OKLAHOMA
State Department
of Health

**Delivery via email to:** lwinship@epworthvilla.org

June 16, 2023

License Number: CC5504AL

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

**RE: Survey Event ID: CH2811**

Dear Ms. Winship:

On **June 6, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on June 6, 2023.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | CC5504AL | A. BUILDING: _____ B. WING _____ | 06/06/2023 |

| 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 |
|---|---|---|---|---|
| C 000 | INITIAL COMMENTS<br><br>A re-licensure survey was conducted on 06/05/23 through 06/06/23.<br><br>Listed below are abbreviations that will be used throughout this document:<br><br>CPR - cardiopulmonary resuscitation<br>CMA - certified medication aide<br>CNA - certified nurse aide | C 000 | | |
| C 543 SS=E | 310:663-5-4(c) CONDUCT OF ASSESSMENT<br><br>(c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure a resident or resident representative interview was included with each comprehensive assessment for three (#2, 4, and #5) of 11 sampled residents reviewed for comprehensive assessments.<br><br>The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 111 residents resided in the facility.<br><br>Findings:<br><br>A "Comprehensive Assessments and the Care | C 543 | | |

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| C 543 | Continued From page 1 | C 543 | | |

Delivery Process" policy, revised 01/02/23, read in parts, "...Comprehensive assessments will be conducted to assist in developing person-centered care plans...Gather relevant information from multiple sources, including...Resident and family interview..."

1. Resident #2 had diagnoses which included hypertension, hearing loss, coronary artery disease, high cholesterol, and falls.

An annual "Assisted Living Resident Assessment" form, dated 08/24/22, documented the resident was alert and oriented times two and they were forgetful. The signature of Resident or Representative interviewed section was blank. The form was signed by RN #1.

On 06/05/23 at 11:15 a.m., RN #1 was asked to review the assessment dated 08/24/22 for Resident #2 and confirm if a family member or representative was present during the assessment. They stated no, the assessment had not been signed by the family or resident.

2. Resident #5 had diagnoses which included dementia, acute cystitis with hematuria, and chronic back pain.

A pre-admission "Assisted Living Resident Assessment" form, dated 07/08/22, documented the resident was alert and oriented times two to three. The signature of Resident or Representative interviewed section was blank. The form was signed by RN #1.

On 06/05/23 at 2:02 p.m., RN #1 was asked if Resident #5 or the resident's representative was involved in the pre-admission assessment dated 07/08/22. They stated there was no signature on

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| C 543 | Continued From page 2<br>the assessment.<br><br>3. Resident #4 had diagnoses which included hypertension and glaucoma.<br><br>A "Preadmission Resident Assessment" form, dated 10/29/22, documented the resident was alert and oriented times four and forgetful with good judgement. The signature of Resident or Representative interviewed section was blank. The form was signed by RN #1.<br><br>On 06/05/23 at 1:30 p.m., RN #1 was asked the policy for including residents or resident representatives in the resident assessments. They stated usually they would get together with nursing staff and ensure what they saw on the assessment matched what the floor staff were seeing. RN #1 stated if a resident was competent, they would try to get the resident to sign the assessment. RN #1 was asked how they documented a resident or resident representative was involved in the assessment. They stated they usually had them sign it annually.<br><br>On 06/05/23 at 1:32 p.m., RN #1 was asked if Resident #1 or their representative had been involved in the assessment dated 10/29/22. They stated, "They did not sign this, no." They were asked if Resident #1 was competent to participate in the assessment. RN #1 stated, "Yes." RN #1 was asked to clarify the assessment dated 10/29/22 marked as preadmission. They stated the assessment should have been marked annual. They stated it was a clerical error. | C 543 | | |
| C 701 SS=D | Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS | C 701 | | |

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| C 701 | Continued From page 3<br><br>(d) Each assisted living center shall comply with the hot water standards set forth in Appendix A.<br><br>Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.)<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview the facility failed to maintain safe water temperatures in one (Resident #1) of six shower rooms observed for safe water temperatures.<br><br>The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 111 residents resided in the facility.<br><br>Findings:<br><br>A facility "Water Temperatures" policy, undated, read in parts, "...Tap water in the facility shall be kept within a temperature range to prevent scalding of residents...Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 115 [degrees Fahrenheit]...Maintenance staff is responsible for regularly checking thermostats and temperature controls in the facility and recording these checks in a maintenance log..."<br><br>Resident #1 had diagnoses which included fibrosis, asthma, and hypertension. | C 701 | | |

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| C 701 | Continued From page 4<br><br>A "Preadmission Resident Assessment" form, dated 09/07/22, documented the resident was oriented times three to four, and forgetful. It documented the resident required one person standby staff assistance for the task of bathing.<br><br>On 06/05/23 at 11:43 a.m., the shower in Resident #1's room was observed to be 143 degrees Fahrenheit.<br><br>On 06/05/23 at 11:50 a.m., Resident #1 was asked about the water temperature in their shower. They stated the water was fine. They stated they did not shower alone, and staff were always with them in the shower.<br><br>On 06/05/23 at 11:53 a.m., the Director of Facility and Facilities Manager were asked the policy for maintaining comfortable water temperatures in resident showers. The Director of Facility stated they checked temperatures weekly and they should be between 105 and 115. The Director of Facility stated when they spot checked they tested one sink and one shower.<br><br>On 06/05/23 at 11:55 a.m., the Director of Facility and Facilities Manager were asked if they had noticed any temperatures too hot or too cold. The Director of Facility stated one resident on the third floor had issues which related to a mixing valve. They were asked what they would do if they observed a temperature reading above 115 degrees. The Director of Facility stated they would adjust the setting. They were made aware of the above observation and stated they would address it immediately. | C 701 | | |

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| C 954 | Continued From page 5 | C 954 | | |
| C 954 SS=E | 310:663-9-5(d) STAFF QUALIFICATIONS<br><br>(d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to provide evidence of CPR training for direct care staff for four (CMA #5, 6 and #7 and CNA #6) of five employee files reviewed.<br><br>The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 111 residents resided in the facility.<br><br>Findings:<br><br>A review of the personnel files for CMA #5, 6, and #7 and CNA #6 revealed there was no documentation of CPR training.<br><br>On 06/06/23 at 10:30 a.m., the Administrator was asked to provide documentation of CPR training for CMA #5, 6, and #7 and CNA #6.<br><br>On 06/06/23 at 12:15 p.m., the Administrator stated they did not have a policy for CPR training. The Administrator stated they had changed training companies and had no documentation of CPR training for CMA #5, 6, and #7 and CNA #6. | C 954 | | |

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| C1972 | Continued From page 6 | C1972 | | |
| C1972 SS=D | 310:663-19-4(c) POLICIES<br><br>(c) The assisted living center shall provide staff, within ninety (90) days of employment, training in the identification of abuse and neglect of residents and misappropriation of resident property and the facility's policies and procedures concerning the same. Verification of the provision of training shall be written, signed by staff attending and retained in the personnel files.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure staff were educated on abuse within 90 days of hire and or annually for two (CMA #6 and CMA #7) of five employees reviewed for abuse training.<br><br>The "Assisted Living Resident Condition and Care Overview" report, dated 06/05/23, documented 111 residents resided in the facility.<br><br>Findings:<br><br>The facility "Abuse Prevention Program" policy, undated, read in part, "...Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse..."<br><br>Employee personnel files were reviewed and revealed CMA #6 and #7 had no documented abuse training. The employee file for CMA #6 and #7 contained no documentation of abuse training within 90 days of hire. | C1972 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | CC5504AL | A. BUILDING: _____ B. WING _____ | 06/06/2023 |

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|---|---|---|---|---|
| C1972 | Continued From page 7<br><br>On 06/06/23 at 10:30 a.m., the Administrator was asked to locate abuse training verification for CMA #6 and #7.<br><br>On 06/06/23 at 12:25 p.m., the Administrator stated they could not locate abuse training for CMA #6 and #7.<br><br>On 06/06/23 at 12:30 p.m., the Administrator was asked what was the time frame for staff to receive abuse training. They stated within the first 30 days of employment. | C1972 | | |

OKLAHOMA
State Department
of Health

**Delivery via email to**: lwinship@epworthvilla.org

July 14, 2023

License Number: CC5504AL

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

**RE: Survey Event CH2811**

Dear Ms. Winship:

On **June 6, 2023**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **July 25, 2023**.

