
Delivery via email to: djoyce@epworthvilla.org

June 9, 2022

License Number: CC5504AL

Ms. Dorothy Joyce, Administrator
Epworth Villa Health Services
14901 North Penn Avenue
Oklahoma City, OK 73134

Survey Event ID: DEPR11

Dear Ms. Joyce:

On **June 1, 2022**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

(6) Be signed by the administrator.

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Epworth Villa Health Services
Address: 14901 North Penn Avenue
City, State, Zip: Oklahoma City, OK, 73134
Provider #: CC5504AL
Complaint #: OK00058887
Investigation Date(s): 06/01/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were not neglected.	S
2. The facility failed to ensure medications were administered according to physician's orders.	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 06/01/2022 at 8:20 a.m.

A sample of three residents including any identified resident, 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 1512 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1 and #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read 'SGreen', written over a horizontal line.

Sarah Green LPN, CHFS

Date report completed: 06/02/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CC5504AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
NAME OF PROVIDER OR SUPPLIER EPWORTH VILLA HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 14901 NORTH PENN AVENUE OKLAHOMA CITY, OK 73134		
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C 000	INITIAL COMMENTS A complaint investigation (#OK00058887) was conducted on 06/01/22. The following abbreviations will be used throughout this document: CPK=creatine phosphokinase d/t=due to IV=intravenous LPN=licensed practical nurse MAR=medication administration record R=right SLUMS=Saint Louis University Mental Status	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences	C1505		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C1505	Continued From page 1 of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review, and interview the facility failed to ensure medication was administered according to physician orders for one (#1) of three sampled residents who were reviewed for the administration of medications. The "Resident Roster," undated, documented 35 residents resided in memory care, and 69 residents resided in assisted living. Findings: An "Administering Medications," policy, undated, read in parts, "...Medications are administered in a safe and timely manner, and as prescribed...For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be 'flagged.' After completing the medication pass, the nurse will return to the missed resident to administer the medication...The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones..."	C1505		

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C1505	Continued From page 2 Resident #1 was admitted with diagnoses which included muscle spasms, Alzheimer's disease, anxiety disorder, behaviors, and pain. Resident #1's assessment, dated 06/25/21, documented the resident was alert and oriented but forgetful. It documented the resident's judgement was fair. It documented the resident ate meals in the dining room and required setup help assistance from staff. Resident #1's care plan, dated 06/28/21, read in parts, "...I make poor decisions and require cues and/or supervision. Related to Alzheimer's disease...Please administer my medications as ordered..." Resident #1's MAR for May 2022, documented the resident received the following medications on May 21st, Saturday, morning: Mobic, Buspirone, Divalproex, Namenda, and Aricept. Resident #1's MAR for May 2022, documented the resident received the following medications on May 21st, Saturday, evening: Buspirone, Divalproex, Namenda, and Gabapentin. Resident #1's "Interdisciplinary Note," dated 05/22/22, read in parts, "...At [10:42 a.m.], this nurse received call from residents [family] stating that [they] had knocked on [the resident's] door and [the resident] wasn't answering..." This nurse knocked on the door and unlocked door...Resident noted laying on the floor in front of toilet, naked...Redness noted to right hip/R upper leg...Resident unable to describe what happened. When asked if [the resident] hit [their] head, resident said 'Yes', Resident states that	C1505		

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C1505	Continued From page 3 [they] have been on floor since last night...EMSA arrived...Resident transferred..." On 06/01/22 at 2:25 p.m., CMA #4 stated they worked on 05/21/22 and 05/22/22 and passed medications. CMA #4 was asked if they administered medication to the resident on 05/21/22. They stated they didn't administer the medication. CMA #4 was asked what the reason was. They stated they got busy and "it slipped my mind." CMA #4 was asked if they reported it to anyone. They stated no. They stated no one asked them about administering medications until after the resident had been found on the floor. On 06/01/22 at 3:24 p.m., the nurse manager was asked what the facility's medication administration policy was. They stated they had a 4 hour window to administer medication to the resident. They stated the staff were to stay with the resident to ensure the resident took the medication. The nurse manager was asked how often Resident #1 received medication. They stated twice a day and as needed. The administrator and nurse manager were asked if the resident received their medication on 05/21/22. They stated the med aides signed out the medication but didn't administer them.	C1505		
C1512 SS=G	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights	C1512		

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C1512	Continued From page 4 and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest,	C1512		

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C1512	Continued From page 5 b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to protect and ensure a vulnerable adult received their medications as ordered, and received safety checks for one (#1) of three sampled residents reviewed for abuse. This resulted in Resident #1 being admitted to the hospital with diagnoses of non-traumatic rhabdomyolysis (damages seen after a prolonged period of pressure on a muscle group), initial encounter for closed head injury, and right hip strain. The "Resident Roster," undated, documented 35 residents resided in memory care, and 69 residents resided in assisted living. Findings: An "Abuse Investigation and Reporting" policy, undated, read in parts, "...All reports of resident...neglect...shall be promptly reported...and thoroughly investigated by facility management...	C1512		

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C1512	Continued From page 6 An alleged violation of...neglect...will be reported immediately, but not later than...Two (2) hours if the alleged violation involves abuse..." Resident #1 was admitted with diagnoses which included muscle spasms, Alzheimer's disease, anxiety disorder, behaviors, and pain. Resident #1's assessment, dated 06/25/21, documented the resident was alert and oriented but forgetful. It documented the resident's judgement was fair. It documented the resident ate meals in the dining room and required setup help assistance from staff. Resident #1's fall risk assessment, dated 06/25/21, documented the resident was considered at moderate risk for falls. Resident #1's care plan, dated 06/28/21, read in parts, "...I am at risk for not having my needs met...I scored 28 on SLUMS indicating mildly impaired cognition d/t forgetfulness...I would like staff to anticipate my needs promptly..." I make poor decisions and require cues and/or supervision. Related to Alzheimer's disease... I may not and often do not remember to use the call light or seek assistance when needed so please check on me to determine care needs such as hydration, toileting/incontinence needs, hygiene, transfer needs to help prevent any impulsive behaviors that may bring harm to myself... I would like to be oriented to my surroundings every shift...	C1512		

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C1512	Continued From page 7 I would like to encouraged/invited to activity programs and meal times... I'm at risk for falls due to requiring limited level of care..." Resident #1's "Interdisciplinary Note," dated 05/22/22, read in parts, "...At [10:42 a.m.], this nurse received call from residents [family] stating that [they] had knocked on [the resident's] door and [the resident] wasn't answering... This nurse knocked on the door and unlocked door...Resident noted laying on the floor in front of toilet, naked...Redness noted to right hip/R upper leg...Resident unable to describe what happened. When asked if [the resident] hit [their] head, resident said 'Yes', Resident states that [they] have been on floor since last night...EMSA arrived...Resident transferred..." A History and Physical note from a local hospital, dated 05/22/22, read in parts, "...[Resident #1]...with known advanced dementia, who presents to [name deleted]... with complaints of being found down. Apparently [the resident] lives in assisted living at [facility name deleted]. Family tried to call [the resident] yesterday evening was unable to reach [the resident]. This morning they again called and were unable to reach [the resident] and therefore someone went to the facility... [Resident #1] was eventually found in the bathroom on the floor. [The resident] reports that [they] had been there since sometime yesterday afternoon. Family reports that the nursing facility have documented that they saw [the resident] and passed [the resident] medications to [the resident] yesterday evening and also this morning. They	C1512		

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C1512	Continued From page 8 also report that the nursing staff admit to not actually performing this. Uncertain how long [the resident] was down due to the patient's dementia. Best estimates are about 18 hours.... [Resident #1] is complaining of right hip pain and right chest pain. Worse with any type of palpation...[The resident] denies any recent fever or infection but [the resident] is having active rigors in the room...Pain is moderate. [Resident #1] is being admitted due to elevated CPK. [The resident] will need IV fluid intervention..." On 06/01/22 at 8:55 a.m., State Incident reports were reviewed. There was no incident report for Resident #1. On 06/01/22 at 9:15 a.m., the Administrator was asked if there were any incident reports that had not been provided. The Administrator stated, "No." On 06/01/22 at 1:55 p.m., LPN #1 was asked what kind of assistance Resident #1 required. They stated the resident required cueing and guidance. LPN #1 was asked if they checked on the resident. They stated the resident was usually out of their room most of the day. LPN #1 was asked if the resident could recall to use the call light. They stated, "Sometimes. During the day [Resident #1] was out and about and would tell staff if they needed something." LPN #1 was asked to describe what happened with the incident on 05/22/22. They stated the resident's family member called them and stated the resident's door was locked. LPN #1 stated they went and unlocked the door and located the resident on the bathroom floor.	C1512		

