

Delivery via email to: lstewart@villagioliving.com

June 15, 2023

License Number: NH5526AL

Ms. Lydia Stewart, Administrator
Bradford Village Healthcare Center
906 North Boulevard
Edmond, OK 73034

RE: Survey Event ID: TYV011

Dear Ms. Stewart:

On **May 31, 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 May 31, 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, 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: NH5526AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/31/2023
NAME OF PROVIDER OR SUPPLIER BRADFORD VILLAGE HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 906 NORTH BOULEVARD EDMOND, OK 73034		
(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 re-licensure survey was conducted on 05/30/23 and 05/31/23. Listed below are abbreviations that will be used throughout this document: ACMA - advanced certified medication aide BP - blood pressure CKD - chronic kidney disease DM - dietary manager DBP - diastolic blood pressure ED - executive director EHR - electronic health record F - Fahrenheit GERD - gastroesophageal reflux disease HCL - hydrochloride HTN - hypertension HWD - health and wellness director LPN - licensed practical nurse MAR - medication administration record mcg - microgram mg - milligrams OA - osteoarthritis OSDH - Oklahoma State Department of Health Res - resident RN - registered nurse SBP - systolic blood pressure tab - tablet	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on observation, record review, and	C 391		

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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C 391	Continued From page 1 interview, the facility failed to ensure: a. the kitchen and food service equipment were kept clean and maintained in good repair, b. food products were held at proper temperatures, c. soiled cloths/rags were properly stored, and d. there were registering temperature indicators for measuring the temperature of the dish washer. The "Assisted Living Resident Condition and Care Overview" report, dated 05/30/23, documented 37 residents resided in the facility. Findings: On 05/30/23 at 1:00 p.m., a tour of the kitchen was conducted. The following observations were made: a. there was an accumulation of black and white residue inside of the ice machine, b. there were multiple soiled cloths/rags stored on the countertops. They were not stored in a sanitizer solution, c. there was an accumulation of black and white residue on the floor in the dish wash area, d. there was an accumulation of black and brown residue on the dish washer, e. there was an accumulation of black residue and food debris on the floor behind the cook area,	C 391		

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C 391	Continued From page 2 f. there was an accumulation of lint on the oven hood filters, g. a gasket on one of the doors to the True two door reach in cooler was not secure to the door. The gasket was split and taped to the door, h. there was an accumulation of black residue on the racks in the True two door reach in cooler, i. the concrete and floor tiles around the floor drain in the reach in cooler/freezer storage room was not level, j. multiple cooked hamburger patties in an orange cast iron skillet with lid were held at 59 degrees F in the True two door reach in cooler. The prep date on the label on the skillet was 05/28/23, k. there was an accumulation of ice buildup and food debris on the bottom floor of the Saturn two door reach in freezer, l. the external thermometer on the Arctic Air two door reach in cooler was 5.0 degrees F and there was no internal thermometer. The ambient air temperature inside of the unit with a handheld thermometer was 58 degrees F. The reach in cooler contained non-potentially hazardous foods. The May 2023 temperature monitoring sheet documented on 05/29/23 at 6:00 p.m. the temperature of the unit was 44 degrees F and on 05/30/23 at 6:00 a.m. the temperature of the unit was 47 degrees F, m. the Arctic Air two door reach in freezer was not in use. The unit was not working. The May 2023 temperature monitoring sheet documented the unit was last in use on 05/08/23,	C 391		

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C 391	Continued From page 3 n. there was an accumulation of dirt on the floor in the reach in cooler/freezer storage room, o. ceiling lights were burned out and/or not working and the light cover was hanging loose from the ceiling in the dry food storage room, p. the wash solution temperature gauge on the high temperature dish washer did not register a temperature when the dish washer was in use, and q. there was no registering temperature indicator for measuring the utensil surface temperature for the high temperature dish washer. On 05/30/23 at 1:26 p.m., the DM was asked if the dish washer was a high temperature machine. They stated it was. They were asked if they had temperature indicators (test strips). They stated they did not. They were asked how they ensured the wash solution temperature reached the proper temperature. They stated they looked at the gauges on the machine. The DM was made aware and shown where the wash solution temperature did not register a temperature when in use. On 05/30/23 at 1:30 p.m., the DM was asked how staff ensured the kitchen was kept clean and maintained in good repair. They stated staff cleaned daily and they reported repair issues to maintenance. They were asked how often the reach in coolers/freezers were checked to ensure foods were maintained at the proper temperature. They stated twice a day and cold foods were to be maintained below 41 degrees F. They were asked where soiled cloths/rags were to be stored. They stated in a sanitizer solution or the dirty linen.	C 391		

