

Delivery via email to: lwinship@epworthvilla.org

December 20, 2023

License Number: CC5504AL

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

Survey Event ID: XTCU11

Dear Ms. Winship:

On **November 17, 2023**, 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 Services**, then **click on Long Term Care**. 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face to face, or a virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,



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

Enclosure

INVESTIGATIVE REPORT

Facility: Epworth Villa Health Services
Address: 14901 North Penn Ave
City, State, Zip: Oklahoma City, OK 73134
Provider #: CC5504AL
Complaint #: OK00061458
Investigation Date(s): 11/13/23 through 11/17/23

ALLEGATION(S)

The center failed to ensure residents were not physically, verbally or psychosocially abused.
The center failed to assess, monitor, intervene and investigate for injuries of unknown origin.
The center failed to ensure residents received adequate nutrition, did not exhibit unavoidable weight loss; prevent the development of new/worsened pressure wounds; and provide care according to the service agreement and care plan.
The facility failed to ensure adequate supervision and/or assistive devices to prevent falls.

An unannounced on-site investigation was initiated 11/13/2023 at 1:30 p.m.

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

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

A Summary of Complaint Investigation:

Observations were made of meal services, staff and resident interactions, and care being provided to residents such as showers, meal assistance and grooming and hygiene. Staff was observed passing medications to residents as ordered by the physician. Residents were observed throughout the survey to be well groomed and free of odors.

Residents were interviewed regarding medications being received as ordered, mistreatment by staff or other residents, falls, skin conditions, weight loss, and meal service.

Staff was interviewed regarding the medications being received as ordered, mistreatment by staff or other residents, falls, skin conditions, weight loss, and meal service. Staff was also interviewed about their knowledge of the facility abuse policy and procedures. All staff were knowledgeable of the facility policy on abuse and who to report any allegations to for investigation.

Facility records were reviewed to include policies and procedures, abuse investigations, nursing assessments, incident reports, reports sent to the Oklahoma State department of Health, care plans, progress notes, service agreements, physician orders, medication administration records, therapy notes and assessments, involuntary discharge, resident weights, resident council and grievances. Employee files were also reviewed for abuse training and pre-hire screening.

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

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/20/2023

INVESTIGATIVE REPORT

Facility: Epworth Villa Health Services
Address: 14901 North Penn Ave
City, State, Zip: Oklahoma City, OK 73134
Provider #: CC5504AL
Complaint #: OK00061704
Investigation Date(s): 11/13/23 through 11/17/23

ALLEGATION(S)

The center failed to ensure residents were no physically, verbally or psychosocially abused.
The center failed to ensure rehabilitation services were received for a fractured femur according to the physician's orders.
The center failed to ensure pain management was received according to the physician's orders.
The Center failed to ensure the right to choose a physician.
The Center failed to ensure residents were no involuntarily discharged and failed to ensure a fall with a fracture was reported to the Oklahoma State Department of Health according to law.

An unannounced on-site investigation was initiated 11/13/2023 at 1:30 p.m.

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

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

A Summary of Complaint Investigation:

Observations were made of residents receiving physical therapy and staff interactions with the residents. Staff was observed passing medications to residents as ordered by the physician. Residents were observed throughout the survey and no residents were displaying signs of uncontrolled pain.

Residents were interviewed regarding therapy services, pain management, medications being received as ordered, rights to choose own physician, and abuse and neglect. No residents had any complaints about their pain management, medications and mistreatment by any staff or resident.

Staff was interviewed regarding the facility providing therapy to residents; residents pain management; medication being provided as ordered and their knowledge on the abuse policy and procedures. All staff were knowledgeable of the facility policy on abuse and who to report any allegations to for investigation.

Facility records were reviewed to include policies and procedures, abuse investigations, nursing assessments, incident reports, reports sent to the Oklahoma State department of Health, care plans, progress notes, service agreements, physician orders, medication administration records, therapy notes and assessments, involuntary discharge, resident weights, resident council and grievances. Employee files were also reviewed for abuse training and pre-hire screening.