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C1512	Continued From page 9 On 06/01/22 at 2:25 p.m., CMA #4 was asked if they had checked on Resident #1 and administered their medication on Saturday 05/21/22. They stated they didn't check on the resident or administer their medication. CMA #4 stated, "it slipped my mind." On 06/01/22 at 3:30 p.m., the Administrator and nurse manager were asked what staff should do if a resident does not answer their door. They stated to notify the nurse and for both of them to go in the room. The Administrator was asked when staff checked on the residents. The Administrator stated safety checks were completed during the medication pass. The administrator was asked to describe the incident that happened on 05/22/22. They stated they looked at the cameras and saw the resident went to their room on Friday, 05/20/22, at 7:11 p.m. They stated they didn't see the resident come out of their room or staff go into the resident's room until the resident was found on 05/22/22. The administrator stated they saw staff go and knock on the resident's door once on Saturday morning, 05/21/22, and twice Saturday evening. They stated the med aide signed out they administered medications but they didn't. The administrator and nurse manager stated the med aides did not report to the nurse the resident was unavailable. The administrator stated the last time anyone made contact with the resident was Friday, 05/20/22, at 7:00 p.m. The administrator was asked if the staff performed the safety checks. They stated, "Not that we can tell."	C1512		

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C1512	Continued From page 10 The administrator was asked how the staff ensured the residents ate their meals. They stated they do not track meal percentages. They stated they tracked monthly weights. The administrator was asked since staff had not checked on the resident for approximately 24 hours, and did not provide care or services, would that be an example of neglect. They stated, "Yes." The administrator was asked when they determined the incident to be neglect. They stated Monday evening after watching the cameras. The administrator was asked what the investigation revealed concerning the incident. They stated they had not finalized anything.	C1512		

Delivery via email to: djoyce@epworthvilla.org

July 13, 2022

License Number: CC5504AL

Ms. Dorothy Joyce, Administrator
Epworth Villa Health Services
14901 North Penn Avenue
Oklahoma City, OK 73134

Survey Event ID: DEPR11

Dear Ms. Joyce:

On **June 1, 2022**, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **July 15, 2022**.

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

Respectfully,

Tempal Killman
Digitally signed by Tempal Killman
Date: 2022.07.13 09:50:45 -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: CC5504AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/01/2022
NAME OF PROVIDER OR SUPPLIER EPWORTH VILLA HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 14901 NORTH PENN AVENUE OKLAHOMA CITY, OK 73134		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A complaint investigation (#OK00058887) was conducted on 06/01/22. The following abbreviations will be used throughout this document: CPK=creatine phosphokinase d/t=due to IV=intravenous LPN=licensed practical nurse MAR=medication administration record R=right SLUMS=Saint Louis University Mental Status	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences	C1505	C1505 Immediate action(s) taken for the resident(s) found to have been affected include: The resident identified was assisted and sent to ER for evaluation 5-22-22. Identification of other residents having the Potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: Mandatory in service for CMA's was immediately started the date of incident, on 5-22-22 on the importance of notifying charge nurse when resident not available for medication pass and correct documentation protocol. In-service has been completed for all CMA's. An investigation was immediately started, which included staff interviews, review of resident care plans and medication administration, and review of facility videotapes. Upon completion of the investigation, CMA #4 was immediately terminated and reported to the registry, and an incident report was filed on 6-2-22 to OSDH as well. The Nurse Manager/designee will do random interviews with residents weekly for <u>2 quarters</u> to ensure meds are being administered per policy.	

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Northey Gayle

Adm TITLE

(X6) DATE
6/20/2022

Oklahoma State Department of Health

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C1505	Continued From page 1 of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review, and interview the facility failed to ensure medication was administered according to physician orders for one (#1) of three sampled residents who were reviewed for the administration of medications. The "Resident Roster," undated, documented 35 residents resided in memory care, and 69 residents resided in assisted living. Findings: An "Administering Medications," policy, undated, read in parts, "...Medications are administered in a safe and timely manner, and as prescribed...For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be 'flagged.' After completing the medication pass, the nurse will return to the missed resident to administer the medication...The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones..."	C1505	Random audits of charting system will be done by Nurse Manager/designee weekly for <u>2 quarters</u> to ensure documentation of med pass is complete. Weekly visual med passes will be conducted at random by Nurse Manager/designee to ensure compliance with med pass for <u>2 quarters</u>. A written safety check policy will be implemented to include safety checks with medication pass, as well as an additional safety check during the night. A waiver will be offered to any resident not wanting an additional safety check. An additional safety check will be added to the MAR for a safety check during the night. A second in-service education was held on 6-15-22 conducted by the Nurse Manager with staff, addressing the following: importance of immediately reporting to charge nurse when residents are not available for med pass/safety check; the importance of following physician orders for medication administration; and the protocol on documentation and the Abuse and Neglect policy.		

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C1505	Continued From page 2 Resident #1 was admitted with diagnoses which included muscle spasms, Alzheimer's disease, anxiety disorder, behaviors, and pain. Resident #1's assessment, dated 06/25/21, documented the resident was alert and oriented but forgetful. It documented the resident's judgement was fair. It documented the resident ate meals in the dining room and required setup help assistance from staff. Resident #1's care plan, dated 06/28/21, read in parts, "...I make poor decisions and require cues and/or supervision. Related to Alzheimer's disease...Please administer my medications as ordered..." Resident #1's MAR for May 2022, documented the resident received the following medications on May 21st, Saturday, morning: Mobic, Buspirone, Divalproex, Namenda, and Aricept. Resident #1's MAR for May 2022, documented the resident received the following medications on May 21st, Saturday, evening: Buspirone, Divalproex, Namenda, and Gabapentin. Resident #1's "Interdisciplinary Note," dated 05/22/22, read in parts, "...At [10:42 a.m.], this nurse received call from residents [family] stating that [they] had knocked on [the resident's] door and [the resident] wasn't answering... This nurse knocked on the door and unlocked door...Resident noted laying on the floor in front of toilet, naked...Redness noted to right hip/R upper leg...Resident unable to describe what happened. When asked if [the resident] hit [their] head, resident said 'Yes', Resident states that	C1505	How the corrective action(s) will be monitored to ensure the practice will not recur: Nurse Manager/designee will conduct a random audit of med pass administration/safety checks throughout the facility. Audit records will be reviewed to ensure that all residents received their medications and safety check. Missed medication/safety checks identified will be addressed immediately, reported to physician and corrective action taken. This plan of correction and the actions set forth in #3 above, will be monitored and reported to Quality Assurance Committee for 2 quarters to ensure consistent substantial compliance has been met. Corrective action will be completed by 7-15-22.	7-15-22

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C1505	Continued From page 3 [they] have been on floor since last night... EMSA arrived...Resident transferred..." On 06/01/22 at 2:25 p.m., CMA #4 stated they worked on 05/21/22 and 05/22/22 and passed medications. CMA #4 was asked if they administered medication to the resident on 05/21/22. They stated they didn't administer the medication. CMA #4 was asked what the reason was. They stated they got busy and "it slipped my mind." CMA #4 was asked if they reported it to anyone. They stated no. They stated no one asked them about administering medications until after the resident had been found on the floor. On 06/01/22 at 3:24 p.m., the nurse manager was asked what the facility's medication administration policy was. They stated they had a 4 hour window to administer medication to the resident. They stated the staff were to stay with the resident to ensure the resident took the medication. The nurse manager was asked how often Resident #1 received medication. They stated twice a day and as needed. The administrator and nurse manager were asked if the resident received their medication on 05/21/22. They stated the med aides signed out the medication but didn't administer them.	C1505	Tag C1512 Immediate action(s) taken for the resident(s) found to have been affected include: The resident identified was assisted and sent to ER for evaluation 5-22-22. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: ADMINISTRATOR RECEIVED ONE ON ONE IN-SERVICE ON THE IMPORTANCE OF FILING REPORTS TIMELY BY C.O.O. Mandatory in service for CMA's was immediately started the date of incident, on 5-22-22 on the importance of notifying charge nurse when resident not available for medication pass and correct documentation protocol. In-service has been completed for all CMA's. An investigation was immediately started, which included staff interviews, review of resident care plans and medication administration, and review of facility videotapes. Upon completion of the investigation, CMA #4 was immediately terminated and reported to the registry, and an incident report was filed on 6-2-22 to OSDH as well. The Nurse Manager/designee will do random interviews with residents weekly for <u>2 quarters</u> to ensure meds are being administered per policy.	
C1512 SS=G	310.663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights	C1512		

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C1512	Continued From page 4 and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest,	C1512	Random audits of charting system will be done by Nurse Manager/designee weekly for <u>2 quarters</u> to ensure documentation of med pass is complete. Weekly visual med passes will be conducted at random by Nurse Manager/designee to ensure compliance with med pass for <u>2 quarters</u>. A written safety check policy will be implemented to include safety checks with medication pass, as well as an additional safety check during the night. A waiver will be offered to any resident <u>not</u> wanting an additional safety check. An additional safety check will be added to the MAR for a safety check during the night. A second in-service education conducted by the Nurse Manager for staff was held on 6-15-22 addressed the following: the importance of immediately reporting to charge nurse when residents are not available for med pass/safety check; the importance of following physician orders for medication administration; the protocol on documentation and the Abuse and Neglect policy.	

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C1512	Continued From page 5 b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to protect and ensure a vulnerable adult received their medications as ordered, and received safety checks for one (#1) of three sampled residents reviewed for abuse. This resulted in Resident #1 being admitted to the hospital with diagnoses of non-traumatic rhabdomyolysis (damages seen after a prolonged period of pressure on a muscle group), initial encounter for closed head injury, and right hip strain. The "Resident Roster," undated, documented 35 residents resided in memory care, and 69 residents resided in assisted living. Findings: An "Abuse Investigation and Reporting" policy, undated, read in parts, "...All reports of resident...neglect...shall be promptly reported...and thoroughly investigated by facility management...	C1512	How the corrective action(s) will be monitored to ensure the practice will not recur: The C.O.O. will do random audits of reports filed with State, to ensure reports were filed timely. Reports will be monitored by Quality Assurance Committee for 2 quarters to ensure consistent substantial compliance has been met. Nurse Manager/designee will conduct a random audit of med pass administration/safety checks throughout the facility. Audit records will be reviewed to ensure that all residents received their medications and safety check. Missed medication/safety checks identified will be addressed immediately, reported to physician and corrective action taken. This plan of correction and the actions set forth in #3 above, will be monitored and reported to Quality Assurance Committee for 2 quarters to ensure consistent substantial compliance has been met. Corrective action will be completed by 7-15-22.		7-15-22

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C1512	Continued From page 6 An alleged violation of...neglect...will be reported immediately, but not later than...Two (2) hours if the alleged violation involves abuse..." Resident #1 was admitted with diagnoses which included muscle spasms, Alzheimer's disease, anxiety disorder, behaviors, and pain. Resident #1's assessment, dated 06/25/21, documented the resident was alert and oriented but forgetful. It documented the resident's judgement was fair. It documented the resident ate meals in the dining room and required setup help assistance from staff. Resident #1's fall risk assessment, dated 06/25/21, documented the resident was considered at moderate risk for falls. Resident #1's care plan, dated 06/28/21, read in parts, "...I am at risk for not having my needs met...I scored 28 on SLUMS indicating mildly impaired cognition d/t forgetfulness...I would like staff to anticipate my needs promptly... I make poor decisions and require cues and/or supervision. Related to Alzheimer's disease... I may not and often do not remember to use the call light or seek assistance when needed so please check on me to determine care needs such as hydration, toileting/incontinence needs, hygiene, transfer needs to help prevent any impulsive behaviors that may bring harm to myself... I would like to be oriented to my surroundings every shift...	C1512		

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C1512	Continued From page 7 I would like to encouraged/invited to activity programs and meal times... I'm at risk for falls due to requiring limited level of care..." Resident #1's "Interdisciplinary Note," dated 05/22/22, read in parts, "...At [10:42 a.m.], this nurse received call from residents [family] stating that [they] had knocked on [the resident's] door and [the resident] wasn't answering..." This nurse knocked on the door and unlocked door...Resident noted laying on the floor in front of toilet, naked...Redness noted to right hip/R upper leg...Resident unable to describe what happened. When asked if [the resident] hit [their] head, resident said 'Yes', Resident states that [they] have been on floor since last night... EMSA arrived...Resident transferred..." A History and Physical note from a local hospital, dated 05/22/22, read in parts, "...[Resident #1]...with known advanced dementia, who presents to [name deleted]... with complaints of being found down. Apparently [the resident] lives in assisted living at [facility name deleted]. Family tried to call [the resident] yesterday evening was unable to reach [the resident]. This morning they again called and were unable to reach [the resident] and therefore someone went to the facility..." [Resident #1] was eventually found in the bathroom on the floor. [The resident] reports that [they] had been there since sometime yesterday afternoon. Family reports that the nursing facility have documented that they saw [the resident] and passed [the resident] medications to [the resident] yesterday evening and also this morning. They	C1512			