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C 391	Continued From page 4 The DM was asked when the hamburger patties in the True two door reach in cooler were cooked. They looked at the label and stated 05/28/23. They were asked if the hamburger patties had been out of the cold hold unit. They stated they did not think they had been out of the cooler. They were shown the temperature reading of the hamburger patties with a handheld thermometer. They were made aware the hamburger patties were not held below 41 degrees F. The DM was shown the external thermometer temperature on the Arctic Air two door reach in cooler. They were asked if there was an internal thermometer in the unit. They looked and stated they did not find one. They were made aware of the ambient temperature inside of the unit with a handheld thermometer and the temperature log readings. They stated they had problems with the Arctic Air two door reach in freezer as well and it was supposed to be repaired, but it has not. The DM was shown and/or made aware of the remainder of the findings.	C 391		
C 393 SS=E	310:663-3-8(c) FOOD PREPARTION, STORAGE AND SERVICE (c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours.	C 393		

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C 393	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure leftover potentially hazardous foods were not held for more than 24 hours. The "Assisted Living Resident Condition and Care Overview" report, dated 05/30/23, documented 37 residents resided in the facility. Findings: On 05/30/23 at 1:00 p.m., a tour of the kitchen was conducted. The following observations were made: a. multiple leftover cooked hamburger patties in an orange cast iron skillet with a lid were held in the True two door reach in cooler. The prep date on the label on the skillet was 05/28/23 and the use by date was 06/06/23, and b. leftover chicken soup in a metal container was held in the True two door reach in cooler. The prep date on the label on the container was 05/28/23 and the use by date was 06/01/23. On 05/30/23 at 1:30 p.m., the DM was asked if the hamburger patties and chicken soup in the True two door reach in cooler were leftover from a previous meal. They stated they were. They were asked how long leftover foods that were potentially hazardous could be held. They stated three to four days. They were made aware of the regulation and the above findings.	C 393		

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C 522	Continued From page 6	C 522		
C 522 SS=E	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 ensure comprehensive assessments were completed every 12 months for two (#2 and #7) of eight residents sampled for assessments. The "Assisted Living Resident Condition and Care Overview" form, dated 05/30/23, documented 37 residents resided in the facility. Findings: 1. Res #2 admitted to the facility on 09/16/19 with diagnoses which included OA, diabetes, stress fracture, HTN, GERD, edema, and hypothyroidism. A record review did not document an annual assessment for 2020. On 05/30/23 at 4:15 p.m., the ED was asked for the annual assessment for 2020. On 05/31/23 at 2:07 p.m., the ED stated they were unable to locate the annual assessment for	C 522		

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C 522	Continued From page 7 2020. 2. Res #7 admitted to the facility on 03/12/19 with diagnoses which included HTN, depression, GERD, lupus, and dementia. A record review did not document an annual assessment for 2020 and 2021. On 05/30/23 at 4:48 p.m., the ED was asked for the annual assessments for 2020 and 2021. On 05/31/23 at 2:07 p.m., the ED stated they were unable to locate the annual assessments for 2020 and 2021.	C 522		
C 531 SS=E	310:663-5-3(a) ASSESSMENT FORM (a) The admission assessment form shall include but not be limited to the following: (1) resident's identification; (2) disease diagnosis/infections; (3) mental health history, and mental retardation or developmental disability; (4) physical functioning which includes the numbers of persons needed to assist with activities of daily living; (5) incontinence; (6) medications; (7) special treatment and procedures; (8) cognitive function; and (9) signatures and dates.	C 531		

