OKLAHOMA
State Department
of Health

Delivery via email to: crystal.gormley@franciscanvilla.com

October 19, 2023

License Number: NH7211AL

Ms. Crystal Gormley, Administrator
Franciscan Villa
17110 E 51 St Street
Broken Arrow, OK 74012

RE: Survey Event ID: RO9G11

Dear Ms. Gormley:

On **October 12, 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 **October 12, 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.

Respectfully,

Lisa Calvin

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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH7211AL	A. BUILDING: _____ B. WING _____	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN VILLA	17110 E 51 ST STREET BROKEN ARROW, OK 74012

(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 relicensure survey was conducted from 10/11/23 through 10/12/23. Listed below are abbreviations that will be used throughout this document. ACT - actuation CMA - Certified Medication Aide DCS - Director of Clinical Services LPN - Licensed Professional Nurse MCG - micrograms	C 000		
C 542 SS=D	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 to ensure assessments were reviewed and signed by a registered nurse or physician, for two (#1 and #3) of nine residents reviewed for assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 10/11/23, documented 50 residents which resided at the facility. Findings: 1. Resident #1 admitted with diagnoses which included hypertension, anxiety, and hyperlipidemia.	C 542		

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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: Res #1, #3 Based on record review and interview, the facility failed to develop a care plan for two (#1 and #3) of nine residents reviewed for care plans. The "Assisted Living Resident Condition and Care Overview" report, dated 10/11/23, documented 50 residents which resided at the	C 552		

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C 552	Continued From page 2 facility. Findings: 1. Resident #1 admitted with diagnoses which included hypertension, anxiety, and hyperlipidemia. Review of the clinical record for Resident #1 revealed no service/care plan had been completed. 2. Resident #3 admitted with diagnoses which included chronic kidney disease, chronic respiratory failure, and diabetes type two. Review of the clinical record for Resident #3 revealed no service/care plan had been completed. On 10/12/23 at 1:21 p.m., the DCS stated they were to complete the service plan but were not aware of the required timeline for completion.	C 552		
C 711 SS=F	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21.	C 711		

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C 711	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire safety inspections were completed annually. The "Assisted Living Resident Condition and Care Overview" report, dated 10/11/23, documented 50 residents resided at the facility. Findings: Review of facility documents revealed a "Fire Inspection Report", dated 02/18/22. On 10/11/23 at 10:45 a.m., the administrator stated they did not have a fire inspection for the year 2023 and were eight months behind.	C 711		
C1505 SS=D	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	C1505		

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C1505	Continued From page 4 medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to administer medications per physician orders and failed to identify and assess for self-administration of medications for one (#9) of four sampled residents observed during medication administration. The "Resident Care and Information" report, dated 10/11/23, documented 50 residents who received medications at the facility. Findings: Resident #9 admitted with diagnoses which	C1505		

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C1505	Continued From page 5 included chronic obstructive pulmonary disease, hypertension and anxiety. A "Self Administration of Medication Evaluation", dated 01/15/21, documented Resident #9 was not safe to self-administer medications. A service plan for Resident #9, revised 06/30/22, documented the facility was to administer all medications to the resident. On 10/12/23 at 7:28 a.m., CMA #1 was observed to prepare medications for Resident #9. The medications prepared did not include Fluticasone Propionate (a nasal spray). The prepared medications were administered and CMA #1 left the apartment of Resident #9. Review of physician's orders for Resident #9 revealed an order for Fluticasone Propionate 50 mcg/ACT for one spray in both nostrils daily. No order for self-administration was observed. On 10/12/23 at 8:25 a.m., CMA #1 stated Resident #9 self-administered the nasal spray and kept it in their apartment. On 10/12/23 at 10:08 a.m., Resident #9 stated staff had observed them administering the nasal spray. Resident #9 stated the proper use of the medication and purpose of the medication and they had self-administered the medication since admission. On 10/12/23 at 10:41 a.m., the DCS and LPN #1 stated assessments were completed on admit, yearly and for a change of condition. They stated Resident #9 had a self-administration of medication assessment completed on admission which documented the resident was not safe to	C1505		

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C1505	Continued From page 6 self-administer medications. They were asked why Resident #9 had medications in their apartment and had self-administrated since admission. They stated they were not aware the resident had been self-administering medications since admission. They stated staff would need to be educated to report and inform to administration.	C1505		

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November 15, 2023

License Number: NH7211AL

Ms. Crystal Reeve-Gormley, Executive Director
Franciscan Villa
17110 E 51 St Street
Broken Arrow, OK 74012

RE: Survey Event RO9G11

Dear Ms. Gormley:

On **October 12, 2023**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **October 30, 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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C 542 SS=D	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 to ensure assessments were reviewed and signed by a registered nurse or physician, for two (#1 and #3) of nine residents reviewed for assessments. The "Assisted Living Resident Condition and Care Overview" report, dated 10/11/23, documented 50 residents which resided at the facility. Findings: 1. Resident #1 admitted with diagnoses which included hypertension, anxiety, and hyperlipidemia.	C 542	1. Both resident #1 and #3 have assessments completed with an RN signature in place. 2. All residents in the facility have the potential to be affected. 3. RN and DCS were educated that all assessments must be coordinated and signed by a registered nurse. An audit of resident assessments was completed to determine any residents missing an assessment or an assessment with a missing required RN signature. Those identified were brought into compliance. 4. All findings will be monitored by QAPI to ensure ongoing compliance until desired compliance is achieved.	10/30/2023

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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: Res #1, #3 Based on record review and interview, the facility failed to develop a care plan for two (#1 and #3) of nine residents reviewed for care plans. The "Assisted Living Resident Condition and Care Overview" report, dated 10/11/23, documented 50 residents which resided at the	C 552	1. Service plans for resident #1 & 3 were completed on 10/13/2023. 2. All residents residing in the facility have the potential to be affected. 3. RN, DCS, and charge nurse were educated on the facility policy for developing and maintaining service plans. A complete audit was conducted on all residents residing in the assisted living: all residents without a completed or updated service plan were completed and /or updated. 4. All findings will be monitored by QAPI to ensure ongoing compliance until desired compliance is achieved.	10/30/2023

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C 552	Continued From page 2 facility. Findings: 1. Resident #1 admitted with diagnoses which included hypertension, anxiety, and hyperlipidemia. Review of the clinical record for Resident #1 revealed no service/care plan had been completed. 2. Resident #3 admitted with diagnoses which included chronic kidney disease, chronic respiratory failure, and diabetes type two. Review of the clinical record for Resident #3 revealed no service/care plan had been completed. On 10/12/23 at 1:21 p.m., the DCS stated they were to complete the service plan but were not aware of the required timeline for completion.	C 552	1. Annual fire inspection was completed by the fire Marshall on 10/19/2023. 2. All residents residing in the facility have the potential to be affected. 3. Maintenance Director was re-educated on the facility procedure for annual fire inspection. 4. Administrator will monitor the annual maintenance logs Q Month to ensure upcoming required inspections are being scheduled appropriately and in a timely manner. 5. Findings will be monitored by QAPI to ensure ongoing compliance until desisted level of compliance is achieved.	10/30/23
C 711 SS=F	310:663-7-1(a) GENERAL REQUIREMENTS (a) Each assisted living center shall comply with applicable construction and safety standards pursuant to Title 74 O.S. Sections 317 through 324.21.	C 711		

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C1505	Continued From page 4 medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to administer medications per physician orders and failed to identify and assess for self-administration of medications for one (#9) of four sampled residents observed during medication administration. The "Resident Care and Information" report, dated 10/11/23, documented 50 residents who received medications at the facility. Findings: Resident #9 admitted with diagnoses which	C1505		

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	NH7211AL	A. BUILDING: _____ B. WING _____	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN VILLA	17110 E 51 ST STREET BROKEN ARROW, OK 74012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 5 included chronic obstructive pulmonary disease, hypertension and anxiety. A "Self Administration of Medication Evaluation", dated 01/15/21, documented Resident #9 was not safe to self-administer medications. A service plan for Resident #9, revised 06/30/22, documented the facility was to administer all medications to the resident. On 10/12/23 at 7:28 a.m., CMA #1 was observed to prepare medications for Resident #9. The medications prepared did not include Fluticasone Propionate (a nasal spray). The prepared medications were administered and CMA #1 left the apartment of Resident #9. Review of physician's orders for Resident #9 revealed an order for Fluticasone Propionate 50 mcg/ACT for one spray in both nostrils daily. No order for self-administration was observed. On 10/12/23 at 8:25 a.m., CMA #1 stated Resident #9 self-administered the nasal spray and kept it in their apartment. On 10/12/23 at 10:08 a.m., Resident #9 stated staff had observed them administering the nasal spray. Resident #9 stated the proper use of the medication and purpose of the medication and they had self-administered the medication since admission. On 10/12/23 at 10:41 a.m., the DCS and LPN #1 stated assessments were completed on admit, yearly and for a change of condition. They stated Resident #9 had a self-administration of medication assessment completed on admission which documented the resident was not safe to	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH7211AL	A. BUILDING: _____ B. WING _____	10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN VILLA	17110 E 51 ST STREET BROKEN ARROW, OK 74012

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C1505	Continued From page 6 self-administer medications. They were asked why Resident #9 had medications in their apartment and had self-administrated since admission. They stated they were not aware the resident had been self-administering medications since admission. They stated staff would need to be educated to report and inform to administration.	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: crystal.gormley@franciscanvilla.com

December 7, 2023

License Number: NH7211AL

Ms. Crystal Reeve-Gormley, Administrator
Franciscan Villa
17110 E 51 St Street
Broken Arrow, OK 74012

RE: Survey Event RO9G12

Dear Ms. Gormley:

On **December 4, 2023,** an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **October 12, 2023,** have now been corrected effective **October 30, 2023.**

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

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH7211AL	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN VILLA	17110 E 51 ST STREET BROKEN ARROW, OK 74012

(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 An offsite/paper revisit was conducted on 12/04/23. The facility was in substantial compliance.	{C 000}		

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