OKLAHOMA
State Department
of Health

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

Survey Event ID: 7HYK11

Dear Ms. Winship:

On **December 19, 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.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

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

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

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Epworth Villa Health Services**
Address: **14901 North Penn Avenue**
City, State, Zip: **Oklahoma City, OK, 73134**
Provider #: **CC5504AL**
Complaint #: **OK00059905**
Investigation Date: **12/19/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to have an effective program for ensuring medications were re-ordered in a timely manner, and medication reconciliations were performed according to standards of practice.	**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 12/19/2022 at 7:45 a.m.

A sample of six 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A 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 C1505 for details.

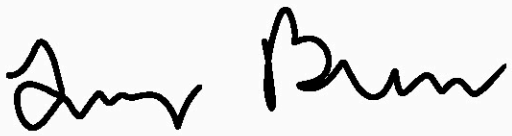
Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

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 survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Thank you for bringing these concerns to our attention.



Tammy Bross, RN, CHFS

Date report completed: 12/20/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CC5504AL	A. BUILDING: _____ B. WING _____	C 12/19/2022

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EPWORTH VILLA HEALTH SERVICES	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 (OK00059905) was conducted on 12/19/2022. The following abbreviations will be used throughout this document. AEB- as evidenced by BID- twice a day CMA- certified medication aide DX- diagnoses GERD- gastroesophogeal 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		

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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	C1505		

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 cervicalgia 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

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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.	C1505		

OKLAHOMA
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Delivery via email to: lwinship@epworthvilla.org

January 13, 2023

License Number: CC5504AL

Ms. Tasha Winship, Administrator
Epworth Villa Health Services
14901 North Penn Avenue
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Survey Event ID: 7HYK11

Dear Ms. Winship:

On **December 19, 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 **February 1, 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: 2023.01.13 14:06:42 -06'00'

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

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Oklahoma State Department of Health

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C 000	INITIAL COMMENTS A complaint investigation (OK00059905) was conducted on 12/19/2022. The following abbreviations will be used throughout this document. AEB- as evidenced by BID- twice a day CMA- certified medication aide DX- diagnoses GERD- gastroesophogeal 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	See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CC5504AL	A. BUILDING: _____ B. WING _____	C 12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EPWORTH VILLA HEALTH SERVICES	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
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 cervicalgia 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.	C1505		

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 12/28/2022
	Facility Name: Epworth Villa Assisted Living
	License Number: CC5504 -AL
	Survey Event ID: 7HYK11
	Date Survey Completed: 12/19/2022

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Record review and interview, the facility failed to ensure medication was: A) administered according to phyicians orders for two (#1 & #2) and B) failed to ensure medications provided by family were reconciled at the facility for one (#2) of two sampled residents reviewed for the administration of medications

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Preparation and execution of this Plan of Correction are not an admission or agreement by the provider of the truth of the allegations in the statement of deficiencies. This Plan of Correction is prepared and executed solely as it is required by state and federal law. Please accept this Plan of Corrction as our Credible Allegation of Compliance.

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	A) Resident #1 and #2 physician's were notified of medication errors. Resident (#2) physicians orders were clarified to help prevent future medication administration errors. The facility completed an audit of resident #2 physician orders and medications for reconciliation. The DON in-serviced clinical staff on administering resident medications per physicians orders. B) Medication Reconciliation Form implemented for receiving medications. Clinical staff in-serviced on use of Medication Reconciliation Form.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents had the potential to be affected by the identified practice. An audit of medications for all residents on the same floor as resident #2 was completed. An audit of medications for all residents will be completed by 1/17/23.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	A) 1. All physician orders will be reviewed in the morning clinical meeting. Additionally, the RN consultant will review all physician's orders for clarity and appropriate dosage instructions and request clarification orders as indicated. 2. All Medication Aides were in-serviced on following physicians orders and documentation of medications given. All medication Aides will receive this training as part of orientation and annually. B) 1) A Medication Reconciliation Form was implemented and will be used to track when medications are ordered and received. This form will include, date ordered, date

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JAN 06 2023
Long Term Care

	received, amount received and family and facility initials. A Medication Reconciliation Book will kept on each medication cart. The DON and/or ADON will review each book weekly to ensure medications are ordered and received in a timely manner. 2) All Medication Aides and Nurses were inserviced on the use of the newly implemented Medication Reconciliation Form. 3) A policy on medication packaging, requiring daily pre-packaged medication and prohibiting bottles, unless prohibited by manufacturer or unavailable through pharmacy of choice, will be sent to all residents/families by 01/05/2023 with required implementation by 01/15/2023.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	1) The DON, ADON and/or Charge Nurse will conduct weekly medication audits twice each week at random for 12 weeks to ensure medications are administered per physicians orders. After 12 weeks audits will be conducted at random. Audits will be kept in the administrators office. Findings will be reviewed by the QA committee to ensure continued compliance and to determine the plan remains effective. 2) The DON, ADON and/or Charge Nurse will pull a missed medication report daily to review for errors and address any issue. This will continue for the first quarter of 2023 and will be reviewed by the QA Committee at the 2023 First Quarter QA meeting . A record of this will be kept in the Adminstrators office. 3) RN Consultant will review all orders monthly and make recommandations to the QA Committee. 4) The Pharmacy Consultant will review physicians orders and documentation at least quarterly and make recommendations to the DON and/ or the residents physician. The Pharmacy Consultant will also observe the medication aides medication administration to ensure appropriate procedure and physician order is followed. Findings will be documented in the monthly pharmacy consultant report. Any identified areas of improvement will be addressed through the facilities QAPI process. Each residents Medication Reconiciliation Forms will be kept on file as part of the residents chart. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/1/2023
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Administrator signature required. Admin	**Date 12/29/2022**

OAC 310:663-25-4(F)			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department of Health

Delivery via email to: Lwinship@epworthvilla.org

February 27, 2023

License Number: CC5504AL

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

Survey Event ID: 7HYK12

Dear Ms. Winship:

On **February 22, 2023,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 19, 2022,** have now been corrected effective **February 1, 2023.**

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

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CC5504AL	A. BUILDING: _____ B. WING _____	R-C 02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{C 000}	INITIAL COMMENTS A revisit was conducted 02/22/23. All deficiencies from the 12/19/22 survey were cleared.	{C 000}		

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