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C 531	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure admission assessments contained all required components for five (#3, 4, 5, 6, and #8) of eight sampled residents reviewed for admission assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 05/30/23, documented 37 residents resided in the facility. Findings: 1. Res #3's admission assessment, dated 04/04/23, did not include signatures and dates on the form. 2. Res #5's admission assessment, dated 11/18/22, did not include signatures and dates on the form. 3. Res #6's admission assessment, dated 01/18/23, did not include signatures and dates on the form. 4. Res #8's admission assessment, dated 09/09/22, did not include signatures and dates on the form. 5. Res #4's pre-admission assessment, dated 08/29/22, did not document signatures and dates from the resident or resident representative, a RN, or participating health professional. On 05/30/23 at 4:45 p.m., the HWD stated there were no signatures and dates on the pre-admit assessment because there was no place to document signatures and dates on the form.	C 531		

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C 542	Continued From page 9	C 542		
C 542 SS=E	310:663-5-4(b) CONDUCT OF ASSESSMENT (b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed ensure residents' assessments were coordinated and signed by the RN or physician for seven (#2, 3, 4, 5, 6, 7, and #8) of eight sampled residents reviewed for assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 05/30/23, documented 37 residents resided in the facility. Findings: 1. Res #3's admission assessment , dated 04/04/23, did not include the signature of the RN or physician on the form. A 14-day assessment, dated 05/15/23, did not include the signature of the RN or physician on the form. 2. Res #5's admission assessment , dated 11/18/22, did not include the signature or the physician on the form. A 14-day assessment, dated 12/29/22 did not include the signature of the RN or physician on the form. 3. Res #6's admission assessment, dated	C 542		

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C 542	Continued From page 10 01/18/23, did not include the signature of the RN or physician on the form. A 14-day assessment, dated 02/09/23, did not include the signature of the RN or physician on the form. 4. Res #8's admission assessment, dated 09/09/22, did not include the signature of the RN or physician on the form. A 14-day assessment, dated 09/28/22, did not include the signature of the RN or physician on the form. 5. Res #2's annual assessment, dated 04/19/21, did not document a signature from the RN or physician. Res #2's annual assessment, dated 04/16/22, did not document a signature from the RN or physician. 6. Res #4's 14 day assessment, dated 09/15/23, did not document a signature from a RN or physician. 7. Res #7's annual assessment, dated 07/20/22, did not document a signature from the RN or physician. On 05/30/23 at 1:45 p.m., the HWD stated there were no RN signature on the annual assessments. She stated there was no way to prove the assessment was coordinated by the RN because there was not a way for the RN to sign the assessment in the EHR.	C 542		
C 543 SS=E	310:663-5-4(c) CONDUCT OF ASSESSMENT	C 543		

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C 543	Continued From page 11 (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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure comprehensive assessments included a personal interview between the resident and the person completing the form for seven (#2, 3, 4, 5, 6, 7, and #8) of eight sampled residents reviewed for assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 05/30/23, documented 37 residents resided in the facility. Findings: 1. Res #3's 14-day assessment, dated 05/15/23, did not include a personal interview. There was no resident signature. 2. Res #5's 14-day assessment, dated 12/29/22, did not include a personal interview. There was no resident signature. 3. Res #6's 14-day assessment, dated 02/09/23, did not include a personal interview. There was no resident signature. 4. Res #8's 14-day assessment, dated 09/28/22, did not include a personal interview. There was	C 543		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH5526AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/31/2023
NAME OF PROVIDER OR SUPPLIER BRADFORD VILLAGE HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 906 NORTH BOULEVARD EDMOND, OK 73034		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 543	Continued From page 12 no resident signature. On 05/30/23 at 4:45 p.m., the HWD was asked about personal interviews between residents and the person completing assessments. They stated there was no place on the form to document the signature of the resident. They stated there wasn't a way to verify an interview was conducted. 5. Res #2's annual assessment, dated 04/19/21, did not document a resident interview. Res #2' annual assessment, dated 04/16/22, did not document a resident interview. 6. Res #4's 14 day assessment, dated 09/15/22, did not document a resident interview. 7. Res #7's annual assessment, dated 07/20/22, did not document a resident interview. On 05/30/23 at 3:38 p.m., the ED stated she was unsure where the resident interview was documented on the annual assessments. On 05/30/23 at 1:45 p.m., the HWD stated there was no documentation of the resident interview on the annual assessments. She stated there was no way to prove the interviews occurred because it was not signed by the resident because it was documented in the EHR.	C 543		
C 544 SS=E	310:663-5-4(d) CONDUCT OF ASSESSMENT (d) The assisted living center shall maintain all assessments for five (5) years from the date of each assessment. The completed form shall be available upon request to the following: (1) the resident;	C 544		

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C 544	Continued From page 13 (2) the resident's personal physician; (3) the resident's representative; and (4) the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain resident assessments for five years from the time of assessment for two (#2 and #7) of eight residents who were sampled for assessments. The "Assisted Living Resident Condition and Care Overview" form, dated 05/30/23, documented 37 residents resided in the facility. Findings: 1. Res #2 had diagnoses which included OA, diabetes, stress fracture, HTN, GERD, edema, and hypothyroidism. On 05/30/23 at 4:15 p.m., the ED was asked for the annual assessment from 2020. 2. Res #7 had diagnoses which included HTN, depression, GERD, lupus, and dementia. On 05/30/23 at 4:48 p.m., the ED was asked for annual assessments from 2020 and 2021. On 05/31/23 at 10:45 a.m., the ED stated the old records were in a special file on the computer and they would try to access them. On 05/31/23 at 2:07 p.m., the ED stated they were unable to locate the annual assessments from 2020 and 2021. They stated they did not have access to the old documentation because the previous management company had been	C 544		

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C 544	Continued From page 14 terminated by the owner and they could not gain access to the file they were kept in.	C 544		
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the results of a resident's assessment were used to develop a care plan for dialysis for one (#3) of eight sampled residents reviewed for care plans. The "Assisted Living Resident Condition and Care Overview" form, dated 05/30/23, documented 37 residents resided in the facility. It document one resident received dialysis services. Findings: An undated "Coordination/Individualization of Services" facility policy, read in parts, "Following the residency Comprehensive Service and Care Assessment and move in, an individualized "Plan of Care"...will be developed within seven days..." Res #3 had diagnoses which included CKD. A admission assessment, dated 04/04/23,	C 552		

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NAME OF PROVIDER OR SUPPLIER BRADFORD VILLAGE HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 906 NORTH BOULEVARD EDMOND, OK 73034		
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C 552	Continued From page 15 documented dialysis was a service needed for the resident. A service plan, initiated on 04/28/23, documented a focus area of dialysis. The interventions did not specify the frequency of dialysis, where the resident received dialysis or the transportation required. A 14-day resident assessment, dated 05/15/23, documented the resident received dialysis. On 05/31/23 at 9:33 a.m., the health and wellness director was asked where it would be documented Res #3 was receiving dialysis. They stated it was documented on the resident's service plan. On 05/31/23 at 12:05 p.m., the health and wellness director was shown the resident's service plan for dialysis. They stated service plans were supposed to be generated from residents' assessments. They were asked if the resident's service plan was fully developed for dialysis. They state it should have been.	C 552		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist.	C 921		

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C 921	Continued From page 16 This LEVEL B is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were reviewed monthly by a RN or pharmacist for seven (#2, 4, 5, 6, 7, and #8) of eight residents sampled for medications. The "Assisted Living Resident Condition and Care Overview" form, dated 05/30/23, documented 37 residents resided in the facility. Findings: 1. Res #2 admitted to the facility on 09/16/19 with diagnoses which included OA, diabetes, stress fracture, HTN, GERD, edema, and hypothyroidism. Order summary reports were reviewed for June 2022 through May 2023. There was no documentation medications were reviewed for the months August 2022, September 2022, November 2022, December 2022, and March 2023. 2. Res #4 admitted to the facility on 09/03/22 with diagnoses which included OA, pulmonary embolism, CKD, GERD, anxiety, diverticulitis, edema, and depression. Order summary reports were reviewed for October 2022 through May 2023. There was no documentation medications were reviewed for the months November 2022, December 2022, and March 2023. 3. Res #7 admitted to the facility on 03/12/29 with diagnoses which included HTN, depression,	C 921		

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C 921	Continued From page 17 GERD, lupus, and dementia. Order summary reports were reviewed for June 2022 through May 2023. There was no documentation medications were reviewed for the months of June 2022, August 2022, September 2022, November 2022, and December 2022. 4. Res #5 was admitted to the facility on 12/15/22 with diagnoses which included aphasia following cerebral infarction, anemia, mixed hyperlipidemia, major depressive disorder, insomnia, and HTN. Order summary reports were reviewed for January 2023 through May 2023. There was no documentation medications were reviewed for the month of March 2023 by the RN or pharmacist. 5. Res #6 was admitted to the facility on 01/26/23 with diagnoses which included hyperlipidemia, insomnia, disorder of the prostate, edema, anemia, diabetes, HTN, acute kidney failure, CKD, heart disease, hypo-osmolality, and fracture of unspecified part of neck of left femur. Order summary reports were reviewed for February 2023 through May 2023. There was no documentation medications were reviewed for the month of March 2023 by the RN or pharmacist. On 05/31/23 at 12:00 p.m., the health and wellness director was asked to locate documentation medications were reviewed by the RN or pharmacist for the month of March 2023. On 05/31/23 at 12:05 p.m., the health and wellness director stated the RN reviewed the March 2023 medications, but there was no documentation to prove they were reviewed. 6. Res #8 was admitted to the facility on 09/14/22	C 921		

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C 921	Continued From page 18 with diagnoses which included HTN, multiple myeloma, hyperlipidemia, autonomic neuropathy, chronic atrial fibrillation, and benign prostatic hyperplasia. Order summary reports were reviewed for January 2023 through May 2023. There was no documentation medications were reviewed for the month of March 2023 by the RN or pharmacist. On 05/31/23 at 2:50 p.m., the health and wellness director was asked to locate documentation medications were reviewed by the RN or pharmacist for the month of March 2023. They stated the RN reviewed them, but there was no documentation to prove they were reviewed.	C 921		
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.	C1505		

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C1505	Continued From page 19 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 medications were administered as ordered for two (#5 and #8) of eight sampled residents reviewed for medications. The "Assisted Living Resident Condition and Care Overview" report, dated 05/30/23, documented 37 residents resided in the facility. Findings: 1. Res #5 had diagnoses which included HTN. A physician order, dated 12/15/22, documented clonidine HCL (antihypertensive medication) tab 0.1 mg. Give tab by mouth every eight hours as needed for SBP greater than 180 or DBP greater than 100. The March 2023 MAR documented on 03/16/23 the resident's SBP was 181. There was no	C1505		

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C1505	Continued From page 20 documentation clonidine was administered. On 05/31/23 at 2:50 p.m., the health and wellness coordinator was made aware of the resident's order for clonidine and of their BP reading on 03/16/23. They stated clonidine should have been administered. 2. Res #8 had diagnoses which included HTN. A physician order, dated 09/14/22, documented losartan (angiotensin receptor blocker) 25 mg one tab every 24 hours as need for BP over 150. A physician order, dated 10/19/22, documented BP daily. If over 150 give dose of losartan. The March 2023 MAR documented 11 out of 31 opportunities the resident's BP was over 150. There was no documentation losartan was administered. The April 2023 MAR documented eight out of 30 opportunities the resident's BP was over 150. There was no documentation losartan was administered. The May 2023 MAR documented seven out of 31 opportunities the resident's BP was over 150. There was no documentation losartan was administered. On 05/31/23 at 2:50 p.m., the health and wellness director was made aware of the resident's order for losartan, BP readings being greater than 150, and no documentation losartan was administered. They stated losartan should have been administered.	C1505		

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C1911	Continued From page 21	C1911		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report a fall with serious injury to OSDH within one business day of the incident's discovery for one (#4) of two residents sampled for falls.	C1911		

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C1911	Continued From page 22 The "Assisted Living Resident Condition and Care Overview" form, dated 05/30/23, documented 37 residents resided in the facility. Findings: Res #4 had diagnoses which included OA, pulmonary embolism, CKD, GERD, anxiety, diverticulitis, edema, and depression. A combined initial and final incident report to OSDH, dated 04/28/23, documented Res #4 had a fall and was sent to the hospital. The report documented Res #4 returned with staples to a skin tear on their leg. A transmission verification report, dated 05/02/23, documented the report was faxed to OSDH at 8:57 a.m. ApplicationXtender documented the incident report was received by OSDH on 05/02/23 at 9:50 a.m. On 05/30/23 at 2:30 p.m., the ED was asked about the timeline for reporting falls with serious injury. They stated incidents should be reported to OSDH in 24 business hours. They were shown the transmission verification report and stated the incident report should have been sent to OSDH on 05/01/23.	C1911		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person	C1923		

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C1923	Continued From page 23 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 record review and interview, the facility failed to ensure medication administration records were accurate for two (#3 and #7) of eight sampled residents whose medications were reviewed. The "Assisted Living Resident Condition and Care Overview" form, dated 05/30/23, documented 37 residents resided in the facility. Findings: 1. Res #7 had diagnoses which included HTN, depression, GERD, lupus, and dementia. A physician order, dated 10/21/21, documented to administer aspirin tablet chewable 81 mg one time a day for preventative. A physician order, dated 10/20/21, documented to administer amlodipine 2.5 mg one time a day for	C1923		

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C1923	Continued From page 24 HTN. A physician order, dated 10/20/21, documented to administer nebivolol 10 mg one time a day for HTN. A physician order, dated 10/20/21, documented to administer gabapentin 300 mg one time a day for lupus. A physician order, dated 10/20/21, documented to administer rabeprazole 20 mg one time a day for GERD. A physician order, dated 10/20/21, documented to administer vitamin D3 50 mcg one time a day for supplement. A physician order, dated 03/11/23, documented to administer aspirin tablet chewable 81 mg one time a day for heart. A physician order, dated 03/11/23, documented to administer amlodipine 2.5 mg one time a day for HTN. A physician order, dated 03/11/23, documented to administer nebivolol 10 mg one time a day for HTN. A physician order, dated 03/11/23, documented to administer gabapentin 300 mg one time a day for lupus. A physician order, dated 03/11/23, documented to administer rabeprazole 20 mg one time a day for GERD. A physician order, dated 03/11/23, documented to administer vitamin D3 50 mcg one time a day for	C1923		

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C1923	Continued From page 25 supplement. The March 2023 MAR documented the aspirin was administered two times four of 18 opportunities. The March 2023 MAR documented the amlodipine was administered two times three of 18 opportunities. The March 2023 MAR documented the nebivolol was administered two times nine of 21 opportunities. The March 2023 MAR documented the gabapentin was administered two times four of 18 opportunities. The March 2023 MAR documented the rabeprazole was administered two times three of 18 opportunities. The March 2023 MAR documented the vitamin D3 was administered two times three of 18 opportunities. A physician order, dated 03/28/23, documented to discontinue the 10/20/21 order for aspirin tablet chewable 81 mg one time a day for preventative. A physician order, dated 03/28/23, documented to discontinue the 10/20/21 order for amlodipine 2.5 mg one time a day for HTN. A physician order, dated 03/28/23, documented to discontinue the 10/20/21 order for gabapentin 300 mg one time a day for lupus. A physician order, dated 03/28/23, documented to discontinue the 10/20/21 order for rabeprazole 20	C1923		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH5526AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/31/2023
NAME OF PROVIDER OR SUPPLIER BRADFORD VILLAGE HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 906 NORTH BOULEVARD EDMOND, OK 73034		
(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
C1923	Continued From page 26 mg one time a day for GERD. A physician order, dated 03/28/23 documented to discontinue the 10/20/21 order for vitamin D3 50 mcg one time a day for supplement. The April 2023 MAR documented the nebivolol was administered two times 19 of 30 opportunities. The May 2023 MAR documented the nebivolol was administered two times 16 of 18 opportunities. A physician order, dated 05/18/23, documented to discontinue the 03/11/23 order for nebivolol 10 mg one time a day for HTN. On 05/31/23 at 3:18 p.m., the HWD was asked about the duplicate documentation. They stated they had investigated and determined the resident did not receive double dosages of the medications. They stated the documentation was incorrect and the staff should have documented the medications as a duplicate order and notified the physician of the discrepancy. 2. Res #3 had diagnoses which included pain. A physician order, dated 05/01/23, documented Norco (narcotic) 5-325 mg. Give one tab every six hours as needed. The May 2023 narcotic record documented Norco was administered on 05/29/23 at 9:30 a.m. and 05/30/23 at 7:00 p.m. There was no documentation on the May 2023 MAR Norco had been administered. On 05/31/23 at 9:22 a.m., ACMA #1 was asked what was the protocol for administering pain	C1923		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH5526AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/31/2023
NAME OF PROVIDER OR SUPPLIER BRADFORD VILLAGE HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 906 NORTH BOULEVARD EDMOND, OK 73034		
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C1923	Continued From page 27 medications. They stated if the medication was a narcotic it should be documented as administered on the narcotic record and on the MAR. They were made aware the administration for the resident's Norco on 05/29/23 and 05/30/23 was not documented on the MAR.	C1923		

Delivery via email to: lstewart@villagioliving.com

June 28, 2023

License Number: NH5526AL

Ms. Lydia Stewart, Administrator
Bradford Village Healthcare Center
906 North Boulevard
Edmond, OK 73034

RE: Survey Event TYV011

Dear Ms. Stewart:

On **May 31, 2023**, a re-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 17, 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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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/19/2023

Facility Name: Bradford Village Healthcare Center

License Number: NH5526AL

Survey Event ID: TYV011

Date Survey Completed: 5/31/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 391

Based on: Based on observation, record review, and interview, the facility failed to ensure: a. the kitchen and food service equipment were kept clean and maintained in good repair, b. food products were held at proper temperatures, c. soiled cloths/rags were properly stored, and d. there were registering temperature indicators for measuring the temperature of the dish washer

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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

1. Kitchen and Food Service Equipment:
 - a. The facility scheduled immediate repairs and cleaning of the ice machine, dishwasher, and reach-in coolers and freezers to eliminate any accumulated residue or debris. All repairs and cleaning were completed on July 12
2. Dietary staff were re-educated on July 3 regarding proper cleaning procedures and equipment maintenance.
3. Food Product Temperature Control:
 - a. The facility implement procedures for monitoring and documenting food product temperatures on June 21, ensuring they are held at proper levels to prevent foodborne illnesses.
 - b. All dietary staff were re educated on proper temperature monitoring policy on July 3
4. Soiled Cloths/Rags Storage:
 - a. Clear guidelines and procedures will be established for the proper storage of soiled cloths and rags, emphasizing the use of a sanitizer solution or designated dirty linen area.
 - b. All dietary staff were reeducated on July 3 the policy for proper storage and disposal of soiled cloths/rags, ensuring they are not left on countertops or other food contact surfaces.
5. Registering Temperature Indicators for Dishwasher:

	a. The facility installed registering temperature indicators for measuring the temperature of the dishwasher. b. Dietary staff were re educated by July 3 on the high temperature dishwasher to ensure that the dishwasher is operating at the appropriate temperature of 160 degrees or above.		
OSDH Response: Element accepted: Yes ☒ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Thirty seven residents had the potential to be affected by the alleged deficient practice.		
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. A weekly maintenance check off was created to ensure regular cleaning and maintenance of kitchen equipment, including routine checks for gaskets, filters, and regular maintenance. 2. Weekly rounds will be conducted by the dietary manager to verify that all food products are stored and at the correct temperatures with temperature logs up to date and all rags are properly stored in a sanitizing 3. A proper temperature check for the high temperature dishwasher is being documented daily.		
OSDH Response: Element accepted: Yes ☐ No ☒			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:	Enter methods to ensure corrections are sustained: Weekly and monthly audits and inspections will be conducted to assess compliance and identify any areas for improvement or further training. Any issues promptly addressed in QA meeting Will be documented on QA agenda times three months.		
OSDH Response: Element accepted: Yes ☐ No ☒			
5. On what date will corrective action be completed?	7/17/2023		
OSDH Response: Element accepted: Yes ☐ No ☒			
Administrator's Signature OAC 310.563-25-4(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.
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.			

10012013



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/19/2023

Facility Name: Bradford Village Healthcare Center

License Number: NH5526AL

Survey Event ID: TYV011

Date Survey Completed: 5/31/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C393

Based on: observation and interview, the facility failed to ensure leftover potentially hazardous foods were not held for more than 24 hours.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?

OSDH Response: Element accepted: Yes ☒ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

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.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

- All leftovers have been discarded.
- All dietary staff have been reeducated on July 3 the policy for food storage and left over foods.

- Review and Update Procedures:
 - Review and revise existing procedures, if needed, for identifying and managing potentially hazardous leftovers, including clear guidelines on labeling, use-by dates, and disposal timelines.

- Monitoring and Oversight:
 - The dietary manager will conduct a weekly audit of refrigerators and freezers to ensure all left over and stored items are discarded within the 24-hour regulation.

Enter methods to ensure corrections are sustained:

Dietary manager and or designee will conduct daily refrigerator and freezer checks to ensure all items are dated and discarded within the appropriate time frames. All findings will be reported times three months to the QA committee.