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

Respectfully,

Tempal Killman

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

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| OKLAHOMA State Department of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE** |
|---|---|
| | **Current Date: 6/19/2023** |
| | **Facility Name:** Epworth Villa Assisted Living |
| | **License Number:** CC5504AL |
| | **Survey Event ID:** CH2811 |
| | **Date Survey Completed: 6/6/2023** |

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 543 | Based on: Based on record review and interview, the facility failed to ensure a resident or resident representive interview was included with each comprehensive assessment for three (#2,4,and 5) of 11 sampled residents reviewed for comprehensive assessments. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Preparation and execution of this Plan of Corrections 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 soley as it is required by state and federal law. Please accept this Plan of Correction 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? | The facility RN conducted an interview with the resident or resident representive for each resident identified ( #2 #4 and #5) as part of the resident assessment. The RN then ensured that each assessment included a signature of the resident or the resident representive. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | There is a potential for all resdients to be affected by the identified practice. An audit of all resident assessments was conducted to ensure the comprehensive assessments are complete and include an interview with the resident or resident representative, as well as their signature. |
| 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? | 1) All Comprehensive Assessments will be reviewed by the DON (Director of Nursing) for accuracy and completion.<br>2) All Comprehensive Assessments will be reviewed during the Monthly QAPI Meeting for one quarter and then as needed. Any findings will be reported to the QA Committee for review.<br>3) The QA Committee will review findings at the quarterly QA Meeting and will make any needed changes to the plan. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | The DON will review all Comprehensive Assessments to ensure completion and accuracy.<br><br>The DON and Administrator will meet weekly to review the plans effectiveness for one quarter.<br><br>All Comprehensive assessments will be reviewed during the monthly QAPI Meeting to ensure continued |

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| | compliance and will determine if the plan remains effective for quarter and then as needed.<br><br>The DON will keep record of reviewed assessments and present it at the monthly QAPI Meeting for one quarter and then as needed. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 7/25/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

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| **Administrator's Signature** Administrator signature required.<br>OAC 310:663-25-4(F) | **Date** Enter a date of signature. |
| 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. |

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|---|
| 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.<br>Facility in Compliance by: Click here to enter a date. |

| OKLAHOMA State Department of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 6/19/2023**<br>**Facility Name:** Epworth Villa Assisted Living<br>**License Number:** CC5504<br>**Survey Event ID:** CH2811<br>**Date Survey Completed: 6/6/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 701 | Based on: Based on observation, record review, and interview, the facility failed to maintain safe water temperatures in one (Resident #1) of six shower rooms observed for safe water temperatures. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Preparation and execution of this Plan of Corrections 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 soley as it is required by state and federal law. Please accept this Plan of Correction 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? | The Facilities Services Manager immediately adjusted the water temperature to 114 degrees Fahrenheit and repaired/ replace the mixing valve in Resident #1's apartment. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | There is a potential for all residents to be affected. The Facility Services Department checked the water temperature on each floor to ensure the water temperature is no higher than 115 degrees Fahrenheit throughout the building. |
| 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? | 1) The Facility Services Department will conduct weekly random water temperature checks. This will be logged on the Weekly Water Temperature Monitoring Form. 2) The Facility Services manager will review the temperature logs with the building Administrator weekly for one quarter and then as needed. 3) The water temperature logs will be reviewed monthly at the QAPI Meeting for one quarter to review the plans effectiveness and report findings to the QA Committee quarterly. The QA Committee will make recommandations and/ or changes to the plan as needed. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | The Facility Services Manager will ensure completion of the weekly temperature logs. The Administrator will review the temperature logs weekly for one quarter with the Facility Services Manager to ensure a hot water temperature is maintained of no greater than 115 degrees Fahrenheit.<br><br>The Facility Services Department will conduct weekly random temperature checks. This information will be reviewed weekly by the Administrator and Building |

| | |
|---|---|
| | Services Manager for one quarter to ensure the ideal hot water teamperature is maintained throughout the building.<br><br>The water temperature logs will be reviewed monthly at the QAPI Meeting for one quarter and make any needed recommendations or revisions to this plan.<br><br>A record of the random temperature checks will be kept in the Facility Services Director's office, as well as in the Administrator's office. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 7/25/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| | | | |
|---|---|---|---|
| **Administrator's Signature** Administrator signature required.<br>OAC 310:663-25-4(F) | Jon Lachmin | **Date** Enter a date of signature. | 06-26-2023 |

