OKLAHOMA
State Department
of Health

Delivery via email to: kbolino@seniorlifestyle.com

July 7, 2021

License Number: AL5520

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

Survey Event ID: EFK011

Dear Ms. Bolino:

On **June 4, 2021,** 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 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.

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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

OKLAHOMA
State Department
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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,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.07.07 11:20:19 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Timberwood AL and MC**
Address: **5020 SE 44th St**
City, State, Zip: **Oklahoma City, OK 73135**
Provider #: **AL5520**
Complaint #: **OK00056854**
Investigation Date(s): **04/01/21, 05/11/21-05/13/21 and 06/04/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have and/or implement their abuse policy.	**S**
2. The center failed to provide medical care and services according to resident contracts and safe environment.	**US**

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

An unannounced on-site investigation was initiated on Thursday, April 1, 2021 at 12:25 p.m.

A sample of 3 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 C1951 and C1971 for details.

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

An investigation specific to contracted services and environment was conducted. Documentation in relation to falls with injury was provided. At the time of survey, no resident or family member complained about medical care or services provided. Hospice provided services as contracted.
Resident rooms were observed. They were neat and tidy throughout the survey. Monthly documented pest control services were provided. No resident or family member complained about bugs, mice, laundry, carpet, housekeeping or exterior doors, at the time of survey.

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.

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.

Melissa Swaim by Pam Anderson

Melissa Swaim RN

Date report completed: 06/11/2021

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Timberwood AL & MC**
Address: **5020 SE 44th St**
City, State, Zip: **OKC, OK 73135**
Provider #: **AL5520**
Complaint #: **OK00056855**
Investigation Date(s): **04/01/21, 05/11/21-05/13/21 and 06/04/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to have and/or implement their abuse policy.	S

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

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A sample of 3 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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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 C1951 and C1971 for details.

Determination Summary and Follow-Up Action:

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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 By Pam Anderson

Melissa Swaim RN

Date report completed: 06/04/2021

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 _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERWOOD ASSISTED LIVING & MEMORY CARE	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 On 04/01/21, 05/11/21 through 05/13/21, and 06/04/21 the Oklahoma State Department of Health conducted a complaint investigation, for complaints #OK00056854 and #OK00056855, and completed a COVID-19 Focused Survey to determine if the center was in compliance with implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. Total Residents: 45	C 000		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure organized and accurate clinical records, with updated assessments and care plans for three (#1, 2 and #3) of three sampled residents who exhibited sexual behaviors or decline in cognition or health. This has the potential to affect all 45 residents who resided in the facility. Findings: 1. Resident #1 admitted to the facility on 10/05/17 with diagnoses which included hypothyroidism, hyperlipidemia, coronary artery disease, hypertension (HTN) and memory loss	C1951		

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C1951	Continued From page 1	C1951		

with a history of depression. She was alert and confused at times with good judgement. She had good mobility, strength and gait using a walker with staff assistance. She was independent with her activities of daily living. She had bladder incontinence at times and she was continent of bowel.

An assessment, dated 11/01/19, documented she had been transferred back to assisted living with additional diagnoses to include dementia, congestive heart failure (CHF), insomnia, osteoarthritis, shoulder pain, back pain, leg pain, agitation and tobacco use with a history of urinary tract infections. The assessment documented undergarment protectors were used and she required assistance with perineal care when her undergarments became soiled.

The assessment further documented to offer toileting before and after meals and activities. The resident was not independent with mobility. She used a walker with ambulation as needed. The resident required reminders to use her walker. She required supervision/assistance with all transfers. She exhibited disturbed thought processes related to loss of memory. She had an inability to process thought accurately and correctly, changes may indicate progressive decline in underlying condition.

The assessment documented to observe and report to licensed staff any situation that endangers her safety as the resident may not understand the consequences of her actions. The assessment documented to observe and report to license staff any situation where the resident can easily be taken advantage of or cannot protect self.

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C1951	Continued From page 2 The assessment section documented: she was alert and oriented times 1-2 (person and place). She had moderate impairment including a current or history of occasional disorientation to person, place, time or situation even in familiar surrounding and she required supervision and oversight for her safety. Also she had a current or history of frequent or difficulty remembering and using information; required directions and reminding from others; cannot follow written instructions. She had good functional status, full range of motion, and a history of falls. She was a one person assist with ambulation and bathing. She needed meal set up with cueing. She was continent of bladder (stress incontinence) and bowel with the use of adult briefs. A physician's note, dated 02/06/20, documented the resident was incontinent. There was a care plan/service plan, dated 04/23/20, but without a completed assessment. The care plan would be developed from the assessment. An incident report, dated 05/10/21, documented the resident was found outside in the smoking area sitting upright on her buttock, complaining of intense pain to her lower back. She was ambulating back into the building when she lost her footing and fell to the ground on her buttock. The resident was transported to the emergency room (ER). She returned from the hospital with a lumbar compression fracture L3, superior endplate. A physician's note, dated 11/23/20, documented the resident's dementia was moderate in severity.	C1951		

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C1951	Continued From page 3 A physician's note, dated 12/03/20, documented the resident declined from moderate severity to severe and was progressively worsening. An incident report, dated 01/10/21, documented, the resident was found on dining room floor with walker laying on top of her beside her chair. Right knee had redness, edema and resident (#1) cried out in pain when knee was manipulated, bruising to dorsal side of left hand. The resident was transferred to the ER. She had stood from her dining room chair, lost her footing and fell to the floor. She returned from the hospital with a right knee fracture. New order for a wheelchair and non weight bearing of right lower extremity. The resident's assessment or significant change assessment or care plan was not updated. An incident report, dated 03/25/21, documented, the resident was found on the floor of her apartment in front of her bathroom. The resident had pain to her right ankle. An x-ray report documented an acute comminuted fracture of the distal shaft of the fibula and acute oblique fracture distal shaft of the tibia with displacement and angulation. The resident was sent to the emergency room for further evaluation which required surgery. There was no documentation if the center could accommodate the residents needs after such an injury or repair of injury. On 05/13/21 at 6:00 a.m., an employee was asked about resident #1. She stated the resident had done everything on her own. She was a smoker. She moved in slow motion, but was able using a walker at first. She stated the staff checked on her to make sure she was dry and when she was in the smoking area. Then she	C1951		

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C1951	Continued From page 4	C1951		

had falls (January 2021 fall with injury). She didn't get around that well any longer. She wore a boot and needed two people to assist her. She still used her arms and thought she could get out of bed and she would try herself.

She was asked if the resident had a sexual relationship with any one. She stated she was pretty they (male residents) probably look at her, but no. She stated resident #2 liked her (resident #1), but I don't think she realized it. He walked using a walker and he couldn't do anything if he wanted.

At 7:35 a.m., an employee was asked about resident #1. She stated she (resident #1) was a two person assist for transfers. She stated she had not seen her walk since the last fall (Jan 2021), but she tried to get up on her own, but she was too weak to walk so fell. She was not cognitive enough to ask for assistance.

At 7:49 a.m., an employee was asked about the resident. She stated at first she had walked, but after she had fallen (with injury Jan 2021) she no longer walked and was a now a two person assist with dressing, transfers and toileting due to the boot.

At 10:47 a.m. the administrator was asked about the resident. She stated the resident had been independent, a smoker, used a walker to ambulate prior to a fall with injury in January 2021. She stated after the fall with injury she started to decline, used a wheelchair, didn't like the brace she wore. She stopped smoking. She didn't remember (she had smoked) or asked (to smoke).

The administrator stated, October or November

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C1951	Continued From page 5 2020 a staff (not named) reported to her resident #2 was in resident #1's room with his hands down her pants. She stated when she got to the room the residents were fully clothed, sitting side by side on the bed and his hands were not down her pants. When she was asked if there was any documentation she stated, "I don't think I documented it. No." There was no documentation about the sexual contact. She stated the residents were independent and could make those decisions. Resident #1 admitted 10/05/17 to assisted living and on 10/24/17 she was transferred to the memory care unit, but there was no documentation with the reason she was moved to memory care. She was moved back to assisted living on 11/01/19 without a documented reason. Her assessment was dated 11/01/19 her care plan/service plan in her chart was dated 04/23/20. The assessment should be used to update the care plan/service plan. On 05/13/21 at 9:23 a.m. the nurse was asked about the lackk of current documentation including a significant change assessment and care plan. She stated once a resident was taken out of the computer system she did not know how to recover the clinical record documentation including assessments and care plans. She stated her assessment and care plan were not accurate. She stated the residen had a fracture (Jan 2021) and could no longer walk, wore a brace and continued to decline and was placed on hospice services. 2. Resident #2 admitted to the facility on 12/27/19 with diagnoses which included chronic kidney disease (CKD) stage 4, pacemaker, seizure disorder, gastroesophageal reflux disease	C1951		

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C1951	Continued From page 6	C1951		

(GERD), left hip pain and rheumatoid arthritis. He had fair mobility, strength and gait using a walker independently. He did not require supervision. he had impaired hearing/decreased hearing and required hearing aides to bilateral ears. He had signs of slight memory loss. He was alert and oriented x 4 (person, place, time and situation.) He needed a one person assist with bathing and dressing. He had a history of abnormal behaviors only agitation was noted. He was continent of both bladder and bowel with use of adult pull up/protective underwear. He did not have disruptive/socially inappropriate behavior.