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Oklahoma State Department of Health
Long Term Care Service

Date report completed: 11/20/2023

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 11/17/2023
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 Complaint investigations (#OK00061458 and #OK00061704) were conducted on 11/13/23 through 11/17/23. Facility Census: 111 The following abbreviations will be used throughout this document. CNA- certified nurse aide CMA- certified medication aide DON- director of nursing LPN- licensed practical nurse RN- registered nurse	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to complete a comprehensive assessment after a decline for one (#9) of two sampled residents reviewed for falls resulting in a decline. Findings:	C 522		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

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 11/17/2023
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C 522	Continued From page 1 Resident #9 had diagnoses that included status post .fall with a fractured femur. An incident report, dated 09/18/23, read in part, "...heard resident yelling aloud from room...resident sitting on the commode, stated she was unable to move her left leg...." A progress note, dated 09/28/23 at 6:34 p.m., read in part, "...Resident had surgery to left distal femur to correct a fracture..." On 11/16/23 at 10:23 a.m., CMA #1 stated Resident #9 required more assistance with toileting and they provided more assistance after the fracture. On 11/16/23 at 10:31 a.m., LPN #1 stated Resident #9 had a decline after the fracture and required a lot more assistance. On 11/16/23 at 10:52 a.m., CNA #1 stated Resident #9 fractured their leg and required more assistance. On 11/16/23 at 11:00 a.m., LPN #2 stated Resident #9 had a decline and required two people for transfers toileting and bathing. On 11/16/23 at 11:19 a.m., RN #1, the consultant, stated they did not do a new assessment after the fall and there was a change. RN #1 further stated a comprehensive assessment should have been completed and it wasn't. On 11/16/23 at 11:53 a.m., physician #1 stated Resident #9 had a decline after the fall and they looked at 24-7 sitter and/or respite in the long term care due to the decline.	C 522		

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 11/17/2023
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C2700 SS=E	310:663-27-1 APPLICATION FORM CHANGES Any substantial change in the information originally reported in the license application shall be submitted to the Department for review. This Rule is not met as evidenced by: Based on record review and interview it was determined the facility failed to report a bankruptcy to the Oklahoma State Department of Health. Findings: A local news paper article, dated 09/29/23, read in part, "...Epworth Villa files for bankruptcy protection..." On 11/17/23 at 1:30 p.m., the Chief Operating Officer was asked if the Assisted Living was currently in a bankruptcy. The Chief Operating Officer stated the bankruptcy was for the whole campus and the assisted living was part of that. The Chief Operating Officer than stated she had not reported the bankruptcy because they did not know it had to be reported.	C2700		

Delivery via email to: lwinship@epworthvilla.org

January 12, 2024

License Number: CC5504AL

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

Survey Event ID: XTCU11

Dear Ms.. Harter:

On **November 17, 2023**, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **February 15, 2024**.

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,



Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/4/2024

Facility Name: Epworth Villa Assisted Living

License Number: CC5504AL

Survey Event ID: XTCU11

Date Survey Completed: 11/17/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522

Based on: Record review and interview, the facility failed to complete a comprehensive assessment after a decline for one (#9) of two sampled residents reviewed for falls resulting in a decline.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Preparation and execution of this Plan of Correction is 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 Correction as our Credible Allegation of Compliance.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The identified resident (#9) no longer resides at the facility. However, the facility RN Consult reviewed all residents records and completed a Comprehensive Significant Change Assessment on all residents who have had a decline.

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 by the identified deficient practice. A record review of all residents was conducted by the Interdisciplinary Team to identify residents who have had a decline to ensure that a comprehensive assessment has been completed for all identified residents.

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 DON will review all incident reports, behavior reports, and hospital visits daily and ensure that a comprehensive assessment is completed for all residents who have experienced a change in condition.
- 2) All residents who have experienced a decline/ change in condition will be reviewed weekly by the Interdisciplinary Team at the At Risk meeting to ensure that a comprehensive assessment has been completed and that any needed additional services have been requested. .
- 3) All identified residents assessments will be reviewed during the monthly AL QAPI Meeting, to ensure completion and that additional support and services have been requested and/ or are in place. Any findings will be reported to the QA Committee for review.
- 4) 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:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

Enter methods to ensure corrections are sustained:

The DON or Designee, RN Consult, and AL Administrator will review all incident reports, hospital visits, and behavior notes to ensure that a comprehensive assessment has been completed for all residents who have experienced a significant change in condition weekly to ensure the plans effectiveness.

The identified residents comprehensive assessments will be reviewed at the monthly AL QAPI Meeting to ensure continued compliance and will determine if the plan remains effective. Any findings will be submitted to the QA Committee quarterly and the QA Committee will determine if any changes need to be made to the plan.

The DON or Designee will complete a review form for the daily review of incident reports, hospital visits, and behavior reports. The DON or Designee and Administrator will keep a record of the weekly meetings to review the comprehensive assessments. The Interdisciplinary Team will keep a record of the weekly At Risk meeting.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

2/15/2024

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

OAC 310:663-25-4(F)

Administrator signature required.

Date 1/4/2024

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
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 1/4/2024

Facility Name: Epworth Villa Assisted Living

License Number: CC5504AL

Survey Event ID: XTCU11

Date Survey Completed: 11/17/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 2700

Based on: record review and interview it was determined, the facility failed to report a bankruptcy to the Oklahoma State Department of Health.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Preparation and execution of this Plan of Correction is 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 required by state and federal law. Please accept this Plan of Correction as our Credible Allegation of Compliance.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The facility filed notice of Chapter 11 bankruptcy in the United States Bankruptcy Court for the Western District of Oklahoma on September 29, 2023. On October 17, 2023 the United States Trustee appointed a Patient Care Ombudsman to monitor, and report to the court, the quality of care provided to residents. The Ombudsman visited the facility [which included interviewing residents, family members and staff, as well as facility policies, employee handbook and admission agreements] on October 24, 2023 and November 8, 2023. The Ombudsman filed a report with the court on November 10, 2023, stating 'Epworth Villa is an impressive facility....'. The facility notified the Oklahoma State Department of Health of the bankruptcy filing on November 21, 2023.

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.

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?

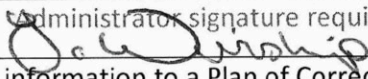
This was an isolated incident of failure to report a federal bankruptcy filing to the Oklahoma State Department of Health. This was accomplished on November 21, 2023. On October 17, 2023 the United States Trustee appointed a Patient Care Ombudsman to monitor, and report to the court, the quality of care provided to the residents. The Ombudsman visited the facility twice and filed a report on November 10, 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;

This was an isolated incident of failure to report a federal bankruptcy filing to the Oklahoma State Department of Health. This was accomplished on November 21, 2023. The facility filed notice of Chapter 11 bankruptcy in the United States Bankruptcy Court for the Western District of Oklahoma on September 29, 2023. On October 17, 2023

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.		the United States Trustee appointed a patient care ombudsman to monitor, and report to the court, the quality of care provided to residents. The ombudsman visited the facility [which included interviewing residents, family members and staff, as well as facility policies, employee handbook and admission agreements] on October 24, 2023 and November 8, 2023. The ombudsman filed a report with the court on November 10, 2023, stating 'Epworth Villa is an impressive facility....'. The facility notified the Oklahoma State Department of Health of the bankruptcy filing on November 21, 2023. The facility maintains copies of the Notice of Chapter 11 Bankruptcy case, Notice of United State's Trustee's Appointment of Patient Care Ombudsman and the Submission of Report by Patient Care Ombudsman. 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?		2/15/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) 		Administrator signature required. Date 1/4/2024	
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.			

