Delivery via email to: kcardneas@prioritylc.com

April 22, 2022

License Number: AL5554

Ms. Kimberly Cardneas, Administrator
John H Johnson Care Suites
1213 N W 122nd Street
Oklahoma City, OK 73120

Survey Event ID: 57NO11

Dear Ms. Cardneas:

On **February 9, 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.

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,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **John H Johnson Care Suites**
Address: **1213 NW 122nd Street**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5554**
Complaint #: **OK00055461**
Investigation Date(s): **02/01/22, 02/02/22, and 02/07/22 through 02/09/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications are properly administered.	**US**
2. The center failed to ensure the resident had the right to choose their physician.	**US**
3. The center failed to ensure residents received adequate and appropriate medical care.	**US**
4. The center failed to ensure care and services were provided as contracted.	**US**
5. The center failed to provide an abuse free environment.	**US**

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

An unannounced on-site investigation was initiated on 02/01/2022 at 11:57 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 unsubstantiated related to this allegation.

An investigation specific to medication administration, staffing and medication administration records was conducted.

On 02/01/22 at 1:48 p.m. a medication pass was observed. The resident's received their medication in a timely manner.

At 4:01 p.m. another medication pass was observed with another employee. The resident's received their medications in a timely manner.

When the medication aide was asked about the timing of the medication administration, she stated she had an hour prior to the physician ordered medication scheduled to administer or an hour after.

At the time of the investigation, there was no deficient practice related to medication administration.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the resident's right to choose their physician was conducted.

On 02/07/22 residents were interviewed. They chose the physician to treat them medically and understood if/when they could change their choice of physician.

A center's form, dated 02/2020, read in part, "...Primary Care Physician Option...allows the resident or resident family, the option of keeping their present PCP (primary care physician) and or choosing an in-house PCP..." When an employee was asked about the form, she stated the form was filled out at admission, but could be changed by the resident or the resident family at any time.

At the time of the investigation, there was no deficient practice related to resident's right to choose their physician.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to physician orders and finger stick blood sugar (FSBS) readings was conducted.

On 02/02/22 resident records were reviewed to include assessments, care plans, self-administration of medication assessments, physician progress notes, treatment administration records and medication administration records.

On 02/07/22 residents were interviewed. A resident complained of nausea and the medication aide administered the resident's prn (as needed) anti-nausea medication in a timely manner. No resident complained about their diabetic management or the staff at the time of the survey.

At the time of the investigation, there was no deficient practice related to physician ordered medications and/or the center monitoring diabetic management.

Allegation #4: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to medication administration, showers/baths and staffing was conducted.

On 02/01/22 at 1:48 p.m. a medication pass was observed. The resident's received their medication in a timely manner.

At 4:01 p.m. another medication pass was observed with another employee. The resident's received their medications in a timely manner.

When the medication aide was asked about the timing of the medication administration, she stated she had an hour prior to the physician ordered medication scheduled to administer or an hour after.

On 02/07/22 residents were asked about showers/baths. One resident stated, "I know when I want a bath." She stated all she had to do was ask. Another resident stated, "I just had one yesterday."

Staffing was observed during the survey to meet the needs of the residents. Staffing records were reviewed. There were no complaints by residents about staffing during the survey. The center had sufficient staff.

On 02/09/22 at 10:38 a.m. staff were asked about showers/baths. They stated residents either showered/bathed Monday, Wednesday, Friday or Tuesday, Thursday, Saturday and prn (as needed) for example, appointments. Electronic documentation was reviewed using the center's point click care computerized system under tasks.

At the time of the investigation, there was no deficient practice related to medication administration, showers/baths or staffing.

Allegation #5: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to abuse was conducted.

Staff was observed interacting appropriately with residents throughout the survey.

There were no complaints about hateful staff or verbally abusive staff by residents at the time of the survey.

Incident reports and investigations were reviewed.

At the time of the investigation, no abuse was substantiated.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1-#5. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 02/10/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **John H Johnson Care Suites**
Address: **1213 NW 122nd Street**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5554**
Complaint #: **OK00055534**
Investigation Date(s): **02/01/22, 02/02/22, and 02/07/22 through 02/09/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate medical care and services.	**US**
2. The center failed to ensure residents' property was not misappropriated.	**US**
3. The center failed to have and/or implement their abuse policy.	**US**

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

An unannounced on-site investigation was initiated on 02/01/2022 at 11:57 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 unsubstantiated related to this allegation.

An investigation specific to quarantine/isolation, room temperature control, assessments, toilet paper, snacks and finger stick blood sugars was conducted.

There was no resident on quarantine or isolation, at the time of the survey.

Resident's stated they stayed in their own rooms if they were required to quarantine or isolate.

Observed in each resident apartment were thermostat's which were controlled by the individual resident.

Residents were observed transferring without difficulty and their assessments were reviewed.

Toilet paper was observed in each resident room. Resident's stated they were responsible for their toiletries, but could ask staff for toilet paper if they needed it.

There were no critically low FSBS during resident record reviews. Snacks were observed provided by dietary staff and nursing staff. Resident's stated they also kept their own snacks/food in their rooms.

At the time of the investigation, there were no resident's quarantined or isolated.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to incident reports and misappropriation of resident property was conducted.

Incident reports and investigations were reviewed.

At the time of the investigation, no residents complained about misappropriation of property.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to abuse was conducted.

Staff was observed interacting appropriately with residents throughout the survey.

There were no complaints about emotionally abusive staff by residents, at the time of the survey.

Incident reports and investigations were reviewed.

At the time of the investigation, no abuse was substantiated.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1-#3. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 02/10/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **John H Johnson Care Suites**
Address: **1213 NW 122nd Street**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5554**
Complaint #: **OK00055846**
Investigation Date(s): **02/01/22, 02/02/22, and 02/07/22 through 02/09/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate medical care and services to residents with changes in condition.	**S**

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

An unannounced on-site investigation was initiated on 02/01/2022 at 11:57 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 1505 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

Date report completed: 02/10/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **John H Johnson Care Suites**
Address: **1213 NW 122nd Street**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5554**
Complaint #: **OK00056190**
Investigation Date(s): **02/01/22, 02/02/22, and 02/07/22 through 02/09/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide services according to residents' contracts.	US

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

An unannounced on-site investigation was initiated on 02/01/2022 at 11:57 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 unsubstantiated related to this allegation.

An investigation specific to call lights/pendants, incident reports/investigations, staffing, contracts, resident records and hospital records was conducted.

There were no problems with the pendants, at the time of the survey.

No resident complained about falls, not preventable injuries, staff or response times to pendants.

Staff stated when residents use their pendants, the centers cell phones (iPads used in past) carried by the employees either vibrate or ring so they know when a resident needs assistance. They have not had any problems with them working properly.

Residents were asked about assistance from staff in a timely manner. One resident stated, "Yeah, they're good about that."

At the time of the investigation, there was no deficient practice in relation to contracted services.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Date report completed: 02/10/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **John H Johnson Care Suites**
Address: **1213 NW 122nd Street**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5554**
Complaint #: **OK00056295**
Investigation Date(s): **02/01/22, 02/02/22, and 02/07/22 through 02/09/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were properly stored.	US
2. The center failed to have a system to keep up with resident belongings.	US

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

An unannounced on-site investigation was initiated on 02/01/2022 at 11:57 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 unsubstantiated related to this allegation.

An investigation specific to medication room and storage of medication was conducted.

The medication room was observed throughout the survey. It remained locked and medications were stored appropriately and in an orderly manner.

The staff stated the medication room remained lock with the door closed, at the time of the survey.

At the time of the investigation, the medications were secured properly and the medication room remained locked.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to diabetic supplies and self-administration assessments was conducted.

Diabetic residents stated they kept their diabetic supplies in their own apartments because they were capable of self-administration. These supplies were observed in their apartments. Their self-administration assessments were reviewed.

The staff stated they had several pharmacies to re-order medication, supplies and insulin.

At the time of the investigation, there were no problems with diabetic supplies.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1 and #2. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Date report completed: 02/16/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **John H Johnson Care Suites**
Address: **1213 NW 122nd Street**
City, State, Zip: **OKC, OK 73120**
Provider #: **AL5554**
Complaint #: **OK00058039**
Investigation Date(s): **02/01/22, 02/02/22, and 02/07/22 through 02/09/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were administered safely, and failed to have a plan in place to obtain medications in a timely manner.	US

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

An unannounced on-site investigation was initiated on 02/01/2022 at 11:57 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 unsubstantiated related to this allegation.

An investigation specific to diabetic supplies, insulin, finger stick blood sugars, refilling prescriptions and medication storage was conducted.

Diabetic residents stated they kept their diabetic supplies in their own apartments because they were capable of self-administration. These supplies were observed in their apartments. Their self-administration assessments and FSBS were reviewed.

The staff stated they had several pharmacies to re-order medication, supplies and insulin.

At the time of the investigation, there were no problems with diabetic supplies.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Date report completed: 02/16/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **John H Johnson Care Suites**
Address: **1213 NW 122nd Street**
City, State, Zip: **Oklahoma City, OK**
Provider #: **AL5554**
Complaint #: **OK00058353**
Investigation Date(s): **02/01/22, 02/02/22, and 02/07/22 through 02/09/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide care to residents according to their contract.	**US**
2. The center failed to ensure medications/O2 therapy were administered as ordered by the physician and by qualified staff.	**US**
3. The center failed to ensure resident money was not misappropriated.	**US**

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

An unannounced on-site investigation was initiated on 02/01/2022 at 11:57 a.m.

A sample of three 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 unsubstantiated related to this allegation.

An investigation specific to meals was conducted.

The kitchen was observed to have a supply of food in the pantry, refrigerator and freezer. A test tray was sampled and the food was warm and palatable.

The residents stated they did not go without food. They kept food in their rooms if they didn't want or like what was being served. There was also an alternative menu for resident's to choose from.

At the time of the investigation, there were no problems with food supply or portions.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to medication administration, staffing, oxygen therapy, medication administration records and qualified staff was conducted.

On 02/01/22 at 1:48 p.m. a medication pass was observed. The resident's received their medication in a timely manner.

At 4:01 p.m. another medication pass was observed with another employee. The resident's received their medications in a timely manner.

When the medication aide was asked about the timing of the medication administration, she stated she had an hour prior to the physician ordered medication scheduled to administer or an hour after.

Physician orders pertaining to oxygen therapy were reviewed.

There were no complaints by residents about their oxygen at the time of the survey.

Staff introduced themselves by name and title. Staffing rosters and staff credentials were reviewed.

At the time of the investigation, there was no deficient practice related to medication administration, oxygen therapy or qualified staff.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to misappropriation of resident money from their bank accounts was conducted.

The center does not have access to resident bank accounts directly.

On 02/01/22 at 2:22 p.m. the (interim) administrator stated, "We do not have a resident trust. We don't do that here."

A list of residents who opted for ACH (automatic bank withdrawal/draft authorization form) was reviewed.

Upon admission, during the review of the residency agreement and if there was a change in resident charges, charges were reviewed with the resident who gave authorization of monthly charges which may include rent and pharmacy charges to automatically be withdrawn.

The last three months of bank account drafts provided by the corporate office were reviewed.

No residents complained about automated withdrawals at the time of the survey.

At the time of the investigation, there was no misappropriation of resident money from their bank accounts.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1-#3. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence

at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Date report completed: 02/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5554	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN H JOHNSON CARE SUITES	1213 N W 122ND STREET 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 On 02/01/22, 02/02/22 and 02/07/22 through 02/09/22 an investigation was conducted for the following complaints (#OK00055461, OK00055534, OK00055846, OK00056190, OK00056295, OK00058039, and #OK00058353). ADON-assistant director of nursing AKI-acute kidney injury ALF-assisted living facility CKD-chronic kidney disease CS-culture and sensitivity DOB-date of birth DON-director of nursing HH-home health LPN-licensed practical nurse NP-nurse practitioner RN-registered nurse SNV-skilled nursing visit UA-urinalysis UTI-urinary tract infection	C 000		
C1505 SS=H	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	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5554	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN H JOHNSON CARE SUITES	1213 N W 122ND STREET 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 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 record review and interview, the facility failed to ensure accurate and complete assessments, monitor and implement interventions timely for one (#4) of three sampled residents who demonstrated a change in condition. The interim administrator identified 91 residents resided in the facility. Findings: Resident #4 had diagnoses which included chronic kidney disease stage 3, major depressive disorder, and heart failure.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5554	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN H JOHNSON CARE SUITES	1213 N W 122ND STREET 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 On 05/18/20 the resident's medical diagnosis was updated by the center to include retention of urine. A Revision To Plan Of Care from the HH agency, dated 05/18/20, read in part, "...Orders...SN to straight cath to relieve urinary retention..." A Coordination Form, dated 05/18/20, read in part, "Straight cath per verbal order and Flomax 0.4 mg by mouth daily...450 cc amber urine return...no signs or symptoms of urinary track infection...notation for change in condition, doctor notified and new orders." There was no documentation to show implementation of intervention for amber urine. A Coordination Form, dated 05/20/20, read in part, "Straight cath 400 cc clear straw colored urine obtained. A Coordination Form, dated 05/22/20, did not have any notation of urine output. A Coordination Form, dated 05/24/20, read in part, "Client states not being able to urinate for some time...unable to say when last urinated...Performed straight cath with 325 cc of cloudy yellow...Notified Doctor Merritt...Spoke with NP states next time client has to be straight cath to obtain UA C& S to check for underlying problem." There was no documentation to show implementation of intervention for cloudy urine. A Coordination Form, dated 05/27/20, did not have any notation of urine output. A Coordination Form, dated 06/01/20, did not have any notation of urine output.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5554	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN H JOHNSON CARE SUITES	1213 N W 122ND STREET 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 A Coordination Form, dated 06/12/20, did not have any notation of urine output. A Coordination Form, dated 06/17/20, did not have any notation of urine output. A Coordination Form, dated 06/25/20, did not have any notation of urine output. A Coordination Form, dated 07/03/20, did not have any notation of urine output. Resident # 4 last known urine output was on 05/24/20. Per John H. Johnson Progress Notes or Coordination Form, there was no documentation to show implementation of interventions regarding urinary retention. A Coordination Form, dated 07/06/20 at 3:45 p.m., read in part, "Creamy discharge from penis...skilled nure to straight cath patient tomorrow for UA with C & S...notation for change in condition, doctor notified and new orders." A John H. Johnson Progress Note, dated 07/07/20 at 7:49 p.m., read in part, "Yesterday at 5:00 p.m. went down the hall to check on resident...Lorimor NPRN was assessing resident...Resident appeared to be unresponsive to touch, pale, eyes glazed...Resident would respond to verbal stimuli...VS 67/37, 72, 20, Sats 66%. A John H. Johnson Progress Note, dated 07/06/20 at 7:49 p.m., read in part, "Got sent to the hospital." There was no documentation to discuss interventions to symptoms prior to hospitalization 07/06/20 and death 07/18/20.	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5554	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN H JOHNSON CARE SUITES	1213 N W 122ND STREET 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 A Certificate of Death, dated 08/03/20, read in part, "Cause of death Urosepsis." On 02/09/20 t 4:50 p.m., LPN #1 was asked about the straight cath order, dated 05/18/20; and stated it was an incomplete order. The nurse stated it should have been sent back for clarification; and there was no frequency, what size cath, what type of equipment/supplies to use, what s/s to monitor. LPN # 1 stated the order should have been verified and made a progress note in the electronic record. On 02/09/20 at 5:05 p.m., LPN #1 was asked about the Coordination Form, dated 05/18/20; and stated a significant change in condition assessment should have been completed with an updated care plan due to urinary retention. The nurse stated it should have been communicated to the staff; and stated the nurses needed to be aware. On 02/09/20 at 5:30 p.m., LPN #1 was asked about the lack of progress notes made in the electronic record; and stated there should have been a note made by the center's nurses at the time the HH had straight cathed the resident since it was an invasive procedure.	C1505		

Delivery via email to: kcardenas@prioritylc.com

May 3, 2022

License Number: AL5554

Ms. Kimberly Cardenas, Administrator
John H Johnson Care Suites
1213 N W 122nd Street
Oklahoma City, OK 73120

Survey Event ID: 57NO11

Dear Ms. Cardenas:

On **February 9, 2022**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1505** – There is no indication on measures put into place such as in-services to ensure that the deficient practice will not recur.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 4/27/2022** **Facility Name:** John H Johnson Care Suites **License Number:** AL5554 **Survey Event ID:** OK00055846 **Date Survey Completed: 02/29/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Based on record review and interview, the facility failed to ensure accurate complete assessments, monitor and impletement interventions timely.

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?	Resident #4 Deceased
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DON or Designee will review all Coordination of care notes submitted for each resident, and followed with notification to the PCP and nurses note if needed. Coordination of Care notes will be signed by the DON or Designee DON or Designee will meet monthly with Home Health companies to ensure all residents are receiving appropriate medical care.
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?	DON or Designee will audit 10% of the residents Charts monthly, to include State assessments and Coordination of Care notes (if applicable). Until all current resident charts have been reviewed. Assessments will be updated as needed for significant change.
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.	The Quality Assurance team will review the Coordination of Care monthly meeting report at the QA quartley meeting. The Quality Assurance team will review monthly audits at the quarterly meetings. The Nursing department will keep and updated audit form to ensure all charts are reviewed and any Coordintaion of Care notes for any resident receiving Home Health Services.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/20/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Teri Ellis** OAC 310:663-25-4(F)			**Date 4/27/2022**
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: kcardenas@prioritylc.com

May 18, 2022

License Number: AL5554

Ms. Kimberly Cardenas, Administrator
John H Johnson Care Suites
1213 N W 122nd Street
Oklahoma City, OK 73120

Survey Event ID: 57NO11

Dear Ms. Cardenas:

On **February 9, 2022,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **June 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.

Respectfully,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2022.05.18 09:26:45 -05'00'

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: 4/27/2022** **Facility Name:** John H Johnson Care Suites **License Number:** AL5554 **Survey Event ID:** OK00055846 **Date Survey Completed: 02/29/2022**
SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Based on record review and interview, the facility failed to ensure accurate complete assessments, monitor and impletement interventions timely.
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?	Resident #4 Deceased
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	DON or Designee will review all Coordination of care notes submitted for each resident, and followed with notification to the PCP and nurses note if needed. Coordination of Care notes will be signed by the DON or Designee DON or Designee will meet monthly with Home Health companies to ensure all residents are receiving appropriate medical care.
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?	DON or Designee will audit 10% of the residents Charts monthly, to include State assessments and Coordination of Care notes (if applicable). Until all current resident charts have been reviewed. Assessments will be updated as needed for significant change. Administrator or designee will inservice the nursing staff every quarter and all new nursing staff upon hire, to ensure Residents or residents POA will be informed of the residents condition in advance of any treatment or new medication. Resident or POA will have the right to refuse medication or treatment after being fully informed and understanding consequences. At Risk Agreement will be signed and placed in residents chart. Residents or POA will be allowed to participate in the Plan of Care, upon admission any significant change and annually.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:	The Quality Assurance team will review the Coordination of Care monthly meeting report at the QA quartley meeting.

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.	The Quality Assurance team will review monthly audits at the quarterly meetings. The Nursing department will keep and updated audit form to ensure all charts are reviewed and any Coordintaion of Care notes for any resident receiving Home Health Services.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	6/20/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Teri Ellis OAC 310:663-25-4(F)	**Date 4/27/2022**

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: KCardenas@prioritylc.com

Certified Mail # 7021 2720 0002 0354 1433

January 6, 2023

License Number: AL5554

Ms. Kimberly Cardenas, Administrator
John H Johnson Care Suites
1213 N W 122nd Street
Oklahoma City, OK 73120

Survey Event ID: 57NO12

Dear Ms. Cardenas:

A revisit conducted **January 4, 2023**, revealed that your facility corrected deficiencies effective **June 20, 2022**.

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
	AL5554	A. BUILDING: _____ B. WING _____	R-C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN H JOHNSON CARE SUITES	1213 N W 122ND STREET 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 01/04/2023. The facility was in compliance.	{C 000}		

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

OKLAHOMA
State Department
of Health

Delivery via email to: kcardenas@prioritylc.com

REPORT REVISED-Admin Review

January 18, 2023

License Number: AL5554
Survey Event ID: 57NO11

Ms. Kimberly Cardenas, Executive Director
John H Johnson Care Suites
1213 N W 122nd Street
Oklahoma City, OK 73120

Dear Ms. Cardenas:

On **February 9, 2022**, agents from our office concluded an investigation at your facility. You were advised of the findings of that investigation in our notice of **April 22, 2022**.

The original STATE FORM report has been revised during administrative review of this case on **January 12, 2023**, to correct the erroneous date in the last three paragraphs for C1505. A copy of the corrected STATE FORM/statement of deficiencies report is included. Deficiencies identified during the investigation are not affected by these corrections and a new plan of correction is not required. The corrected statement of deficiencies (STATE FORM) report is being provided for your records and no additional action on your part is required at this time.

If we can be of any further assistance, please contact us at 405-426-8200.

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 000	INITIAL COMMENTS On 01/12/23, after administrative review the 2567 was amended. On 02/01/22, 02/02/22 and 02/07/22 through 02/09/22 an investigation was conducted for the following complaints (#OK00055461, OK00055534, OK00055846, OK00056190, OK00056295, OK00058039, and #OK00058353). ADON-assistant director of nursing AKI-acute kidney injury ALF-assisted living facility CKD-chronic kidney disease CS-culture and sensitivity DOB-date of birth DON-director of nursing HH-home health LPN-licensed practical nurse NP-nurse practitioner RN-registered nurse SNV-skilled nursing visit UA-urinalysis UTI-urinary tract infection	C 000		
C1505 SS=H	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	C1505		6/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 1 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 record review and interview, the facility failed to ensure accurate and complete assessments, monitor and implement interventions timely for one (#4) of three sampled residents who demonstrated a change in condition. The interim administrator identified 91 residents resided in the facility. Findings: Resident #4 had diagnoses which included	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C1505	Continued From page 2 chronic kidney disease stage 3, major depressive disorder, and heart failure. On 05/18/20 the resident's medical diagnosis was updated by the center to include retention of urine. A Revision To Plan Of Care from the HH agency, dated 05/18/20, read in part, "...Orders...SN to straight cath to relieve urinary retention..." A Coordination Form, dated 05/18/20, read in part, "Straight cath per verbal order and Flomax 0.4 mg by mouth daily...450 cc amber urine return...no signs or symptoms of urinary track infection...notation for change in condition, doctor notified and new orders." There was no documentation to show implementation of intervention for amber urine. A Coordination Form, dated 05/20/20, read in part, "Straight cath 400 cc clear straw colored urine obtained. A Coordination Form, dated 05/22/20, did not have any notation of urine output. A Coordination Form, dated 05/24/20, read in part, "Client states not being able to urinate for some time...unable to say when last urinated...Performed straight cath with 325 cc of cloudy yellow...Notified Doctor Merritt...Spoke with NP states next time client has to be straight cath to obtain UA C& S to check for underlying problem." There was no documentation to show implementation of intervention for cloudy urine. A Coordination Form, dated 05/27/20, did not have any notation of urine output.	C1505		

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C1505	Continued From page 3 A Coordination Form, dated 06/01/20, did not have any notation of urine output. A Coordination Form, dated 06/12/20, did not have any notation of urine output. A Coordination Form, dated 06/17/20, did not have any notation of urine output. A Coordination Form, dated 06/25/20, did not have any notation of urine output. A Coordination Form, dated 07/03/20, did not have any notation of urine output. Resident # 4 last known urine output was on 05/24/20. Per John H. Johnson Progress Notes or Coordination Form, there was no documentation to show implementation of interventions regarding urinary retention. A Coordination Form, dated 07/06/20 at 3:45 p.m., read in part, "Creamy discharge from penis...skilled nure to straight cath patient tomorrow for UA with C & S...notation for change in condition, doctor notified and new orders." A John H. Johnson Progress Note, dated 07/07/20 at 7:49 p.m., read in part, "Yesterday at 5:00 p.m. went down the hall to check on resident...Lorimor NPRN was assessing resident...Resident appeared to be unresponsive to touch, pale, eyes glazed...Resident would respond to verbal stimuli...VS 67/37, 72, 20, Sats 66%. A John H. Johnson Progress Note, dated 07/06/20 at 7:49 p.m., read in part, "Got sent to the hospital." There was no documentation to discuss	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN H JOHNSON CARE SUITES	1213 N W 122ND STREET OKLAHOMA CITY, OK 73120

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C1505	Continued From page 4	C1505		

interventions to symptoms prior to hospitalization 07/06/20 and death 07/18/20.

A Certificate of Death, dated 08/03/20, read in part, "Cause of death Urosepsis."

On 02/09/22 at 4:50 p.m., LPN #1 was asked about the straight cath order, dated 05/18/20; and stated it was an incomplete order. The nurse stated it should have been sent back for clarification; and there was no frequency, what size cath, what type of equipment/supplies to use, what s/s to monitor. LPN # 1 stated the order should have been verified and made a progress note in the electronic record.

On 02/09/22 at 5:05 p.m., LPN #1 was asked about the Coordination Form, dated 05/18/20; and stated a significant change in condition assessment should have been completed with an updated care plan due to urinary retention. The nurse stated it should have been communicated to the staff; and stated the nurses needed to be aware.

On 02/09/22 at 5:30 p.m., LPN #1 was asked about the lack of progress notes made in the electronic record; and stated there should have been a note made by the center's nurses at the time the HH had straight cathed the resident since it was an invasive procedure.