Review of items related to food storage to be included in ongoing QA meetings for three months and documented in the QA notes.

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OSDH Response: Element accepted: Yes ☐ No ☐		Enter methods to keep monitoring records:	
5. On what date will corrective action be completed?		Click here to enter a date when corrective action will be completed.	
OSDH Response: Element accepted: Yes ☐ No ☐		7/17/23	
Administrator's Signature Administrator signature required OAC 310:663-25-4(F) <i>Rylea Stewart</i>		Date Enter a date of signature. 6/27/23	
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			
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Facility in Compliance by: Click here to enter a date.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/20/2023

Facility Name: Bradford Village Healthcare Center

License Number: NH5526AL

Survey Event ID: TYV011

Date Survey Completed: 5/31/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522

Based on: record review and interview, the facility failed to ensure comprehensive assessments were completed every 12 months for two (#2 and #7) of eight residents sampled for assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?

OSDH Response: Element accepted: Yes ☒ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

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.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The annual assessments for Res #2 and Res #7 for the years 2020 and 2021, were retrieved from offsite storage and are attached.

The ED, or designee, will conduct an audit of current residents to ensure all annual assessments are complete. ED will implement a calendar process to ensure that all annual assessments are completed yearly.

1. The facility has provided training to the ED and DON on conducting and documenting resident assessments. Staff will be educated on the proper procedures for completing and documenting annual assessments and assessments following significant changes in residents' conditions by July 3.

Enter methods to ensure corrections are sustained:

The facility EHR provides ongoing monitoring of resident assessments. This program will involve periodic reviews of a representative sample of assessments to ensure compliance with regulatory requirements. Findings from these reviews will be used to identify areas for improvement and implement corrective measures.

The facility will report the findings of audits and quality assurance reviews, if any, to the QA committee. In cases of non-compliance, the facility will promptly take corrective action to address the identified deficiencies.

Audit information will be maintained in the QA binder.

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OSDH Response Element accepted: Yes ☐ No ☐			
5. On what date will corrective action be completed?		Click here to enter a date when corrective action will be completed.	
OSDH Response Element accepted: Yes ☐ No ☐		7/17/23	
Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required.	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.		6/27/23	
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Item: Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable		Date: Click here to enter a date. Surveyor: Surveyor	
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Facility in Compliance by: Click here to enter a date.			



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 6/20/2023

Facility Name: Bradford Village Healthcare Center

License Number: NH5526AL

Survey Event ID: TYV011

Date Survey Completed: 5/31/2023

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C531

Based on: Record review and interview, the facility failed to ensure admission assessments contained all required components for five (#3, 4, 5, 6, and #8) of eight sampled residents reviewed for admission assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?

OSDH Response: Element accepted: ☒ Yes ☐ No

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

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;

ASSISTED LIVING CENTER'S PLAN ELEMENTS

a. Review and update the admission assessment form:

- i. Revise the admission assessment form to include a designated section for signatures and dates. Beginning June 24 the admission assessments will be printed to allow for dates and signatures and then uploaded to EHR
ii. Ensure the RN consultant is aware of this as well.

Auditing and quality assurance:

- i. Implement routine audits of admission assessments to monitor compliance with regulatory requirements.

Continuous staff education and training:

- a. Schedule periodic educational sessions and training programs to reinforce the importance of accurate and complete documentation on admission assessments.
b. Provide ongoing education on any updates or revisions to the admission assessment form.
c. Distribute updated policies and procedures, if any, to all staff members and ensure their understanding and adherence.

The Administrator will ensure that all new completed assessments contain the signatures and dates and are uploaded to EHR.

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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.		Maintain documentation of staff education and training sessions in the in-service binder. Any audits or corrective actions will be maintained. Incorporate the findings and lessons learned from the corrective actions into the facility's quality improvement program. Monitoring records will be maintained in the QA binder.	
OSDH Response: Element accepted: ☒ Yes ☐ No			
5. On what date will corrective action be completed?		Click here to enter a date when corrective action will be completed.	
OSDH Response: Element accepted: ☒ Yes ☐ No		7/17/23	
Administrator's Signature OAC 310:663-25-4(F)		Administrator Signature required: <i>Stewart</i>	Date Enter a date of signature. <i>6/27/23</i>
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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