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C1512	Continued From page 8 also report that the nursing staff admit to not actually performing this. Uncertain how long [the resident] was down due to the patient's dementia. Best estimates are about 18 hours.... [Resident #1] is complaining of right hip pain and right chest pain. Worse with any type of palpation...[The resident] denies any recent fever or infection but [the resident] is having active rigors in the room...Pain is moderate. [Resident #1] is being admitted due to elevated CPK. [The resident] will need IV fluid intervention..." On 06/01/22 at 8:55 a.m., State Incident reports were reviewed. There was no incident report for Resident #1. On 06/01/22 at 9:15 a.m., the Administrator was asked if there were any incident reports that had not been provided. The Administrator stated, "No." On 06/01/22 at 1:55 p.m., LPN #1 was asked what kind of assistance Resident #1 required. They stated the resident required cueing and guidance. LPN #1 was asked if they checked on the resident. They stated the resident was usually out of their room most of the day. LPN #1 was asked if the resident could recall to use the call light. They stated, "Sometimes. During the day [Resident #1] was out and about and would tell staff if they needed something." LPN #1 was asked to describe what happened with the incident on 05/22/22. They stated the resident's family member called them and stated the resident's door was locked. LPN #1 stated they went and unlocked the door and located the resident on the bathroom floor.	C1512		

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C1512	Continued From page 9 On 06/01/22 at 2:25 p.m., CMA #4 was asked if they had checked on Resident #1 and administered their medication on Saturday 05/21/22. They stated they didn't check on the resident or administer their medication. CMA #4 stated, "it slipped my mind." On 06/01/22 at 3:30 p.m., the Administrator and nurse manager were asked what staff should do if a resident does not answer their door. They stated to notify the nurse and for both of them to go in the room. The Administrator was asked when staff checked on the residents. The Administrator stated safety checks were completed during the medication pass. The administrator was asked to describe the incident that happened on 05/22/22. They stated they looked at the cameras and saw the resident went to their room on Friday, 05/20/22, at 7:11 p.m. They stated they didn't see the resident come out of their room or staff go into the resident's room until the resident was found on 05/22/22. The administrator stated they saw staff go and knock on the resident's door once on Saturday morning, 05/21/22, and twice Saturday evening. They stated the med aide signed out they administered medications but they didn't. The administrator and nurse manager stated the med aides did not report to the nurse the resident was unavailable. The administrator stated the last time anyone made contact with the resident was Friday, 05/20/22, at 7:00 p.m. The administrator was asked if the staff performed the safety checks. They stated, "Not that we can tell."	C1512			

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C1512	Continued From page 10 The administrator was asked how the staff ensured the residents ate their meals. They stated they do not track meal percentages. They stated they tracked monthly weights. The administrator was asked since staff had not checked on the resident for approximately 24 hours, and did not provide care or services, would that be an example of neglect. They stated, "Yes." The administrator was asked when they determined the incident to be neglect. They stated Monday evening after watching the cameras. The administrator was asked what the investigation revealed concerning the incident. They stated they had not finalized anything.	C1512			

Delivery via email to: Lwinship@epworthvilla.org

December 21, 2022

License Number: CC5504AL

Ms. LaTasha Winship, Administrator
Epworth Villa Health Services
14901 North Penn Avenue
Oklahoma City, OK 73134

RE: Survey Event [EVENT()]

Dear Ms. Winship:

Enclosed is the Assisted Living Center Licensure inspection deficiency report form, showing the summary of deficiencies noted during the revisit at your facility on **December 19, 2022**. These deficiencies remain uncorrected since your complaint survey of **June 1, 2022**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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,

Lisa Calvin

Lisa Calvin, 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: CC5504AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 12/19/2022
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{C 000}	INITIAL COMMENTS A follow-up survey was conducted on 12/19/22. Current census was 112. The following abbreviations will be used throughout this document. AEB- as evidenced by BID- twice a day CMA- certified medication aide DX- diagnoses GERD- gastroesophageal reflux disease HRS- hours MAR- medication administration record MCG- microgram MD- medical doctor MG- milligram MON- manager of nursing PO- by mouth Q- every QD- every day R/T- related to TID- three times a day TOP- topical X- times	{C 000}		
{C1505} SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally	{C1505}		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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{C1505}	Continued From page 1 incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review, and interview the facility failed to ensure medication was: a. administered according to physician orders for two (#1 and #2), and b. failed to ensure medications provided by family member were reconciled at the facility for one (#2) of two sampled residents reviewed for the administration of medications. The "Resident Roster," dated 12/19/22, documented 36 residents resided in memory	{C1505}		