Delivery via email to: lwinship@epworthvilla.org

March 27, 2024

License Number: CC5504AL

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

RE: Survey Event XTCU12

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 **March 1, 2024**. These deficiencies demonstrate noncompliance since your survey of **November 17, 2023**.

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 Services**, then **click on Long Term Care**. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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- (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;
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- (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.

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

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

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

- Alleged inadequacy or inaccuracy of the informal dispute resolution process

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

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

Respectfully,



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

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 03/01/2024
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 revisit was conducted from 02/28/24 through 03/01/24. All deficiencies from the 11/17/23 survey were cleared. Additional deficiencies were identified. Listed below are abbreviations that will be used throughout this survey. ADON- assistant director of nursing CMA- certified medication assistant DON- director of nursing Dc'd- discontinued mcg- microgram mg- milligram	{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	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 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 observation, record review, and interview, the facility failed to: a. implement the facilities policy for narcotics for three (#13, 15, and #20), of 10 sampled residents for pharmacy services, and b. ensure a policy was in place for removing and destroying non-narcotics for four (#8, 13, 18, and #19) of 10 sampled residents reviewed for pharmacy services. A "Census", dated 02/19/24, documented 152 residents resided in the facility. Findings: A policy titled "Discarding and Destroying Medications" policy, April 2019, documented all unused controlled substances should be retained in a secured and locked area with restricted access until they are disposed of. The policy documented disposal of controlled substances must take place immediately, no longer than	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 2 three days, after discontinuation of use by the resident. The policy documented non-controlled substances should be disposed of in accordance with state regulations. The policy did not identify the process for non-controlled substances. A policy titled "Medication Room/Medication Cart Review", dated 11/29/23, documented to check all medications and gels on the medication cart for outdated/discontinued medications. The policy documented to destroy discontinued medications in the medication room or lock them up. Resident #20 Resident #20 had diagnoses which included dementia and hip pain. "Physician's Orders" showed an order for: a. Tramadol 50 mg was to be administered as needed with a start date of 11/10/23 and stop date of 11/29/23. b. Belbuca 150 mcg to be administered twice a day with a start date of 12/05/23 and stop date of 12/28/23. On 02/29/24 at 9:34 a.m., a medication cart was observed to have Belbuca and Tramadol was observed on the medication cart for Resident # 20, which was discontinued. Resident #18 Resident #18 had diagnoses which included fracture unspecified part of neck of right femur, cerebrovascular disease, unspecified osteoarthritis, mixed hyperlipidemia and unspecified fall.	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 3 "Physician's Order" showed an order for: a. Macrobid 100 mg was to be administered every night with a start date of 10/07/22 and stop date of 11/29/23. On 02/29/24 at 9:34 a.m., a medication cart was observed to have Macrobid on the medication cart for Resident # 18, which was discontinued. Resident #8 Resident #8 had diagnoses which included chronic pain and hypertension. "Physician's Order" showed an order for: a. Ibuprofen 600 mg by mouth every six hours as needed for oral pain with a start date of 09/14/21 and a stop date of 02/14/24. b. Hydrochlorothiazide 25 mg daily for blood pressure with a start date of 08/25/22 and a stop date of 02/27/24. c. Lotrel 5 mg-40 mg capsule daily for hypertension with a start date of 12/30/22 and a stop date of 02/27/24. d. Norco 5 mg-325 mg tablet by mouth four times daily for pain with a start date of 04/05/23 and a stop date of 02/27/24. On 02/28/24 at 4:12 p.m., a medication cart was observed to have Lotrel, Hydrochlorothiazide, Ibuprofen, and Norco discontinued medications for Resident #8 which was discontinued. Resident #15	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 4 Resident #15 had diagnoses which included pain. "Physician's Order" showed an order for Oxycontin 40 mg tablet by mouth every 12 hours as needed for pain with a start date of 06/13/23 and stop date of 12/22/23. On 02/28/24 at 5:54 p.m., a medication cart was observed with Oxycontin for Resident #15, which was discontinued. Resident #19 Resident #19 had diagnoses which included urinary tract infection. "Physician's Order" showed an order for: a. Trimethoprim 100 mg daily for urinary tract infection with a start date of 09/03/23 and stop date of 02/13/24. b. Macrobid 100 mg twice daily with a start date of 02/13/24 and end date of 02/23/24. On 02/29/24 at 9:18 a.m., a medication cart was observed with Trimethoprim and Macrobid for Resident #19 Trimethoprim and Macrobid, which was discontinued. Resident #13 Resident #13 had diagnoses which included pain. "Physician's Order" showed an order for Hydrocodone/APAP 5/325 mg tablet every 12 hours as needed for pain with a start date of 08/21/23 and stop date of 02/07/24. On 02/29/24 at 9:40 a.m., a medication cart was	C1505		

