Oklahoma State Department of Health
Creating a State of Health

October 2, 2019

License Number: AL5520

Ms. Kara Bolino, Administrator
Timberwood Assisted Living & Memory Care
5020 Southeast 44th Street
Oklahoma City, OK 73135

RE: Survey Event ID: 52M811

Dear Ms. Bolino:

Enclosed is a report of the inspection conducted at your Assisted Living Center on **September 23, 2019.** No deficiencies were cited. Oklahoma Statutes 63-1-1910 require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Timberwood Assisted Living and Memory Care**
Address: **5020 Southeast 44th Street**
City, State, Zip: **Oklahoma City, OK 73135**
Provider #: **AL5520**
Complaint #: **OK00053964**
Investigation Date(s): **09/19/19 and 09/23/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure the resident's rights were not violated.	US
2. The center failed to provide contracted services.	US

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

An unannounced on-site investigation was initiated on Thursday, September 19, 2019 at 8:58 a.m.

A sample of 8 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 statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, 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 confidentiality was conducted.

On 09/19/19 at 10:00 a.m. during report and record review with the registered nurse there were no resident's identified as having a diagnosis of Parkinson's disease with Lewy body dementia at the time of the survey.

On 09/23/19 residents were asked about care plan meetings with family and confidential personal information. No resident was concerned or complained about the contents of the care plan meetings. No staff or resident had any concerns or complaints about residents with sexual behaviors.

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

An investigation specific to housekeeping was conducted.

On 09/19/19 at 9:06 a.m. a tour of the center was completed. There were no dirty floors or trash in rooms observed.

On 09/23/19 residents were asked about housekeeping. They stated they had no concerns or complaints. The sampled resident's rooms were observed to be clean, tidy and swept.

At 3:45 p.m. the executive director (ED) was asked about housekeeping. The ED stated there had been turnover during previous months, but always had it covered since the staff pulls trash from residents rooms each shift. . The housekeeping schedule had been reviewed and each resident had an assigned day with housekeeping.

Determination Summary and Follow-Up Action:

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

Deficient practice was unsubstantiated for allegation 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.

M Swaim RN

Melissa Swaim RN

Jennifer Major RN

Date report completed: 09/24/2019

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
	AL5520	A. BUILDING _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERWOOD ASSISTED LIVING & MEMORY	5020 SOUTHEAST 44TH STREET OKLAHOMA CITY, OK 73135

(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 re-licensure survey was conducted on 09/19/19 and 09/23/19, in conjunction with complaint #OK00053964. Resident census was 45. No deficient practice was cited.	C 000		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL5520	TIMBERWOOD ASSISTED LIVING & MEMORY CARE

Type of Survey (select all that apply)

2	3			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. MS 34460	09/19/2019	09/23/2019	0.75	0.00	14.50	0.00	4.25	1.25
2. DM 42023	09/19/2019	09/23/2019	1.50	0.00	15.00	0.00	2.50	2.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

OCT 03 2019