were all inserviced verbally on 10/31/2019-11/1/2019 and again on 11/14/2019 regarding facility policy and procedures.
OSDH Response: Element accepted Yes No	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DON has audited resident roster and determined which resident medications are at risk for not being in the facility when they will be needed; none were 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?	Medical Director is to be notified prior to the next scheduled dose if a refill is not received and a medication runs out so that he can provide instructions. Policy was updated to include notificaiton to resident and responsible party if medication is not given due to supply. Medical Director educated provider about policy and procedures for timely response for medication requests.
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 policy was updated and staff were inserviced to ensure corrections are sustained. QA Committee will review each quarter if any medications were not dispensed due to not being in the facility. QA will monitor for effectiveness and will continue to monitor until new policy is determined to be effective. Records will be included in quarterly QA minutes.
OSDH Response: Element accepted Yes No	
5. On what date will corrective action be completed?	1/15/2019
OSDH Response: Element accepted Yes No	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 12/18/19

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.			

ORDERING AND RECEIVING MEDICATIONS BY THE ASSISTED LIVING FACILITY

Medications (prescription and non-prescription) and related equipment and supplies are ordered and received from the pharmacy provider on a timely basis WEST WIND maintains accurate records of medications and supplies ordered and received.

PREOCEDURES-ORDERING MEDICATIONS

- New written prescriptions may be sent, faxed, or picked up by the pharmacy provider, or phone in to the pharmacy provider by the prescriber, in accordance with applicable federal and state laws and regulations, WEST WIND policy, and policies of the pharmacy provider. Requests for prescription refills, non-prescription (over-the-counter) medications, and supplies are phoned or faxed to the pharmacy provider or picked up from WEST WIND by the pharmacy provider. All requests for refills, non-prescription medications, and supplies are documented by WEST WIND in the Med Order Book and all faxes to physician regarding refills of medication will be kept until medication arrives to the facility.
  - Refill request should be made when a (7) day supply remains by the designated WEST WIND staff, to allow for timely refill of the prescription.
    - The designated WEST WIND staff shall draw a / on the medication to alert the medication has been reordered.
    - The designated WEST WIND staff will follow up the next day to ensure the medication arrived to the facility, if the medication is found in overflow the designated WEST WIND staff shall put a (X) on the card.
    - In the event that the medication has not arrived to the facility, the designed WEST WIND staff shall contact the pharmacy and/or physician's office.
    - In the event the medication still has not arrived to the facility, and there is a (3) say supply remaining, the designated WEST WIND staff shall notify the ADON and/or DON, to ensure medication arrives to facility before the medication runs out.
      - In the event that resident runs out of medication, the Medical Director is to be notified prior to the next scheduled dose to provide instructions regarding medication.

- In the event that medication was not administered as ordered to a resident related to medication supply, qualified staff must notify resident and responsible party.

- WEST WIND will notify the pharmacy provider of all discontinued or changed medication orders.

PROCEDURES-RECEIVING MEDICATIONS

- The pharmacy provider provides a pharmacy delivery record with the delivery of medications.
- The designated WEST WIND staff will document the receipt of medication delivered to WEST WIND on the pharmacy delivery record.
- The designated WEST WIND staff will document the receipt of medications delivered to WEST WIND on the pharmacy delivery record
- WEST WIND will verify the receipt of the correct medications as ordered. Discrepancies and omissions are reported promptly to the pharmacy provider.
- The designated WEST WIND staff verifies that all medications received are documented in the Medication Sign-In Book.
- Medications are locked in the designated medication storage area as soon as received or until delivered to the resident.

RELATED APPENDICES
Appendix 11- Medication Reorder/Order Change Form
Appendix 13- Pharmacy Deliver Receipt Log
RELATED POLICIES
Contract Pharmacy Hours and Delivery Schedule

TRANSMITTING PRESCRIPTIONS VIA FACSIMILE MACHINE

New prescriptions and prescription refill orders may be transmitted via facsimile machine to the pharmacy provider in accordance with applicable federal and state laws and regulations.

- Original prescription orders and refill request may be faxed to the provider pharmacy.
- The original prescription must be provided to the pharmacy provider when the medication is delivered.
- Refill requests must contain the date, resident's name, prescription number, medication name, directions for use, and prescriber name.

- Refill requests should be made when a seven-day supply remains to allow for timely refill of the prescription.
- Urgent prescription orders may be faxed at any time during regular pharmacy hours. Routine and refill prescriptions orders are faxed at a designated time in accordance with facility policy and provisions of the contract with the pharmacy provider.
- Routine and refill prescriptions orders are faxed Monday, Wednesday, and Friday and will be delivered at the next scheduled delivery time.
- Responsibility for routine faxing is assigned to designated WEST WIND staff.

RELATED APPENDICES
Appendix 11- Medication Reorder/ Order Change Form

RELATED POLICIES
Contract Pharmacy Hours and Delivery Schedule

JAN 0 9 2020

Oklahoma State Department of Health
Creating a State of Health

February 18, 2020

License Number: AL6904

Jennifer Carney, Administrator
West Wind Assisted Living
111 North 9th Street
Marlow, OK 73055

RE: Survey Event DHG512

Dear Ms. Carney:

On **February 13, 2020,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 31, 2019,** have now been corrected effective **January 15, 2020.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Katie Stagner

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6904	A. BUILDING. _____ B. WING _____	R 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST WIND ASSISTED LIVING	111 NORTH 9TH STREET MARLOW, OK 73055

(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
{N 000}	Initial Comments A follow up survey was completed on 02/13/2020. Census was 28. Deficient practice was cleared.	{N 000}		
{C 000}	INITIAL COMMENTS A follow up survey was completed on 02/13/2020. Census was 28. Deficient practice was cleared.	{C 000}		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL6904	WEST WIND ASSISTED LIVING

Type of Survey (select all that apply)

2	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
NC 1. 41872	02/13/2020	02/13/2020	1.00	0.00	3.25	0.00	3.50	1.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**