OKLAHOMA
State Department
of Health

Delivery via email to: Sslemp@StoreyOaks.com

January 14, 2022

License Number: AL5536

Mr. Scott Slemp, Administrator
Storey Oaks
8300 North May Avenue
Oklahoma City, OK 73120

Survey Event ID: JFDY11

Dear Mr. Slemp:

On **January 5, 2022,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Katie Stagner Digitally signed by Katie Stagner
Date: 2022.01.14 16:23:26 -06'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Storey Oaks**
Address: **8300 N May Ave**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5536**
Complaint #: **OK00058182**
Investigation Date(s): **01/04/2022 and 01/05/2022**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate medical care or properly assess newly admitted residents.	S

☐ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 01/04/2022 at 10:40 a.m.

A sample of three residents including any identified resident(s), 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 Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 01/06/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOREY OAKS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A complaint investigation (#OK00058182) was conducted on 01/04/22 and 01/05/22. The administrator identified 32 residents resided in the center. Listed below are abbreviations used throughout this document. ADLs (activities of daily living) am (morning) APAP (acetaminophen) BLE (bilateral lower extremities) BP (blood pressure) CMA (certified mediation aide) eMAR (electronic medication administration record) FSBS (finger stick blood sugar) HR (heart rate) hs (at bedtime) LPN (licensed practical nurse) LTCA (long term care aide) max (maximum) mg (milligrams) O2 (oxygen saturation) pm (after noon) prn (as needed) Pt (patient) RA (room air) RN (registered nurse) RR (respiratory rate) rt (right) T (temperature) u/ml (units per milliliter) V/S (vital signs) w/c (wheel chair)	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOREY OAKS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 1 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 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 interview, and record review, the center	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOREY OAKS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 2	C1505		

failed to have the resident's medications on hand for administration at admission for one (#2) vulnerable resident of three sampled residents who were reviewed for the administration of medications.

The administrator identified 32 residents resided at the center.

Findings:

The resident's "A Living Will," dated 01/23/13, read in part, "...If there is no reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die...I do not fear death as much as I fear the indignity of deterioration, dependence, and hopeless pain. I ask that drugs be mercifully administered to me for terminal suffering ever if they hasten the moment of death..."

The "Move-In Information" policy, dated 01/30/16, read in part, "...Move-in Coordinators Checklist: This should be used by the move-in coordinator to ensure a smooth transition for the Resident to the Community..."

The resident's "Resident Admission Agreement," dated 11/16/21, read in part, "...Every resident shall have the right to receive adequate and appropriate medical care..."

The resident's "Comprehensive Assessment," read in part, "...admission date 11/17/21. Diagnoses of dementia, metastatic melanoma, diabetes [insulin dependent], and bullous pemphigoid with infection...alert and oriented x 1 [person] with confusion, forgetfulness, and poor judgment...poor mobility, strength, and gait...limited range of motion...Usual Mood:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOREY OAKS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 3	C1505		

Calm...can be agitated...History of Mood Disorder: behavioral disturbance...Skin condition/General Condition and Turgor: poor...Describe abnormalities: bullous pemphigoid r/t [related to] Keytruda use, metastatic, melanoma...wounds: back, buttocks, thigh, toes..."

The resident's "Resident Care/Service Plan," dated 11/17/21, read in part, "...Medication...unable to self administer...am, noon, pm, hs...resident will receive mediations & as ordered..."

The eMAR, dated 11/2021, documented missing medications from 11/17/21 pm through 11/19/21 am which included medications as:
acetaminophen two caplets by mouth 500 mg, one time a day, at bedtime for pain/aches,
Doxycycline hyclate capsule 100 mg by mouth, two times a day for bullous pemphigoid,
niacinamide one tablet by mouth 500 mg, three times a day for bullous pemphigoid,
Lantus Solostar 100 u/ml, inject 10 units, one time a day in the evening for blood sugar [diabetes]; and
Mupirocin ointment 2%, apply thin film to open areas of buttocks, thighs, and toes topically two times a day for bullous pemphigoid until resolved.

The resident's [hospice company name deleted] hospice "Statement of Informed Consent," dated 11/18/21, read in part, "...Hospice services are designed in part to provide pain and symptom management in an effort to attain maximum comfort during my life limiting illness..."

The resident's [hospice company name deleted] hospice "RN Initial/Comprehensive Assessment," dated 11/18/21 at 1:30 p.m., read in part,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOREY OAKS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 4	C1505		

"...principal diagnosis: cancer...speech limited to approximately 6 (six) words or less in an average day...Type of Pain Scale Used: Staff observation...Is pain an active problem for the patient: Yes...Nonverbal pain cues: grimacing...Abnormal breath sounds: diminished [decreased sounds]...Oxygen safety risk noted: No...Abnormal heart sounds: faint, pacemaker, fatigue/weakness..." There was no documentation the resident received pain medication at this time.

The resident's [hospice company name deleted] hospice "Initial Plan of Care," dated 11/18/21, read in part, "...admission date 11/18/2021...terminal diagnosis malignant melanoma of skin...Problem: unable to make self understood...Related to disease progression and/or senile degeneration of the brain...Problem: Risk for untreated pain secondary to inability to verbalize pain...Problem: Patient is new admission to hospice and requires a coordinated transition to hospice care...Pt is bed to chair bound...Pt was being treated for melanoma with Keytruda when started having bullous pemphigoid lesions to trunk, BLE and toes...stage 2 to rt buttock..."

The resident's [hospice company name deleted] hospice "Psychosocial Comprehensive Assessment," dated 11/19/21 at 10:10 a.m., read in part, "...Patient is unable to make needs known and needs must be anticipated for him..."

A "Resident Notes," dated 11/19/21 at 1420 [2:20 p.m.], read in part, "...notified routine hospice nurses...of no meds [medications] from VA [veteran's affairs] or hospice in house [center]..."

A "Resident Notes", dated 11/19/21 at 2130 [9:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOREY OAKS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 p.m.], read in part, "...residents medication & insulin arrived..." The eMAR, dated 11/2021, documented missing doses of medications 11/21/21 pm medications and 11/24/21 pm medications which included: acetaminophen for pain/aches, Doxycycline for bullous pemphigoid; and niacinamide for bullous pemphigoid. The resident's [hospice company name deleted] hospice "Skilled Nurse Visit," dated 11/22/21 at 10:00 a.m., read in part, "...Facial expression: Facial grimacing...pt reports some discomfort to his buttocks, as he has multiple blisters r/t disease..." There was no documentation the resident had received pain medication at this time. The resident's [hospice company name deleted] hospice "Skilled Nurse prn Visit," dated 11/26/21 at 9:45 a.m., read in part, "...Reason for prn visit: summoned to facility related to facility nurse with concerns with low b/p increased resp (respirations) and low oxygen sat (saturation) level...unable to obtain blood pressure, R 20, T 97.3 degrees Fahrenheit, pulse rate: 62...Imminence of Death...Coolness to skin...increased fatigue...Abnormal behavior: Agitated, Anxious, Combative/Physical Aggression, Irritability...Abnormal color: Jaundice, Pallor...Facial Expression: sad/frightening/frowning...Body Language: Tense, distressed pacing, fidgeting...LPN [name-deleted center's staff] pt was back to normal that this agitation is the normal for this pt..." There was no documentation the resident had received pain medication at this time. The resident's [hospice company name deleted]	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOREY OAKS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 6	C1505		

hospice "Psychosocial prn Visit," dated 11/26/21 at 11:35 a.m., read in part, "...Assessment Obtained By Phone...Assessment Obtained From Caregiver: Patients son...Pain Status...Comments: Nurse aware of patient's pain...Patient's son reports that when he arrived at the facility patient was yelling and none of the staff appeared to want to assist patient or assist him with the patient...not sure if patient was yelling out due to being in pain or if he was agitated from being out around others..." There was no documentation the resident had received pain medication at this time.

A "Resident Notes," dated 11/26/21 at 1424 [2:24 p.m.], read in part, "...Observed resident at start of shift with eyes fixed, reaching in air with arms and moaning. V/S B/P 72/44, [HR] 55, [RR] 28, [T] 97.2 [degrees Fahrenheit], [O2 sats] 73% RA. Hospice notified. Son...in community with c/o [complaint of] resident appearing to be uncomfortable, requested resident be put in bed. Hospice notified x 2 [twice]...Hospice nurse...in community to F/U (follow-up) with resident and family...N/O [new order] from...hospice for Norco [Hydrocodone/APAP] 5 mg/325 mg (1) PO (by mouth) Q [every] 6 hours, prn [as needed]..." There was no documentation the resident had received pain medication at this time.

A "Physician's Order," dated 11/26/21, documented, Hydrocodone/APAP [Norco] tablet 5/325 mg, 1 tablet by mouth, every six hours, as needed for pain.

The eMAR, dated 11/2021, documented no doses of prn Hydrocodone/APAP was administered.

The resident's [hospice company name deleted] hospice "Death Visit," dated 11/27/21 at 5:50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOREY OAKS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 7	C1505		

p.m., read in part, "...date of death: 11/27/21...time of death 5:50 p.m..."

On 01/04/22 at 3:30 p.m., CMA #1 was asked about the eMAR notation of 'waiting on prior approval'. She stated it meant the medication was not in the center. She was asked what a blank square on the eMAR indicated. She stated, "If it is blank the medication wasn't given." She was asked about Res #2. She stated there was nothing to make her think he was in pain. She was asked if he yelled out. She stated, "Yes, but he did." She stating yelling out was normal for the resident.

On 01/05/22 at 9:50 a.m., CMA #2 was asked how she would know a resident was in pain. She stated, "Expressions on their face. Moaning." She stated he would move around in his chair, "I don't know if he had pain or was uncomfortable." CMA #3 stated, "He was bound to hurt because of his illness." CMA #2 stated, "Yeah."

At 11:11 a.m., during review of the physician orders and November 2021 eMAR the RN was asked if the physician was notified the resident missed doses of medication. She stated upon admission the physician was notified of the resident's status. There was no documentation provided the physician was notified.

She was asked who was responsible for having medications available for administration. She stated, "We are ultimately responsible for having the medications available for administration." She stated if the resident used a different pharmacy the center was responsible for getting medications to the center.

She was asked if the resident had a prn pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOREY OAKS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 8 medication available for administration. She stated, "No." At 11:56 a.m., the administrator was asked about their policy about medications available upon admission. He stated, "We don't have a policy specific to medications at the time of admission." At 12:16 p.m., the RN was asked about the resident's prn Norco medication. She stated she had contacted the hospice and hospice pharmacy about the medication. It was during a holiday, the pharmacy had not received a physician signed prescription so the medication was not filled or delivered. There was no documentation the medication had been delivered to the center.	C1505		

OKLAHOMA
State Department of Health

Delivery via email to: mgarrett@12oaks.com

January 26, 2022

License Number: AL5536

Michelle Garrett, Administrator
Storey Oaks
8300 North May Avenue
Oklahoma City, OK 73120

Survey Event ID: JFDY11

Dear Ms. Garrett:

On **January 5, 2022,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **February 20, 2022**.

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.

Sincerely,

Tempal Killman
Digitally signed by Tempal Killman
Date: 2022.01.26 10:33:45 -06'00'

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

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/25/2022** **Facility Name:** Storey Oaks **License Number:** AL5536 **Survey Event ID:** JFDY11 **Date Survey Completed: 1/5/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: Interview and record review, the center failed to have the resident's medication on hand for administration at admission for one (#2) vulnerable resident of three sampled residents who were reviewed for the administration of medications.

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	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Resident Cited expired on 11-27-21 noted by summary statement of deficiencies.
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 Medication Aides and Nursing Staff will be educated on proper procedure for medications that are not immediately available, onsite. Med Aide will notify nurse on duty or nurse on call immediately of any medication unavailable. Family and Pharmacy will also be notified. All staff of Storey Oaks will be in-serviced on 1-26-22 to include Resident Rights and Responsibilities under Title 63.
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?	Resident Care Director or appointed Medication Aide will perform routine audits to verify that all medication is available for administration. If not available, physician will be notified immediately for further direction.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	a. Routine Audits will be performed by the Resident Care Director or appointed Medication Aide to ensure that all medications are available for administration as ordered by the physician. b. All Nursing Staff and Medication Aides will receive written communication/training to notify nurse on duty or on call immediately of any medications unavailable for administration. c. Evidence of correction made will be reflected through review of EMARS to ensure medications are available for administration. Evidence of correction made will be reflected by reviewing EMARS to ensure medications are available for administration.
OSDH Response: Element accepted Yes ☐ No ☐	

5. On what date will corrective action be completed?		2/20/2022	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Michelle Alexander Garrett** OAC 310:663-25-4(F)			**Date 1/25/2022**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department
of Health

Delivery via email to: Jonna.Warrick@iriseniorliving.com

January 5, 2023

License Number: AL5536

Ms. Jonna Warick, Administrator
Storey Oaks
8300 North May Avenue
Oklahoma City, OK 73120

RE: Survey Event [EVENT()]

Dear Ms. Warick:

Enclosed is the Assisted Living Center Licensure inspection deficiency report form, showing the summary of deficiencies noted during the revisit at your facility on **December 21, 2022**. These deficiencies remain uncorrected since your survey of **January 5, 2022**.

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 Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance.

However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

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

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

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

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

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

- Remedy(ies) imposed by the Department,

- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	R-C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRIS MEMORY CARE OF NICHOLS HILLS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 follow-up survey was conducted on 12/21/22. Listed below are the abbreviations that will be used throughout this document. ACMA- advanced certified medication aide eMAR- electronic medication administration record HTN- hypertension MAR- medication administration record MEDS- medications MG-milligram WD- wellness director	{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 informed of and understanding the consequences	{C1505}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	R-C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRIS MEMORY CARE OF NICHOLS HILLS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C1505}	Continued From page 1 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 administer admission medications as ordered for two (#2 and #3) of three sampled residents reviewed for administration of medication. The Regional Director identified 36 residents resided in the facility. Findings: A "Medication Administration Times" policy, revised 08/07/12, read in part, "...Medications may be administered according to established schedules in order to provide uniform and efficient practices for administering medications..." Resident #2 had diagnoses included late onset Alzheimer's disease, depression, and anxiety. Resident #2's "Resident Negotiated Service Plan Without Schedule," and "Resident Evaluation," dated 12/13/22, read in part, "...Severe	{C1505}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	R-C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRIS MEMORY CARE OF NICHOLS HILLS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 2	{C1505}		

orientation deficits. Only oriented to self...Requires employee assist/administer medications..."

The Resident's admission orders, dated 04/21/22, included multivitamin one by mouth every day, and memantine hydrochloride 10 mg by mouth twice a day.

Resident #2's MAR documented memantine not given on 04/24/22, with reason of, "Waiting on prior approval" and multivitamin not given on 04/24/22, with reason of, "Waiting on prior approval."

Resident #3 had diagnoses included HTN and chronic myelogenous leukemia.

Resident #3's "Resident Negotiated Service Plan Without Schedule," and "Resident Evaluation," dated 12/13/22, read in part, "...Has occasional confusion and some difficulty recalling details. Needs occasional prompting or orientation...Requires employees assist/administer medications..."

The Resident's admission orders, dated 11/03/22, included lotrel 5mg/20 mg by mouth daily, and hydroxyurea 500 mg by mouth every Monday, Wednesday, and Friday.

A "Resident Drug Receipt Ledger," dated 11/07/22, included hydroxyurea 500 mg, received 13. The ledger did not include lotrel 5mg/20 mg.

Resident #3's MAR documented hydroxyurea not given on 11/04/22, 11/07/22, 11/09/22, and 11/11/22, with reason of, "Waiting on prior approval." Lotrel not given on 11/04/22, 11/07/22, 11/08/22, and 11/09/22, with reason given of,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	R-C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRIS MEMORY CARE OF NICHOLS HILLS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 3 "Waiting on prior approval." On 12/21/22 at 1:03 p.m., WD #1 was asked what "Waiting for prior approval" indicated for the reason not given on the MAR. They stated it meant the pharmacy was waiting on the insurance approval to pay. They were asked the reason a resident would receive the medication at admission for a few days then not receive the medication. They stated, "The pharmacy will go ahead and send them out before they receive the billing information." They stated, "Then, once billing aware, they will wait to send more until approved by insurance." WD #1 stated on admission they would send out the medication automatically then billing would get involved. They were shown both residents' MARs and were asked to explain the reason Resident #2's multivitamin and memantine hydrochloride was not given on the third day of admission and Resident #3's lotrel and hydroxyurea was not given the first few days after admission. They stated "I don't know, should have been sent unless billing stepped in early." They were asked how would they know if billing had stepped in. They stated they would have to call WD #2 as they were not familiar with the eMAR to say whether there was an "other" option to use. They were asked where the documentation for a medication not given would be located. They stated they would ask WD #2. On 12/21/22 at 1:35 p.m., WD #2 provided Resident #3's drug receipt ledger, and stated the meds were in the facility and they did not know the reason the med was not given. WD #1 stated the med was in the facility and should have been given. WD #2 stated Resident #2 did not have any documentation of the reason the meds were	{C1505}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	R-C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRIS MEMORY CARE OF NICHOLS HILLS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 4	{C1505}		

not given. WD#1 stated it was probably there since it was missed one day, but the WD at that time was no longer employed at the facility to ask. They were asked if there was any documented reason the meds were not given. They stated, "No."

The facility did not provide a receipt ledger for Resident #2.

On 12/21/22 at 2:06 p.m., WD#1 was asked what the policy was for medication administration. They stated the facility did not have one prior to new ownership. They stated staff were to give meds on time. WD #2 was asked if the medication for Resident #2 was administered as ordered. They stated, "According to the documentation, no."

WD#1 was asked what the policy was for medication administration at admission. They stated it was the same as the medication administration policy. WD #2 was asked when Resident #3 admitted to the facility. They stated, "11/04/22." WD#2 was asked, according to the receipt ledger provided, when did Resident #3' hydroxyurea arrive to the facility. They stated, "11/07/22." They were asked when did the lotrel arrive to the facility. They stated, "Not listed." WD #2 was asked if Resident #3's medications were administered as ordered. They stated, "No."

On 12/21/22 at 2:18 p.m., WD #2 provided a facility policy and the pharmacy policy for medication administration. They were asked if they followed the pharmacy medication administration policy. They stated, "Yes."

On 12/21/22 at 2:38 p.m., WD #1 and #2 were asked how they ensured staff followed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	R-C 12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRIS MEMORY CARE OF NICHOLS HILLS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 medication administration policy. WD #2 stated by inservices and skills check offs. They were both asked how they ensured medications were administered as ordered. WD #1 and #2 stated going forward, there would be a monthly assessment of the med carts. They were both asked what kind of oversight was provided for staff administering medications. WD #1 stated the nurse provided the oversight. They stated they had quarterly pharmacy reviews and if errors resulted, staff would be re-trained/inserviced.	{C1505}		

OKLAHOMA
State Department
of Health

Delivery via email to: Jolinda.Ross@IrisSeniorLiving.com; Jonna.Warrick@irisSeniorliving.com

February 21, 2023

License Number: AL5536

Ms. Jonna Warrick, Regional Director of Operations
Iris Memory Care of Nichols Hills
8300 North May Avenue
Oklahoma City, OK 73120

Survey Event ID: JFDY12

Dear Ms. Warrick:

On **December 21, 2022,** a complaint follow-up survey 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 have been corrected and you were in substantial compliance by **February 1, 2023**.

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

Respectfully,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2023.02.21 09:21:21 -06'00'

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

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 1/27/2023
	Facility Name: Iris Memory Care of Nichols Hills
	License Number: AL5536
	Survey Event ID: OK00058182
	Date Survey Completed: 12/21/2022

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: record review and interview, the facility failed to administer admission medications as ordered for two (#2 and #3) of three sampled residents reviewed for administration of medication.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION	
Assisted Living Center's Comments:	
REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	Residents cited on 12-21-22 had all meds available in house and given as ordered on date of survey.
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 nursing staff (to include medication aides) have been inserviced on the proper procedure for ordering medications upon admission/readmission to the community. DOW will ensure that meds are ordered and/or available on the day of admission/readmission. If any meds are not available to be given during med pass, the nurse will be immediately notified and meds will be ordered for STAT delivery per pharmacy agreement.
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?	DOW or designee will complete an audit form on day of admission, 24 hours after admission, and weekly for the first month. All staff will be inserviced on resident's rights in January 2023. Routine audits of med carts to ensure availability of medications will be conducted. These audits will be reviewed by the regional nurse routinely at the same time as other nursing audits are performed.
OSDH Response: Element accepted Yes No	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	a. Routine cart audits for med availability will be completed as scheduled with electronic record of audits maintained. b. All nursing staff (to include medication aides) will be inserviced on the proper procedure for ordering medications upon admission/readmission to the community. DOW will ensure that meds are ordered and/or available on the day of admission/readmission. If meds are not available to be given during any med pass, the nurse will be immediately notified and meds will be ordered for STAT delivery per pharmacy agreement. If a medication is not given because it is unavailable the med error will be reported in the QA. All residents have a current agreement with the pharmacy to provide medications. If meds that are filled at an outside pharmacy are not available in the community to be given, the community pharmacy will provide those medications with STAT delivery. c. Monitoring for evidence of correction will be kept via electronic records of audits and reflected through review of the eMAR.
OSDH Response: Element accepted Yes No	
5. On what date will corrective action be completed?	2/1/2023

OSDH Response: Element accepted Yes No			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		**Date** Enter a date of signature.	1/30/23
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			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department
of Health

Delivery via email to: Jolinda.Ross@IrisSeniorLiving.com;

FINAL DETERMINATION NOTICE
#7021 2720 0002 0354 1556

April 28, 2023

License Number: AL5536

Ms. Jolinda Ross, Administrator
Iris Memory Care of Nichols Hills
8300 North May Avenue
Oklahoma City, OK 73120

Survey Event ID: JFDY13

Dear Ms. Ross:

A revisit conducted **April 25, 2023**, revealed that your facility corrected deficiencies effective **February 1, 2023**.

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure:

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5536	A. BUILDING: _____ B. WING _____	R-C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRIS MEMORY CARE OF NICHOLS HILLS	8300 NORTH MAY AVENUE OKLAHOMA CITY, OK 73120

(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 04/25/23. All deficiencies from the 01/05/22 survey were cleared.	{C 000}		

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