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{C1505}	Continued From page 2 care, and 76 residents resided in assisted living. Findings: An "Accepting Delivery of Medications" policy, undated, read in part, "...All staff shall follow a consistent procedure in accepting medications..." An "Administering Medications" policy, undated, read in part, "...Medications are administered...as prescribed...Medications are administered in accordance with prescriber orders, including any required time frame..." If a dosage is believed to be inappropriate...for a resident...the person preparing or administering the medication will contact the prescriber... The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones..." 1. Resident # 1 was admitted with diagnoses which included cervicgia and unspecified mood [affective] disorder, anxiety disorder, and muscle weakness. Resident #1's care plan, dated 07/21/22, read in parts, "... I am at risk for not having my needs met AEB a dx of unspecified dementia without behaviors. I have a need to use Psychotropic drugs...Please administer my medication(s) as ordered by my physician...I am at risk for pain due to dx of chronic back pain and muscle weakness. Be sure to offer me pain medication as ordered by my physician..." A "Physician Order," dated 07/12/22, read in part, "Buspirone 5mg tablet[generic]5mg by mouth	{C1505}		

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{C1505}	Continued From page 3 Three times daily for ANXIETY DISORDER, UNSPECIFIED 5MG TID." A "Physician Order," dated 07/12/22, read in part, "Depakote 125 mg tablet, delayed release [Divalproex] 125 mg By mouth Twice a day with breakfast and supper For mental/mood disorder, Sundowning 125 mg PO BID." A "Physician Order," dated 07/16/22, read in part, "Lidocaine 4% topical patch [generic] 4% Topical Q 12 hour for PAIN, UNSPECIFIED... 20:00 remove patch." A "Physician Order," dated 07/16/22, read in part, "Lidocaine 4% topical patch [generic] 4% Topical Q 12 hour for PAIN, UNSPECIFIED...08:00 site." A "Physicians Order," dated 08/04/22, read in part, "Buspirone 7.5 mg tablet [generic] 7. 5 mg Three times daily for ANXIETY DISORDER, UNSPECIFIED 7.5 mg TID." Resident #1's July 2022 MAR, documented blanks for buspirone 5 mg on 07/14/22 at 3:00 p.m., depakote 125 mg on 07/14/22 at 5:00 p.m., and lidocaine 4% topical patch removal on 07/20/22 at 8:00 p.m. Resident #1's August 2022 MAR, documented lidocaine 4% topical patch held on 08/22/22 at 8:00 a.m., and blanks for the lidocaine at 8:00 p.m. on 08/06/22, 08/13/22, 08/19/22, and 08/25/22. It documented a blank for depakote 125 mg tablet on 08/04/22 at 5:00 p.m. Resident #1's November 2022 MAR, documented depakote 125 mg was held on 11/04/22 at 8:00 a.m., 11/03/22 and 11/04/22 at 5:00 p.m.	{C1505}		

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{C1505}	Continued From page 4 On 12/19/22 at 1:58 p.m., the MON and Administrator were asked the reason the depakote for Resident #1 was held on 11/03/22 and 11/04/22 twice. The administrator stated, "There was no documentation from the nurse nor the med aide." They were asked what the procedure was for holding medication. The MON stated they got a physician's order to put meds on hold, the reason why, and for how long. The MON stated, "The CMA could have not notified the nurse." They were asked if there was an order for the medication to be held. The Administrator stated "I don't see an order." On 12/19/22 at 4:43 p.m., the Administrator and MON were asked the reason the Lidocane was blank on 07/14/22, 07/20/22, 08/06/22, 08/13/22, 08/19/22, and 08/25/22. They stated there was no documentation. They were asked the reason the lidocane was held on 08/22/22. They stated there was no documentation. The administrator was asked if there was an order to hold any of the medications. They stated "No, nothing documented." 2. Resident #2 had diagnoses which included unspecified dementia without behavioral disturbances, long term use of anticoagulants, hypothyroidism, major depressive disorder, and GERD. A "Physician Order," dated 12/14/21, documented the resident was to receive Levothyroxine 50 mcg tablet by mouth once daily. A "Physician Order," dated 12/14/21, documented the resident was to receive Namenda 10 mg	{C1505}		

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{C1505}	Continued From page 5 tablet twice a day. A "Physician Order," dated 12/14/21, read in part, "Sertraline 100 mg tablet...150mg By mouth Once Daily..." A "Physician Order," dated 04/19/22, documented the resident was to receive Eliquis 2.5 mg tablet by mouth twice a day. A "Physician Order," dated 06/08/22, documented the resident was to receive Omeprazole 40 mg capsule delayed release by mouth once daily with breakfast. Resident #2's July 2022 MAR documented Sertraline 150mg was initialed as administered on all dates. Resident #2's August 2022 MAR documented: 1. Sertraline 150mg was initialed as administered on all dates, 2. Omeprazole 40 mg was blank on the 3rd, 4th, 15th and 22nd, 3. Levothyroxine 50 mcg was blank on the 5th, 12th, and 24th and 4. Eliquis 2.5 mg was blank on the 18th. An "After Visit Summary Report," dated 11/03/22, documented the resident was to stop taking Donepezil 5 mg tablet. An "Interdisciplinary Note," dated 11/03/22, read in part, "...hold aricept...holding aricept may improve hallucinations..."	{C1505}		

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{C1505}	Continued From page 6 A "Physician Order," dated 11/07/2022, documented the resident was to receive Donepezil 5 mg tablet by mouth once daily. Resident #2's November 2022 MAR documented: 1. an "H" for the 7:00 p.m. to 11:00 p.m. dose of Donepezil 5 mg on the the 8th, 9th, 14th, 15th, 16th, and 20th. All other doses were initialed as given and, 2. Sertraline 150mg was initialed as given on each day except the 10th when the resident was out of the facility. An "Interdisciplinary Note," dated 12/08/22, read in part, "...Late Entry 12/7...This nurse was notified by on duty CMA at this time that the resident's Zoloft was completely out, stated the medication was attempted to be reordered on 12/5. This nurse contacted the pharmacy to refill, was notified that a new Escript was needed... At this time missing the 50 mg dose, contacted provider's office and spoke with nurse states [staff member] would send in the new script for 50 mg..." A "Prescription Record 12/01/2021 THRU 12/11/2022," dated 12/11/22, documented Sertraline 50 mg was filled on 12/13/21, 12/30/21, 03/28/22, 07/05/22, 09/21/22 and 12/08/22. It documented Sertraline 100 mg was filled on 12/07/22. There was no documentation Sertraline 100mg was filled on any other date. An "Interdisciplinary Note," dated 12/12/22, read in part, "This Nurse Manager was notified that resident wasn't receiving correct dosage of Zoloft	{C1505}		

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{C1505}	Continued From page 7 150mg QD as ordered. Nurse Manager notified MD office of medication error, awaiting for new orders at this time..." An "Interdisciplinary Note," dated 12/13/22, read in part, "[physician name] notified this nurse this morning R/T med error of Zoloft 150mg. MD ordered to continue Zoloft 150mg QD and to monitor x72hrs..." A "Physician Order," dated 12/13/22, documented the resident was to receive Sertraline 100 mg tablet by mouth once daily to be taken with 50mg tablet to equal 150mg daily. A "Physician Order," dated 12/13/22, documented the resident was to receive Sertraline 50mg tablet by mouth once daily to be taken with 100mg tablet to equal 150mg daily. Resident #2's December 2022 MAR documented Sertraline 150mg was initialed as administered on the 1st, 2nd, 3rd, 8th, 9th, 10th, 11th and 12th. It documented an "H" on the 4th, 5th and 7th, and an "O" on the 6th. On 12/19/22 at 9:10 a.m., Resident #2's family member stated the resident had a long history of depression. They stated approximately two years ago, the resident's Zoloft was increased to 150 mg. They stated on approximately 12/07/22, they were notified by the facility the resident's Zoloft was out. They stated the facility called in the refill to the pharmacy. They stated the family went to the pharmacy to pick up the medication, but were notified the resident was out of refills. Resident #2's family member stated when they asked the facility staff how long the resident had been without the medication the answer was	{C1505}		

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{C1505}	Continued From page 8 unclear. They stated they believed the resident was without the medication for three days at least. They stated when the script for the Zoloft was made available at the pharmacy, it was noted to only be for the 100mg tablet. They stated there was not a script for the 50mg tablet to be picked up. They stated upon further review with the pharmacy records, the resident's Zoloft 100mg had not been filled in a year. They stated they were concerned other medications were not being administered as ordered. On 12/19/22 at 12:44 p.m., the Administrator was asked to explain Resident #2's Zoloft order. They stated before the 13th of December, there was one order. They stated the facility had fixed the order and it was now divided into two orders: one order for 100mg and one order for 50 mg to be taken together to equal 150mg. The Administrator was asked the policy for reconciling medications when a family member brought medications into the facility. They stated they had changed the policy. They stated staff were to log the medication into the log book with the date it was ordered, the date it was received, and the family and staff were to initial it. They were asked when this went into affect. The Administrator stated, "This week." On 12/09/22 at 12:55 p.m., the MON joined the interview. They were asked the process of reordering medications resident family members provided. The MON provided 14 white pharmacy bags with the prescription labels still attached for Resident #2. They stated these were the medications the facility could show were brought in by the family. There was one with the label Sertraline 100mg quantity 90 dated 12/07/22 and	{C1505}		