

Delivery via email to: Pluker@12oaks.net; agm-ed@12oaks.net

May 1, 2023

License Number: AL5101

Ms. Paige Luker, Administrator
Azalea Gardens Memory Care
3211 Chandler Road
Muskogee, OK 74403

RE: Survey Event ID: Z9J511

Dear Ms. Luker:

On **April 27, 2023**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on April 27, 2023.

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

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at:

<http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,



Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER AZALEA GARDENS MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 A relicensure survey was conducted from 04/25/23 through 04/27/23. Listed below are the abbreviations that will be used throughout this document. Res - resident	C 000		
C 522 SS=D	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a 14 day assessment was completed within 14 days for one (#3) of eight residents whose assessments were reviewed. The "Entrance Conference Checklist" form documented 37 residents resided in the facility. Findings: Res #3 was admitted to the facility on 02/02/22 and had diagnoses which included glaucoma, hypertension, and Alzheimer's disease A preadmission assessment was completed on	C 522		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER AZALEA GARDENS MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 522	Continued From page 1 02/02/22. A 14 day assessment, dated 03/22/22, was completed outside of the of the 14 day timeframe. On 04/26/23 at 3:21 p.m., the administrator stated the 14 day assessment for Res #3 had not been completed in the required timeframe.	C 522		
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to utilize the assessment to develop the resident's care plan for one (#5) of eight residents whose records were reviewed. The "Entrance Conference Checklist" form documented 37 residents resided in the facility. Findings: Res #5 had a diagnosis of vascular dementia. A care plan, dated 07/09/22, revealed documentation Res #5 required minimum assistance with toileting and was occasionally	C 552		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER AZALEA GARDENS MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 552	Continued From page 2 incontinent. The care plan documented the resident required cueing and reminders with transfers and ambulation, was alert and oriented to situation, and had aggressive tendencies. The care plan documented the resident needed moderate help, such as laying out supplies and assist with brushing hair, teeth, and moderate assistance with bathing. A combined 14 day/significant change assessment, dated 07/22/22, documented the resident required 1-2 staff for bathing, dressing, transferring, toileting, and ambulation. The assessment documented the resident utilized a geri-chair, and had to be fed. The assessment documented the resident was non-verbal and experienced agitation. The assessment documented the resident received hospice services. On 04/25/23 at 4:45 p.m., the resident was observed sitting in a geri-chair and was unable to be interviewed. A family member of the resident was interviewed at that time and stated the resident was total care and unable to speak. They stated he ate a pureed diet and had to be fed. At 04/26/23 at 12:26 p.m. the administrator stated the resident's care plan was not up to date. The administrator confirmed the care plan documented the resident required reminders to use his cane was a minimum assist with toileting and was alert and oriented. The administrator stated this resident was not alert and oriented, was incontinent, and did not walk. On 04/27/23 at 12:09 p.m., the administrator stated the resident's significant change conducted on 07/22/22 was not used to ensure	C 552		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/27/2023
NAME OF PROVIDER OR SUPPLIER AZALEA GARDENS MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 552	Continued From page 3 his care plan was appropriate.	C 552		

Delivery via email to: PLuker@12oaks.net; agm-ed@12oaks.net

May 11, 2023

License Number: AL5101

Ms. Lauren Luker, Administrator
Azalea Gardens Memory Care
3211 Chandler Road
Muskogee, OK 74403

RE: Survey Event Z9J511

Dear Ms. Luker:

On **April 27, 2023**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 26, 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: 2023.05.11 16:19:13 -05'00'

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: 5/3/2023	
	Facility Name: Azalea Gardens Memory Care	
	License Number: 5101	
	Survey Event ID: Z9J511	
Date Survey Completed: 4/27/2023		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C522, C552	Based on: Refer to POC Template, Survey Event ID #:(Z9J511), Prefix Tag (C522) Refer to POC Template, Survey Event ID#:(Z9J511), Prefix Tag (C552).	
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 #1 and #3 charts audited quarterly by ED or designee to ensure service plans are accurately updated to reflect residents current level of care. ED or designee to audit charts monthly for 1 quarter to ensure 14-day assessments are completed within a 14 day time frame per OAC 310:663.
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?		ED or designee to conduct random audit of charts monthly for 1 quarter to ensure all service plans are kept up to date with the most accurate information reflecting the individual residents level of care or assistance.
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?		ED or designee to audit all new admissions within 14 day time frame to ensure all assessments and service plans are accurate reflecting residents level of care or assistance.
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.		ED or designee will conduct random audit of resident charts for 1 quarter during Quality Assurance Meetings to ensure accuracy for residents level of care or assistance, and for 1 quarter thereafter to ensure compliance. ED or designee to conduct random audit charts for to quarter ensure 14 day assessments, and service plans are accurate reflecting residents level of care or assistance. ED or designee to conduct random audit of resident charts for 1 quarter to ensure 14 day assessments, and service plans are accurate reflecting residents level of care or assistance. ED or designee will keep a log book of all new admissions, and ensure all assessments and service plans are created and kept up to date reflecting the individual residents level of care or assistance needed.
OSDH Response: Element accepted Yes ☐ No ☐		

5. On what date will corrective action be completed?		5/26/2023	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)		Date Enter a date of signature. 05/11/2023	
<i>Lauren Luker</i>			
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
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.			

Delivery via email to: PLuker@12oaks.net; agm-ed@12oaks.net

June 22, 2023

License Number: AL5101

Ms. Lauren Luker, Administrator
Azalea Gardens Memory Care
3211 Chandler Road
Muskogee, OK 74403

RE: Survey Event Z9J512

Dear Ms. Luker:

On **June 20, 2023**, an offsite/paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **April 27, 2023**, have now been corrected effective **May 26, 2023**.

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

Sincerely,



Lisa Calvin, Enforcement 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: AL5101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/20/2023
NAME OF PROVIDER OR SUPPLIER AZALEA GARDENS MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 An offsite/paper revisit was conducted on 06/20/23. The facility was in substantial compliance.	{C 000}		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE