OKLAHOMA
State Department
of Health

Delivery via email to: hgt-ed@12oaks.net; jbraun@12oaks.net

April 10, 2024

License Number: AL5101

Ms. Carla Gay, Administrator
Azalea Gardens Memory Care
3211 Chandler Road
Muskogee, OK 74403

Survey Event ID: PQ7311

Dear Ms. Gay:

On **March 26, 2024,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face to face, or a virtual meeting. The facility shall receive written confirmation of the IDR results.

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

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

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

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

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

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Azalea Gardens Memory Care**
Address: **3211 Chandler Road**
City, State, Zip: **Muskogee, OK, 74403**
Provider #: **AL5101**
Complaint #: **OK00063155**
Investigation Date(s): **03/25/24 and 03/26/24**

ALLEGATION(S)

The center failed to ensure residents were not physically, verbally, or psychosocially abused.
The center failed to ensure adequate supervision to prevent major falls with injury.
The center failed to ensure residents received adequate hydration.
The center failed to provide effective communication methods for residents' representatives.

An unannounced on-site investigation was initiated 03/25/2024 at 9:00 a.m.

A sample of four residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) 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 Summary of Complaint Investigation:
Upon entrance and throughout the survey residents were observed in their rooms and in common areas being assisted by staff. The staff interacted with the residents in a pleasant. Staff were observed offering snacks, drinks, and activities of daily living. An ice water container and snacks were observed on a table in the dining area and available all day. Residents stated they had their own drinks, but staff would provide drinks upon request. Staff stated drinks and snacks were offered twice a day between meals and was always available in the dining area. Residents denied care concerns or needs. The staff reported a problem with the main telephone system recently and an app was purchased to transfer call to the employee cell phones if not answered on main line. Residents were unaware of a problem regarding communication with the facility from family or outside sources. Resident contracts, service plan/care plans, physician orders, incident reports, and nurse notes were reviewed.

The attached CMS 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/27/2024

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 03/26/2024

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 A complaint investigation (#OK00063155) was conducted on 03/25/24 and 03/26/24. Facility Census: 21 Listed below are abbreviations that will be used throughout this document. CNA - certified nurse aide ED - executive director	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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 03/26/2024

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

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C1505	Continued From page 1	C1505		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview the facility failed to develop and implement fall prevention interventions for one (#1) of two residents reviewed for falls.

The ED identified nine residents who have fallen in the last three months.

A policy titled "RESIDENT FALL RESPONSE" documented "...All Direct Care staff should be trained in Resident Fall Response and shall respond in an appropriate and timely manner..."

Resident #1 had diagnoses which included acute kidney failure, bipolar disorder, dementia, and urinary tract infection.

An incident report, dated 06/09/23, documented the resident informed staff they had fallen in their apartment. The report documented the resident was assessed and sent to the emergency room for evaluation.

A nurse note, dated 06/14/23, documented the physician reviewed the residents medication due to dizziness being the cause of the fall.

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 03/26/2024

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
C1505	Continued From page 2 The current service plan detail/care plan for the resident, dated 07/24/23, documented the resident was a low potential for falls and to personalize interventions. Resident #1 had six falls from 06/09/23 to 03/20/24. The service plan detail/care plan was not updated with new interventions to prevent falls after each occurrence. On 03/25/24 at 2:00 p.m., CNA #1 stated staff make every two hour rounds to check on the residents in the facility. The CNA stated for resident #1 a fall mat was placed bedside the residents bed and reminded the resident to call for assistance when needed. On 03/25/24 at 3:15 p.m., an observation of two staff members providing toileting assistance for the resident was conducted. On 03/26/24 at 3:10 p.m., the ED reviewed the clinical records for resident #1. The ED stated new fall interventions were not documented or implemented for all resident falls.	C1505		

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Delivery via email to: hgt-ed@12oaks.net; jbraun@12oaks.net

April 16, 2024

License Number: AL5101

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

Survey Event ID: PQ7311

Dear Ms. Braun:

On **March 26, 2024,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 12, 2024**.

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,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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: 4/12/2024** **Facility Name:** Azeala Gardens Memory Care **License Number:** AL5101 **Survey Event ID:** PQ7311 **Date Survey Completed: 3/26/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505 SS=E	Based on: This requirement is not met as evidenced by: Based on observation, record review, and interview the facility failed to develop and implement fall preventions for one (#1) of two residents reviewed for falls.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Azaela Garden Memory Care appreciates the survey that was conducted on 3/26/2024 and the continued partnership with Oklahoma State Department of Health.

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?	C1505: Executive Director or Designee will conduct random audits on incident reports related to falls, fall care plans and interventions on all residents for falls for 30 days to ensure appropriate interventions have been implemented for falls. All staff have been in-serviced on resident fall response policy, resident rights, abuse, neglect and exploitation policy and resident care director and executive director have been in-serviced on fall care plans and interventions. Incident reports related to falls, fall care plans and fall interventions will be reviewed monthly and quarterly thereafter.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	C1505: Executive Director or Designee will conduct random audits on incident reports related to falls, fall care plans and interventions on all residents for falls for 30 days to ensure appropriate interventions have been implemented for falls. All staff have been in-serviced on resident fall response policy, resident rights, abuse, neglect and exploitation policy and the resident care director and executive director has been in-serviced on fall care plans and fall interventions. Incident reports related to falls, fall care plans and interventions will be reviewed monthly and quarterly thereafter.
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?	C1505: Executive Director or Designee will conduct random audits on incidents reports related to falls, fall care plans and interventions on all residents for falls for 30 days to ensure appropriate interventions have been implemented for falls. All staff have been in-serviced on resident fall response policy, resident rights, abuse neglect and exploitation policy and resident care director and executive director have been in-serviced on fall care plans and fall interventions. Incident reports related to falls, fall

	care plans, and interventions will be reviewed monthly and quarterly thereafter.
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 on fall related incident reports, fall care plans and interventions to establish 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 Quality Assurance meetings to ensure continued compliance. Community will set up a falls binder with random audits conducted for review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/12/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Jennifer Braun-Administrator OAC 310:663-25-4(F)	**Date 4/12/2024**

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
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of Health

Delivery via email to: jbraun@12oaks.net; tgm-ed@12oaks.net

June 3, 2024

License Number: AL5101
Survey Event ID: PQ7312

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

Dear Ms. Braun:

On **May 21, 2024**, a complaint revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **March 26, 2024,** have now been corrected and your facility is in compliance with licensure standards effective **May 12, 2024**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5101	A. BUILDING: _____ B. WING _____	R-C 05/21/2024

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 A revisit was conducted on 05/21/24. All deficiencies from the 03/26/24 survey were cleared	{C 000}		