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<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 6/19/2023**<br>**Facility Name:** Epworth Villa Assisted Living<br>**License Number:** CC5504<br>**Survey Event ID:** CH2811<br>**Date Survey Completed: 6/6/2023** |
|---|---|

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 954 | Based on: Based on record review and interview, the facility failed to provide evidence of CPR training for direct care staff for four (CMA #5, 6, and #7 and CAN #6) of the five employee files reviewed |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Preparation and execution of this Plan of Corrections 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 soley as it is required by state and federal law. Please accept this Plan of Correction 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? | No residents were identified. However, corrective measures will be taken to ensure all direct care staff have completed CPR training upon hire and annually as required. |
| 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 have the potential to be effected. |
| 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? | Direct Care Staff #5,#6, and #7 have received CPR training. All newly hired direct care staff will receive CPR training during onboarding and twice annually to ensure the facility remains compliant. The Don will review the direct care staffs training compliance monthly for two quarters to ensure training is being completed as required. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | The DON will review direct care staffs employee files at least quarterly for two quarters to ensure CPR training requirements are completed.<br><br>Direct care staff training will be reviewed monthly at the QAPI Meeting for two quarters and will report any findings to the Quality Assurance Committee at least quarterly.<br><br>The QA Committee will review and discuss direct care staff training and compliance with CPR quarterly and make recommendations and/ or revisions to the plan as needed.<br><br>The DON will keep a record of the CPR training and compliance and will present it at the monthly QAPI Meeting for review for two quarters and then as needed. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 7/25/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature** OAC 310:663-25-4(F) Administrator signature required. | **Date** Enter a date of signature. |
|---|---|
| J. Wendling for/Admin | 06-26-2023 |

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<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE** |
|---|---|
| | **Current Date: 6/19/2023** |
| | **Facility Name:** Epworth Villa Assisted Living |
| | **License Number:** CC5504 |
| | **Survey Event ID:** CH2811 |
| | **Date Survey Completed: 6/6/2023** |

| **SUMMARY OF DEFICIENCY CITED BY OSDH** | |
|---|---|
| ID Prefix Tag: C 1972 | Based on: Based on record review and interview, the facility failed to ensure staff were educated on abuse within 90 days of hire and/ or annually for two (CMA #6 and CMA #7) of five employees reviewed for abuse training. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Preparation and execution of this Plan of Corrections 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 soley as it is required by state and federal law. Please accept this Plan of Correction 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? | No residents were identified as being affected. However, corrective measures were taken to ensure all direct care staff have received abuse training to include CMA #6 and CMA #7. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 2. How will other residents having the potential to be affected by the same deficient practice be identified? | There is a potential for all residents to be affected. |
| 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? | Identified employee (CMA #6 and CMA #7) have received abuse training. All new employees will receive abuse training during onboarding. All staff will receive abuse training twice annually. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | The DON will review/ audit all employee files for compliance at least quarterly, to ensure abuse training is completed as required.<br><br>Employee training/ education will be reviewed for effectiveness and to ensure compliance at the monthly QAPI Meeting for two quarters and as needed.<br><br>The QA Committee will review and discuss employee abuse training/ education compliance for two quarters and make any needed revisions to the plan.<br><br>The DON will keep a record of all employee trainings, to include abuse and present it at the monthly QAPI Meeting for review for two quarters. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 7/25/2023 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature** Administrator signature required.<br>OAC 310:663-25-4(F) | **Date** Enter a date of signature. |
|---|---|
| [signature] Jon/Admin | 06-26-2023 |

| 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.<br>Facility in Compliance by: Click here to enter a date. | | | |

OKLAHOMA
State Department of Health

**Delivery via email to:** lwinship@epworthvilla.org

August 29, 2023

License Number: CC5504AL

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

**RE: Survey Event CH2812**

Dear Ms. Winship:

On **August 28, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 6, 2023,** have now been corrected effective **July 25, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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 08/28/2023 |

| 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 |
|---|---|---|---|---|
| {C 000} | INITIAL COMMENTS<br><br>An offsite/paper revisit was conducted on 08/25/23 and 08/28/23. The facility was in substantial compliance. | {C 000} | | |

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