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C1505	Continued From page 5 observed with Hydrocodone for Resident # 13, which was discontinued. On 02/29/24 at 9:43 a.m., Employee #2 stated when medications were discontinued, they removed the medication, would put the medication in the medication room; and Employee #2 would ask the DON what staff needed to do with the medication. Employee #2 stated they asked the charge nurse, about a month ago, what staff should do with the medications and the charge nurse stated to leave the medications on the cart until the ADON was available. On 02/29/24 at 10:53 a.m., Employee #3 was asked what the process was for destroying discontinued medications. Employee #3 pointed to a sign posted in the med room and stated when non-narcotic medications were discontinued, staff put the medications in the med room, and medications were to be destroyed on the 15th and 30th each month. Employee #3 stated the CMAs were supposed to have discontinued books for staff to write up the medications, but the CMAs don't have the book. Employee #3 stated the CMAs haven't had the book for a while. Employee #3 stated nurses discontinued the narcotics. They stated the nurse tells the CMAs the medication was discontinued but to leave the medication on the med cart until the ADON comes with the pharmacist, they count and destroy the narcotics. Employee #3 stated they have alerted the administrator and ADON regarding discontinued medications on cart. Employee #3 stated they have been told the medications would be removed from the cart the following week but weren't. On 02/29/24 at 11:01 a.m., Employee #7 was	C1505		

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C1505	Continued From page 6 asked what their role was in the facility. They stated they came to the facility about every 90 days, and they would review charts, medication storage, and observe medication pass. They were asked if they had anything to do with destroying medications. They stated, "No." Employee #7 was asked if they were aware of the facility's process for destroying medications in the facility. They stated they knew the medications were destroyed with two licensed nurses. On 02/29/24 at 11:27 a.m., Employee #6 stated CMAs destroyed non-narcotic medications immediately after the medications were discontinued. Employee #6 was asked what the process was for destroying discontinued narcotic medications. They stated they had been waiting to implement a new policy. Employee #6 stated they asked staff to keep the narcotics on the medication cart. They stated they destroyed medications about three weeks ago. Employee #6 stated they did not go to the medication carts to get medications to destroy them because they were limited on time.	C1505		
C1920 SS=E	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure discontinued narcotic medications were reconciled with restricted access until disposed of for two (#15	C1920		

Oklahoma State Department of Health

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C1920	Continued From page 7 and #20) of 10 sampled residents reviewed for pharmacy services. A "Census", dated 02/19/24, documented 152 residents resided in the facility. Findings: Resident #20 Resident #20 had diagnoses which included dementia and hip pain. "Physician's Orders" showed an order for: a. Tramadol 50 mg was to be administered as needed with a start date of 11/10/23 and stop dated of 11/29/23. b. Belbuca 150 mcg to be administered twice a day with a start date of 12/05/23 and stop date 12/28/23. The Tramadol narcotic count sheet dated last on 11/29/23. The medication was on the cart 91 days after the stop date. The Belbuca narcotic count sheet dated last on 12/28/23. The medication was on the cart 62 days after the stop date. Resident #15 Resident #15 had diagnoses which included pain. "Physician's Order" showed an order for Oxycontin 40 mg tablet by mouth every 12 hours as needed for pain with a start date of 06/13/23	C1920		

