OKLAHOMA
State Department
of Health

Delivery via email to: richard.manganya@northcountyseniorliving.com

November 16, 2023

License Number: AL7218

Mr. Richard Manganya, Administrator
North County Assisted Living
523 North 22nd
Collinsville, OK 74021

RE: Survey Event ID: 14GR11

Dear Mr. Manganya:

On **November 3, 2023**, agents from our office concluded a State Licensure survey along with complaint investigations at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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 **November 3, 2023**.

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) 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.

Respectfully,

Lisa Calvin

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **North County Assisted Living**
Address: **523 N. 22nd Street**
City, State, Zip: **Collinsville, OK 74021**
Provider #: **AL7218**
Complaint #: **OK00058976**
Investigation Dates: **11/01/23 through 11/03/23**

ALLEGATION

The center failed to provide a safe environment with equipment in proper working condition.

An unannounced on-site investigation was initiated 11/01/2023 at 11:20 a.m.

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

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

A Summary of Complaint Investigation:

Throughout the survey, observations of the facility equipment and room temperatures were made.

Interviews with residents and staff were conducted regarding the equipment in the kitchen and throughout the facility. The identified resident was interviewed and asked about the living conditions, electricity, and heat and air.

Review of documents included work orders and invoices.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/06/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **North County Assisted Living**
Address: **523 N. 22nd Street**
City, State, Zip: **Collinsville, OK 74021**
Provider #: **AL7218**
Complaint #: **OK00059558**
Investigation Dates: **11/01/23 through 11/03/23**

ALLEGATION

The facility failed to ensure a clean, sanitary, homelike environment.

An unannounced on-site investigation was initiated 11/01/2023 at 11:20 a.m.

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

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

A Summary of Complaint Investigation:

Throughout the survey, observations of the facility cleanliness were made, including the number and efficiency of the housekeeping staff.

Interviews with residents and staff were conducted regarding the cleanliness throughout the facility. Residents were asked about housekeeping, the frequency of housekeeping and the thoroughness of housekeeping.

Review of documents included grievances and employee records.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/06/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **North County Assisted Living**
Address: **523 N. 22nd Street**
City, State, Zip: **Collinsville, OK 74021**
Provider #: **AL7218**
Complaint #: **OK00060422**
Investigation Dates: **11/01/23 through 11/03/23**

ALLEGATIONS

The facility failed to ensure residents received drinks consistent with residents' preferences.
The facility failed to ensure residents were treated with dignity and respect.

An unannounced on-site investigation was initiated 11/01/2023 at 11:20 a.m.

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

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

A Summary of Complaint Investigation:

Throughout the survey, observations of drink availability and dishware were made in the dining room and in the halls.

Interviews were conducted with staff and residents regarding the availability of and choice of drink options available after meals. Residents and staff were interviewed regarding the type of dishware and utensils provided to the residents.

Review of records included, invoices and workorders, as well as grievances.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/06/2023

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **North County Assisted Living**
Address: **523 N. 22nd Street**
City, State, Zip: **Collinsville, OK 74021**
Provider #: **AL7218**
Complaint #: **OK00061725**
Investigation Dates: **11/01/23 through 11/03/23**

ALLEGATIONS

The center failed to ensure residents' right to be informed and make treatment decisions.

An unannounced on-site investigation was initiated 11/01/2023 at 11:20 a.m.

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

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

A Summary of Complaint Investigation:

Throughout the survey, observations of drink availability and dishware were made in the dining room and in the halls.

Interviews were conducted with staff and residents regarding the communication between the physician/facility and the residents. The identified resident was interviewed regarding the allegation.

Review of records included the resident clinical record, physician documentation, grievances/investigations, and resolutions.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7218	A. BUILDING: _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH COUNTY ASSISTED LIVING	523 NORTH 22ND COLLINSVILLE, OK 74021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted from 11/01/23 through 11/03/23. Complaint investigations (#OK00058976, OK0005958, OK00060422, and #OK00061725) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. DON - Director of Nursing RN - Registered Nurse	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: (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 interview and record review, the facility failed to ensure comprehensive assessments were completed every 12 months as required for one (#7) of eight residents sampled. The DON identified 31 residents who resided at the facility. Findings: Resident #7 was admitted with diagnoses which	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7218	A. BUILDING: _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH COUNTY ASSISTED LIVING	523 NORTH 22ND COLLINSVILLE, OK 74021

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C 522	Continued From page 1 included chronic obstructive pulmonary disease, hypertension, and depression. Review of the clinical record revealed no annual assessments following February 2020. On 11/03/23 at 11:30 a.m., after searching through documents and binders, the DON stated the assessments were not found.	C 522		
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments were coordinated and signed by a registered nurse for one (#3) of eight residents sampled. The DON identified 31 residents resided at the facility. Findings: Resident #3 admitted with diagnoses which included Parkinsonism, depression, and hypertension. An annual assessment, dated 07/02/21, was not signed by an RN or physician. An annual assessment, dated 07/06/22, was not signed by an RN or physician.	C 542		

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 542	Continued From page 2 On 11/02/23 at 2:30 p.m., the DON stated the assessments were not signed by the RN or physician and they did not know why.	C 542		
C 544 SS=D	310:663-5-4(d) CONDUCT OF ASSESSMENT (d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be available upon request to the following: (1) the resident; (2) the resident's personal physician; (3) the resident's representative; and (4) the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain records of five years for one (#7) of eight residents sampled. The DON identified 31 residents resided at the facility. Findings: Resident #7 admitted with diagnoses which included chronic obstructive pulmonary disease, hypertension, and depression. Review of the clinical record revealed the last comprehensive assessment was dated 02/27/19. No assessments were found for the years of 2021, 2022, and 2023. On 11/03/23 at 2:30 p.m., the DON stated they did not know where the assessments could be, and they were unable to locate the assessments.	C 544		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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OKLAHOMA
State Department
of Health

Delivery via email to: richard.manganya@northcountyseniorliving.com

December 7, 2023

License Number: AL7218

Mr. Richard Manganya, Administrator
North County Assisted Living
523 North 22nd
Collinsville, OK 74021

Survey Event ID: 14GR11

Dear Mr. Manganya:

On **November 3, 2023,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **December 20, 2023**.

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

Respectfully,

Tempal Killman

Tempal Killman, Administrative Assistant 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 relicensure survey was conducted from 11/01/23 through 11/03/23. Complaint investigations (#OK00058976, OK0005958, OK00060422, and #OK00061725) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. DON - Director of Nursing RN - Registered Nurse	C 000	C 522 Assessment Timeframe 1. Corrective action taken for the identified problem. -Complete a comprehensive assessment for resident #7 and perform a complete audit of assessments for all residents. 2. Residents potential to be affected. -The deficient practice has the potential of impact all residents at North County Assisted Living	12/20/23
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: (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 interview and record review, the facility failed to ensure comprehensive assessments were completed every 12 months as required for one (#7) of eight residents sampled. The DON identified 31 residents who resided at the facility. Findings: Resident #7 was admitted with diagnoses which	C 522	3. Systematic changes put in place -DON or designee will perform audits of residents for complete assessments 3 times a week for the next 4 weeks or until in substantial compliance with the regulatory requirements. 4.How the facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur? -Administrator or designee will perform once a week audits for the next 4 weeks or until substantial compliance is met. Any deficient practices will be reported to the QA committee.	

Oklahoma State Department of Health

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C 522	Continued From page 1 included chronic obstructive pulmonary disease, hypertension, and depression. Review of the clinical record revealed no annual assessments following February 2020. On 11/03/23 at 11:30 a.m., after searching through documents and binders, the DON stated the assessments were not found.	C 522	C 542 Conduct of Assessment. 1. Corrective action taken for the identified problem. -Complete and sign resident #3 annual assessment and in service RN about the importance of signing the assessments in a timely manner.	12/20/23
C 542 SS=D	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure assessments were coordinated and signed by a registered nurse for one (#3) of eight residents sampled. The DON identified 31 residents resided at the facility. Findings: Resident #3 admitted with diagnoses which included Parkinsonism, depression, and hypertension. An annual assessment, dated 07/02/21, was not signed by an RN or physician. An annual assessment, dated 07/06/22, was not signed by an RN or physician.	C 542	2. Residents potential to be affected - This deficient practice has the potential of impacting all the residents at North County Assisted Living. 3. Systematic changes put in place -Review all assessments during clinical meetings for the next 4 weeks and signed by RN supervisor. 4. How the facility will monitor the corrective actions toi ensure that the deficient practice is being corrected and will not recur? -RN supervisor and DON will audit 3 residents per week for the next 5 weeks and any deficient practices will be reported to the Administrator and the quality assurance committee to improve quality of care.	

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C 542	Continued From page 2 On 11/02/23 at 2:30 p.m., the DON stated the assessments were not signed by the RN or physician and they did not know why.	C 542	C 544 Conduct of assessment 1. Corrective action taken for the identified problem. A. Administrator will inservice/educate staff on keeping resident records for 5years as a regulatory requirement. B. RN and DON to conduct a complete audit of all residents to ensure that assessments were completed/signed by RN or physician. 2. Residents potential to be affected - This deficient practice has the potential to affect all the residents at North County Assisted Living. 3. Systematic changes put in place -A.Upload all completed residents assessments in electronic records. B. Review all residents assessments in the facility to ensure they are conducted 4. How the facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur? - Admin or designee will conduct once a week audit for the next 4 weeks or until in substantial compliance with state regulatory guidelines. -Any deficient practices will be reported to QAPI committee to improve quality of care.	12/20/23
C 544 SS=D	310:663-5-4(d) CONDUCT OF ASSESSMENT (d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be available upon request to the following: (1) the resident; (2) the resident's personal physician; (3) the resident's representative; and (4) the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain records of five years for one (#7) of eight residents sampled. The DON identified 31 residents resided at the facility. Findings: Resident #7 admitted with diagnoses which included chronic obstructive pulmonary disease, hypertension, and depression. Review of the clinical record revealed the last comprehensive assessment was dated 02/27/19. No assessments were found for the years of 2021, 2022, and 2023. On 11/03/23 at 2:30 p.m., the DON stated they did not know where the assessments could be, and they were unable to locate the assessments.	C 544		

Oklahoma State Department of Health

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OKLAHOMA
State Department
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Delivery via email to: richard.manganya@northcountyseniorliving.com

January 17, 2024

License Number: AL7218

Mr. Richard Manganya, Administrator
North County Assisted Living
523 North 22nd
Collinsville, OK 74021

RE: Survey Event 14GR12

Dear Mr. Manganya:

On **January 11, 2024,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 3, 2023,** have now been corrected effective **December 20, 2023.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker 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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	AL7218	A. BUILDING: _____ B. WING _____	R-C 01/11/2024

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 01/11/23. All tags have been cleared for this survey.	{C 000}		

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