OKLAHOMA
State Department
of Health

Delivery via email to: providenceplaceww@yahoo.com; blowae76@yahoo.com

May 2, 2023

License Number: AL7702

Ms. Ashley Miller
Providence Place
1109 Downs Avenue
Woodward, OK 73801

RE: Survey Event ID: 4NIU11

Dear Ms. Miller:

On **April 12, 2023**, 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 **April 12, 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.

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 on 04/11/23 and 04/12/23. The following abbreviations will be used in the writing of this report. COPD - Chronic Obstructive Pulmonary Disease LPN - Licensed Practical Nurse RN - Registered Nurse	C 000		
C 542 SS=E	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 center failed to ensure resident assessments were coordinated and signed by an RN for two (#3 and #4) of eight sampled residents. The Administrator stated 29 residents resided in the center. Findings: 1. Resident #3 had diagnoses to include carcinoma of the prostate, morbid obesity, edema, COPD, tremor, and dementia. A "Significant Change" assessment, dated 11/23/22, documented Resident #3 was alert, oriented to person, place, was forgetful and required the assist of one staff for bathing, and dressing.	C 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 542	Continued From page 1 The assessment had not been signed by an RN. On 04/12/23 at 2:44 p.m., LPN #1 was asked if the significant change assessment, dated 11/23/22, had been signed by an RN. They stated the assessment did not have signatures. 2. Resident #4 had diagnoses to include hypertension, bradycardia, Von Willebrand's Disease, Diabetes Mellitus - type two, chronic kidney disease - stage three, and emphysema. A "Significant Change" assessment, dated 11/23/22, documented Resident #4 was alert, oriented to person and place, was forgetful, and required the assistance of one staff for bathing and dressing. The Assessment had not been signed by an RN. On 04/12/23 at 2:02 p.m., LPN #1 was asked if the significant change of assessment on 11/23/32 had been signed by an RN. They stated the chart may have been thinned and will look for the signed copy. No further information was provided.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 543	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure resident assessments were signed by the resident or resident representative for two (#3 and #4) of eight sampled residents. Findings: 1. Resident #3 had diagnoses to include carcinoma of the prostate, morbid obesity, edema, COPD, tremor, and dementia. A "Significant Change" assessment, dated 11/23/22, documented Resident #3 was alert, oriented to person, place, was forgetful and required the assist of one staff for bathing, and dressing. The assessment had not been signed by the resident or resident representative. On 04/12/23 at 2:44 p.m., LPN #1 was asked if the significant change assessment, dated 11/23/22, had been signed by the resident or resident representative. They stated the assessment did not have signatures. 2. Resident #4 had diagnoses to include hypertension, bradycardia, Von Willebrand's Disease, Diabetes Mellitus - type two, chronic kidney disease - stage three, and emphysema. A "Preadmission" assessment, dated 12/22/21, documented Resident #4 was alert, oriented to person, place, date, time, and required the assistance of one staff for bathing, dressing and ambulation.	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 543	Continued From page 3 The assessment had not been signed by the resident or resident representative. A "Significant Change" assessment, dated 11/23/22, documented Resident #4 was alert, oriented to person and place, was forgetful, and required the assistance of one staff for bathing and dressing. The Assessment had not been signed by the resident or resident representative. On 04/12/23 at 2:02 p.m., LPN #1 was asked if the significant change of assessment on 11/23/22 had signatures of resident or resident representative. They stated the chart may have been thinned and will look for the signed copy. No further information was provided. On 04/12/23 at 2:40 p.m., LPN #1 was asked if the pre-admission assessment had been signed by the resident or representative. They stated, the assessment was not signed by the resident or representative.	C 543		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident.	C 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 552	Continued From page 4 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to develop care plans to reflect resident assessments for two (#1 and #5) of eight sampled residents reviewed for care plans. The Administrator identifed 29 residents resided in the center. Findings: 1. Resident #1 had diagnoses which included dehydration, congestive heart failure and muscle weakness. A "Plan of Accommodation," dated 03/14/22, read in parts, "...Resident has requested to be placed on Hospice care...[they] do not want to be sent to the emergency room...Hospice had admitted resident..." A "Significant Change Assessment," dated, 03/15/22, did not document Resident #1 was receiving hospice services. A "Care Plan," last revised on 03/16/22, did not document Resident #1 was receiving hospice services. A "Plan Accommodation," dated 03/15/23, read in parts, "...Resident continues on Hospice..." An "Annual Assessment," dated 03/15/23, documented Resident #1 received hospice services, and did not use side rails. A "Care Plan," last revised 03/23/23, did not contain any documentation the resident was	C 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 552	Continued From page 5 receiving hospice services, and used side rails for positioning. On 04/11/23 at 11:28 a.m., Resident #1 was observed to be lying in their bed with their eyes closed, one side rail was observed to be in the up position. On 04/12/23 at 4:02 p.m., LPN #1 was asked if Resident #1's care plan, dated 03/23/23, had been updated to reflect hospice services and the use of side rails. They stated, "No." 2. Resident #5 had diagnoses which included, chronic kidney disease stage 4, and type two diabetes mellitus. A "Plan of Accommodation," dated 03/24/23, read in parts, "...Hospice had began service for resident and will provide ongoing assessment for needs and changes in needs...Our staff will provide pericare and will empty the catheter at least twice daily and log the amount emptied..." A "Significant Change Assessment," dated 03/24/23, read in parts, "...transfers with assist at this time...hospice will assist when they are here...side rails used? N ...Hospice is providing nurse visits, pastor visits, aid visits, social worker visits..." A "Care Plan," last revised on 03/24/23, did not contain documentation Resident #5 was receiving hospice services, used side rails for positioning, and had a catheter. On 04/11/23 at 11:31 a.m., Resident #5 was lying in bed with side rails in the up position on both sides of the bed. A catheter bag was observed to be hanging from the foot of the bed.	C 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 552	Continued From page 6 On 04/12/23 at 1:56 p.m., LPN #1 was asked if Resident #5's care plan had been updated to reflect the resident was receiving hospice services, had a catheter and used side rails for positioning. LPN #1 stated, "No."	C 552		