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C1920	Continued From page 8 and stop date of 12/22/23. The Oxycontin narcotic count sheet dated last on 12/26/22. The medication was on the cart 68 days after the stop date. On 02/29/24 at 9:40 a.m., a medication cart was observed with narcotics for Resident #15 which were discontinued. The medications were not reconciled after the order was received to discontinue and were accessible to employee's who worked cart. On 02/29/24 at 9:43 a.m., Employee #4 was asked what brown paper bags meant. They stated, "Dc'd meds." On 02/29/24 at 11:40 a.m., Employee #4 was asked if the Dc'd narcotics were counted every shift. They stated, "No, not once they are Dc'd." On 02/29/24 at 11:46 a.m., Employee #3 stated they don't count discontinued narcotic medications still on the medication carts. They were asked how they would know if the medication was missing. Employee #3 stated they wouldn't know unless they counted them.	C1920		
C1921 SS=D	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order	C1921		

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C1921	Continued From page 9 This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a narcotic was not administered without a physician order for one (#8) of five sampled residents reviewed for medications. A "Census", dated 02/19/24, documented 152 residents resided in the facility. Findings: Resident #8 had diagnoses which included chronic pain. A "Physician's Order", start date 04/05/23, stop date 02/27/24, documented Norco 5/325 mg tablet by mouth four times daily for pain. On 02/28/24 at 4:12 p.m., Resident # 8 Norco card and narcotic sheet was observed with Employee #5. One tablet was not accounted for on the narcotic sheet. On 02/28/24 at 4:13 p.m., Employee #5 They stated they had given the Norco before they knew it was discontinued. Employee #5 stated they had not signed the Norco out on the narcotic count sheet. On 02/28/24 at 5:29 p.m., Employee #5 stated when they administered medications they were to go by the MAR, compare it to the directions on the medication, punch the medication, make sure it is the correct dose, and take it to the resident.	C1921		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION	C1923		

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C1923	Continued From page 10 (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to prevent medication error for one (#8) of five sampled residents reviewed for narcotics. A "Census", dated 02/19/24, documented 152 residents resided in the facility. Findings: A "Medication Error" policy, undated, documented a medication error was defined as administration of drugs no in accordance with physician's orders. Resident #8 had diagnoses which included chronic pain and hypertension.	C1923		

Oklahoma State Department of Health

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C1923	Continued From page 11 A "Physician's Order", start date 04/05/23, stop date 02/27/24, documented Norco 5/325 mg tablet by mouth four times daily for pain. On 02/28/24 at 4:12 p.m., a medication cart was observed with Norco for Resident #8's, which was discontinued. A narcotic count sheet documented there were 48 tablets remaining of Norco. The Norco punch card contained 47 tablets. On 02/28/24 at 4:13 p.m., Employee #5 stated had not had time to remove the medications from the cart. They were shown the Norco count sheet and asked to explain the discrepancy. Employee #5 stated that was their fault. They stated they had given the Norco before they knew it was discontinued. On 02/29/24 at 11:27 a.m., Employee #6 was asked what the process was for ensuring discontinued medications were removed from circulation in order to prevent medication errors. They stated the nurses would inform the CMAs of Dc'd medications and the CMAs would pull them off the cart.	C1923		

FINAL DETERMINATION
USPS Tracking # 7021 2720 0002 0354 1648

June 11, 2024

License Number: CC5504AL

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

Survey Event ID: XTCU13

Dear Ms. Winship:

A revisit conducted **June 10, 2024**, revealed that your facility corrected deficiencies effective **May 30, 2024**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me 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

Respectfully,



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

Enclosure:

Oklahoma State Department of Health

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{C 000}	INITIAL COMMENTS A re-visit was conducted on 06/10/24. All deficiencies from the 03/01/24 survey were cleared.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE