OKLAHOMA
State Department
of Health

Delivery via email to: ed@azaleagardensmc.com

September 9, 2021

License Number: AL5101

Ms. Jennifer Braun, Administrator
Azalea Gardens Memory Care
3211 Chandler Road
Muskogee, OK 74403

Survey Event ID: ICLW11

Dear Ms. Braun:

On **August 26, 2021,** representatives from the Oklahoma State Department of Health (OSDH) concluded a Covid-19 focused survey along with 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 <u>not</u> use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

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State Department
of Health

- 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: **Azalea Gardens Memory Care**
Address: **3211 Chandler Road**
City, State, Zip: **Muskogee OK, 74403**
Provider #: **AL5101**
Complaint #: **OK00057579**
Investigation Date(s): **08/26/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to allow residents to have visitors and/or unrestricted visits.	S

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

An unannounced on-site investigation was initiated on 08/26/2021 at 9:15 a.m.

A sample of six 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 1507 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.

Kristie Leak, RN

Enter name and title

Date report completed: 08/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5101	A. BUILDING: _____ B. WING _____	C 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA GARDENS MEMORY CARE	3211 CHANDLER ROAD MUSKOGEE, OK 74403

(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 08/26/21, the Oklahoma State Department of Health completed a complaint investigation for complaint #OK00057579 and a COVID-19 Focused Survey to determine if the facility was in compliance with implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. Total residents: 20	C 000		
C1507 SS=E	310:663-15-1 & 63 OS 1-1918(B)(7) RESIDENT RIGHTS - Reasonable Accommodation 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)(7) (7) Every resident shall have the right to reside and to receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered; This REQUIREMENT is not met as evidenced	C1507		

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C1507	Continued From page 1 by: Based on interview and record review, it was determined the facility failed to ensure in door and unsupervised visitation was allowed at all times for five (#2, #3, #4, #5, and #6) of six residents sampled for visitation. This had to potential to effect 20 residents living in the facility. Findings: The facility's COVID-19 strategy plan, updated 08/20/21, documented, " . . Conversation Shield - 'Welcome Window" (using a see through separation wall) and Outdoor Visits . . . Schedule the visit with the families. Limit the number of visitors to two per resident. Visitors must be 6 ft apart . . . Have a staff with the resident to monitor safety and social distancing . . . " 1. Resident #6 was admitted to the facility on 08/19/20 with diagnoses that included anxiety disorder, chronic obstructive pulmonary disease, and Alzheimer's disease. On 08/26/21 at 2:33 p.m., a family interview was conducted. The resident's family member stated "No." The family member stated they had agreed upon set times to visit on Tuesdays and Fridays, but would like to visit more. The family member stated they had some porch visits where staff was present, but in March they were able to come into the facility. The family member stated currently they had private, indoor visitation. 2. Resident #5 was admitted to the facility on 03/15/21 with diagnoses that included anxiety disorder, hypertension, and Alzheimer's disease. On 08/26/21 at 3:22 p.m., a family interview was conducted. The resident's family member stated	C1507		

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C1507	Continued From page 2	C1507		

porch visits were frustrating because the family member was told different things regarding the rules by staff members. The family member stated staff sat with them during their visits, and he did not like that because he had private things to talk with the resident about. The family member stated he were never contacted and told they were able to come in the building for visits. He stated he had been told recently that he could have indoor visits with the resident.

3. Resident #2 was admitted to the facility on 04/02/21 with diagnoses that included cerebral infarction, hypertension, anxiety disorder, and diabetes mellitus.

Resident #3 was admitted to the facility on 04/02/21 with diagnoses that included heart failure, anxiety disorder, and Alzheimer's disease.

On 08/26/21 at 3:15 p.m., a family member for residents #2 and #3 was interviewed. The residents' family member stated the facility asked families to call and give notice before visiting. The family member stated during the porch visits, sometimes you could visit alone and then sometimes the staff stayed for the visit. The family member stated she was called when the facility went on lockdown but not called when it opened back up; however, she stated she was able to take the residents to dinner not long ago.

4. Resident #4 was admitted to the facility on 06/14/21 with diagnoses that included dementia without behavioral disturbance, anxiety disorder, and Alzheimer's disease.

On 08/26/21 at 3:03 p.m., a family interview was conducted. The resident's family member stated they were only allowed porch visits. The family

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C1507	Continued From page 3	C1507		

member stated they were also told the resident could not leave the building or the resident would have to quarantine when they returned to the facility. The family member stated on 08/15/21, the family was told by a staff member the staff had to be outside during a porch visit. The resident's family member stated the staff had never been with them on any prior porch visits. The family member stated they called yesterday to schedule a visit and was told they could now come back into the facility.

On 08/26/21 at 10:44 a.m., certified nurse aide (CNA) #1 stated right now visitation is two people at a time and they have to schedule visits. The CNA stated the visitor can come in the resident's room as long as the have been screened and have on person protective equipment (PPE). No one under the age of 18 is allowed to visit at this time.

On 08/26/21 at 11:34 a.m., medication aide #1 stated all visitors could now enter the building after being screened. She stated in July only porch visits were allowed. She stated appointment were the best way to visit, but visitors just showed up.

On 08/26/21 at 12:32 p.m., licensed practical nurse (LPN) #1 stated everyone was allowed in the building for visitation. She stated after the visitor was screened, staff escorted them to the resident's room and asked if they would social distance and wear personal protective equipment (PPE). LPN #1 stated the resident could leave the facility with their loved ones. LPN #1 stated there were some families that preferred porch visits with a staff member present.

On 08/26/21 at 2:11 p.m., the administrator stated

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C1507	Continued From page 4 the facility started porch visitation on 08/06/21 when the county positivity rate went back up. He stated after the facility received a call from the state health department, they opened back up for visitation on 08/17/21. The administrator stated the visitation grid was now part of the facility's policy for visitation. The administrator stated the facility informed their staff of visitation changes through stand up meetings, and they let the families know of changes by phone calls or tests. He stated they would still like the families to call and schedule visits, but if they wanted to come daily that was also alright. On 08/26/21 at 3:40 p.m., LPN #1 stated normally the facility notified the staff of changes in stand up meetings or in the communications binder. She looked in the communications binder and could not find where the facility had addressed visitation. The LPN stated the health and wellness director called the families regarding visitation. On 08/26/21 at 3:52 p.m., the health and wellness director was interviewed by phone. She stated she had called families to let them know the facility would like to do porch visits, but the policy did not change and porch visits were never forced. She stated the facility did not supervise the visits unless the family asked them to. She stated the facility never told the families they could not come in the building.	C1507		

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Delivery via email to: ed@azaleagardensmc.com

September 27, 2021

License Number: AL5101

Ms. Jennifer Braun, Administrator
Azalea Gardens Memory Care
3211 Chandler Road
Muskogee, OK 74403

Survey Event ID: ICLW11

Dear Ms. Braun:

On **August 26, 2021,** a complaint investigation and a COVID Focused Survey were 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 **September 17, 2021**.

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: 2021.09.27 13:12:20 -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: 9/17/2021
	Facility Name: Azalea Gardens Memory Care
	License Number: AL5101-5101
	Survey Event ID: ICLW11
	Date Survey Completed: 8/26/2021

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1507	Based on: interview and record review it was determined the facility failed to ensure indoor & unsupervised visitation was allowed at all times for five (# 2,, #3 , #4, #5 and #6) of six residents sampled for visitation. This had the potential to effect 20 residents living in the facility.

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?	Residents #2, #3, #4, #5 & #6 continue to live at the community. Community has updated the visitation policy to meet state regulated visitation grid.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All residents receiving visitation have the potential to be affected by the same deficient practice.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Policy and procedure will be updated to incorporate state regulated visitation grid. All staff have been in-serviced over state regulated visitation grid and updated visitation policy. The Quality Assurance Committee will monitor the effectiveness of the plan until compliance is achieved and continue to monitor for one quarter after compliance.
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.	Executive Director or designee will conduct random audits and interviews with the residents to establish compliance. and will continue to monitor through one quarter of QA meetings to ensure continued compliance. The Quality Assurance Committee will monitor the effectiveness of the plan until compliance is achieved and continue to monitor for one quarter after compliance. Executive Director or designee will continue to monitor through one quarter of QA meetings to ensure continued compliance. Community will keep a binder with random audits conducted for compliance.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/17/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Peter Blanchard -Executive Director**	**Date 9/17/2021**
OAC 310:663-25-4(F)	

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.			

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State Department of Health

Delivery via email to: ed@azaleagardensmc.com;

February 18, 2022

License Number: AL5101

Mr. Peter Blanchard, Administrator
Azalea Gardens Memory Care
3211 Chandler Road
Muskogee, OK 74403

RE: Survey Event ICLW12

Dear Mr. Blanchard:

On **February 14, 2022,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **August 26, 2021,** have now been corrected effective **October 12, 2021.**

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

Sincerely,

Lisa Calvin

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

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
	AL5101	A. BUILDING: _____ B. WING _____	R-C 02/14/2022

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AZALEA GARDENS MEMORY CARE	3211 CHANDLER ROAD MUSKOGEE, OK 74403

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{C 000}	INITIAL COMMENTS A revisit was conducted on 02/14/22. All deficiencies from the 08/26/21 survey were cleared.	{C 000}		

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