OKLAHOMA
State Department
of Health

Delivery via email to: providenceplaceww@gmail.com

May 17, 2023

License Number: AL7702

Ms. Ashley Miller
Providence Place
1109 Downs Avenue
Woodward, OK 73801

RE: Survey Event 4NIU11

Dear Ms. Miller:

On **April 12, 2023**, 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 **May 31, 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

Digitally signed by Tempal Killman
Date: 2023.05.17 11:52:20 -05'00'

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

enc

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
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 on 04/11/23 and 04/12/23. The following abbreviations will be used in the writing of this report. COPD - Chronic Obstructive Pulmonary Disease LPN - Licensed Practical Nurse RN - Registered Nurse	C 000		
C 542 SS=E	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 center failed to ensure resident assessments were coordinated and signed by an RN for two (#3 and #4) of eight sampled residents. The Administrator stated 29 residents resided in the center. Findings: 1. Resident #3 had diagnoses to include carcinoma of the prostate, morbid obesity, edema, COPD, tremor, and dementia. A "Significant Change" assessment, dated 11/23/22, documented Resident #3 was alert, oriented to person, place, was forgetful and required the assist of one staff for bathing, and dressing.	C 542	**C542** Resident #3 and #4 Assessments have been signed accordingly as of: 5/10/2023 Wellness Coordinator will ensure signatures are made upon completion of assessment. New Assessments will be audited for signatures by Administrator upon completion or at least once weekly for 4 weeks, then quarterly at QA until resolved.	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 542	Continued From page 1 The assessment had not been signed by an RN. On 04/12/23 at 2:44 p.m., LPN #1 was asked if the significant change assessment, dated 11/23/22, had been signed by an RN. They stated the assessment did not have signatures. 2. Resident #4 had diagnoses to include hypertension, bradycardia, Von Willebrand's Disease, Diabetes Mellitus - type two, chronic kidney disease - stage three, and emphysema. A "Significant Change" assessment, dated 11/23/22, documented Resident #4 was alert, oriented to person and place, was forgetful, and required the assistance of one staff for bathing and dressing. The Assessment had not been signed by an RN. On 04/12/23 at 2:02 p.m., LPN #1 was asked if the significant change of assessment on 11/23/32 had been signed by an RN. They stated the chart may have been thinned and will look for the signed copy. No further information was provided.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.	C 543		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 543	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the center failed to ensure resident assessments were signed by the resident or resident representative for two (#3 and #4) of eight sampled residents. Findings: 1. Resident #3 had diagnoses to include carcinoma of the prostate, morbid obesity, edema, COPD, tremor, and dementia. A "Significant Change" assessment, dated 11/23/22, documented Resident #3 was alert, oriented to person, place, was forgetful and required the assist of one staff for bathing, and dressing. The assessment had not been signed by the resident or resident representative. On 04/12/23 at 2:44 p.m., LPN #1 was asked if the significant change assessment, dated 11/23/22, had been signed by the resident or resident representative. They stated the assessment did not have signatures. 2. Resident #4 had diagnoses to include hypertension, bradycardia, Von Willebrand's Disease, Diabetes Mellitus - type two, chronic kidney disease - stage three, and emphysema. A "Preadmission" assessment, dated 12/22/21, documented Resident #4 was alert, oriented to person, place, date, time, and required the assistance of one staff for bathing, dressing and ambulation.	C 543	**C543** Resident #3 and Resident #4 Assessments have been signed accordingly as of: 5/10/2023 Wellness Coordinator will ensure signatures are made upon completion of assessment. Assessment will be presented to resident for signature upon completion. If resident is unable to sign, resident responsible parties will be notified of need for signature. Wellness Coordinator or other LPN will document conversation with resident responsible party. New Assessments will be audited for signatures by Administrator upon completion or at least once weekly for 4 weeks, then quarterly at QA until resolved.	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 543	Continued From page 3 The assessment had not been signed by the resident or resident representative. A "Significant Change" assessment, dated 11/23/22, documented Resident #4 was alert, oriented to person and place, was forgetful, and required the assistance of one staff for bathing and dressing. The Assessment had not been signed by the resident or resident representative. On 04/12/23 at 2:02 p.m., LPN #1 was asked if the significant change of assessment on 11/23/22 had signatures of resident or resident representative. They stated the chart may have been thinned and will look for the signed copy. No further information was provided. On 04/12/23 at 2:40 p.m., LPN #1 was asked if the pre-admission assessment had been signed by the resident or representative. They stated, the assessment was not signed by the resident or representative.	C 543		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident.	C 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 552	Continued From page 4 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to develop care plans to reflect resident assessments for two (#1 and #5) of eight sampled residents reviewed for care plans. The Administrator identifed 29 residents resided in the center. Findings: 1. Resident #1 had diagnoses which included dehydration, congestive heart failure and muscle weakness. A "Plan of Accommodation," dated 03/14/22, read in parts, "...Resident has requested to be placed on Hospice care...[they] do not want to be sent to the emergency room...Hospice had admitted resident..." A "Significant Change Assessment," dated, 03/15/22, did not document Resident #1 was receiving hospice services. A "Care Plan," last revised on 03/16/22, did not document Resident #1 was receiving hospice services. A "Plan Accommodation," dated 03/15/23, read in parts, "...Resident continues on Hospice..." An "Annual Assessment," dated 03/15/23, documented Resident #1 received hospice services, and did not use side rails. A "Care Plan," last revised 03/23/23, did not contain any documentation the resident was	C 552	**C552** Care plan for Resident #1 has been updated to reflect assessment as of: 5/10/2023 Wellness Coordinator will ensure that all services identified on assessments are included in care plan for each resident. Through 5/31/23, new assessments and care plans will be audited by Administrator upon completion or at least once weekly for 4 weeks, then quarterly at QA until resolved.	5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 552	Continued From page 5 receiving hospice services, and used side rails for positioning. On 04/11/23 at 11:28 a.m., Resident #1 was observed to be lying in their bed with their eyes closed, one side rail was observed to be in the up position. On 04/12/23 at 4:02 p.m., LPN #1 was asked if Resident #1's care plan, dated 03/23/23, had been updated to reflect hospice services and the use of side rails. They stated, "No." 2. Resident #5 had diagnoses which included, chronic kidney disease stage 4, and type two diabetes mellitus. A "Plan of Accommodation," dated 03/24/23, read in parts, "...Hospice had began service for resident and will provide ongoing assessment for needs and changes in needs...Our staff will provide pericare and will empty the catheter at least twice daily and log the amount emptied..." A "Significant Change Assessment," dated 03/24/23, read in parts, "...transfers with assist at this time...hospice will assist when they are here...side rails used? N ...Hospice is providing nurse visits, pastor visits, aid visits, social worker visits..." A "Care Plan," last revised on 03/24/23, did not contain documentation Resident #5 was receiving hospice services, used side rails for positioning, and had a catheter. On 04/11/23 at 11:31 a.m., Resident #5 was lying in bed with side rails in the up position on both sides of the bed. A catheter bag was observed to be hanging from the foot of the bed.	C 552		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7702	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 552	Continued From page 6 On 04/12/23 at 1:56 p.m., LPN #1 was asked if Resident #5's care plan had been updated to reflect the resident was receiving hospice services, had a catheter and used side rails for positioning. LPN #1 stated, "No."	C 552		

OKLAHOMA
State Department of Health

Delivery via email to: providenceplaceww@gmail.com

June 7, 2023

License Number: AL7702

Ms. Ashley Miller
Providence Place
1109 Downs Avenue
Woodward, OK 73801

RE: Survey Event 4NIU12

Dear Ms. Miller:

On **June 6, 2023,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 12, 2023,** have now been corrected effective **May 31, 2023.**

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

Sincerely,

Katie Stagner

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

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
	AL7702	A. BUILDING: _____ B. WING _____	R 06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	1109 DOWNS AVENUE WOODWARD, OK 73801

(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 An offsite/paper revisit was conducted on 06/06/23. 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