An assessment, dated 12/27/19 documented the resident was alert and oriented x 2 (person and place) with a mild neurocognitive impairment with occasional disorientation to person, place, time and situation with occasional difficulty remembering and using information. He did not exhibit issues with self-awareness, victimization or exploitation. He did not have verbal or socially inappropriate behaviors.

A care plan/service plan, dated 08/05/20, documented psychosocial: resident does not have current or history of issues with self-awareness, victimization or exploitation. Resident does not have current or history of verbal or socially inappropriate behaviors.

An assessment, dated 02/10/21, documented the resident was alert and oriented x three (person, place and situation). He exhibited good judgement, did not have issues with self-awareness, vitimization, exploitation, verbal or socially inappropriate behaviors. He had forgetful at times with good judgement.

A care plan/service plan, dated 02/10/21,

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C1951	Continued From page 7	C1951		

documented he had a current or history of frequent difficulty communication and receiving information and could not follow instuctions. He had a severe hearing impairment.

A physician review, dated 04/28/21, documented additional diagnoses to include CHF, age related memory loss and diabetes mellitus.

On 05/13/21 at 6:25 a.m., an employee stated the resident loved women. She stated he was outspoken and blunt and he would ask female residents if they were sexually active. He would ask if they liked to have sex. He was instructed he wasn't to ask her (resident #1).

At 8:38 a.m., an attempt to interview resident #2 was made, but he was very hard of hearing.

On 06/04/21 at 8:10 a.m., an employee was asked about the resident. She stated he was a man who had a (sexual) need or sexual desire. She stated at some point she was told to watch the resident, because he'd been seen knocking on resident #1's door. She stated she had a conversation with resident #2 and told him to stay away from resident #1, because she can't give consent and he had a girlfriend. He stated, I didn't know she couldn't consent. She stated he was forgetful and didn't remember. She stated the morning shift caught them kissing, but resident #1 wasn't all there (cognitively.) She stated his conversation was filthy.

Resident #2's last care plan (service plan) was dated 08/05/20 without an updated assessment dated 12/27/19. The assessment should be used to update the care plan/service plan. The care plan would be developed from the assessment.

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TIMBERWOOD ASSISTED LIVING & MEMORY CARE	5020 SOUTHEAST 44TH STREET OKLAHOMA CITY, OK 73135

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C1951	Continued From page 8 On 06/04/21 at 11:31 a.m., the nurse was asked about resident #2's assessment and care plan. She stated, "The sexual stuff. No, I didn't put any of that in there." She stated she understood why documentation which was unique to each individual would be important. 3. Resident #3 admitted to the facility on 09/18/18 with diagnoses which included hypertension, glaucoma and GERD. She was alert and oriented x two (person, place), forgetful with good judgement. She had good mobility, strength, and gait without assistance. She was independent with her activities of daily living. She was continent of both bladder and bowel. There were no changes to her assessment dated 03/25/20. There was a care plan, dated 06/25/20, but no assessment. The care plan would be developed from the assessment. An assessment, dated 05/03/21, documented a mild impairment to her neurocognitive status with a current or history of occasional disorentation to person, place, time or situation. Also, occasional difficulty remembering and using information. On 05/13/21 at 2:46 p.m, resident #3 was asked about resident #2. She stated they were together a little while. She stated he'd say, "Oh come on, don't be a fuddy duddy." She stated she told him no and he stopped. All three residents had power of attorney's (POA). There was no documentation provided any POA had been notified of behaviors or incidents between the residents. There were no physician progress notes, no nurses notes, no	C1951		

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 _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERWOOD ASSISTED LIVING & MEMORY CARE	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
C1951	Continued From page 9 current or updated assessments or care plans addressing the behavior or decline in cognition or health.	C1951		
C1971 SS=D	310:663-19-4(b) POLICIES (b) The administrator of the assisted living center who becomes aware of abuse or neglect of a resident or misappropriation of a resident's property shall immediately act to rectify the problem and shall make a report of the incident and its correction to the Department. This Rule is not met as evidenced by: Based on interview and record review, it was determined the administrator failed to identify, investigate and report to the OSDH (Oklahoma State Department of Health) allegations of sexual abuse, including suspected resident to resident abuse for two (#1 and #2) of two sampled residents after being aware of sexual contact/allegation of sexual abuse. This had the potential to affect at 45 residents who resided in the facility. Findings: On 05/13/21 at 10:47 a.m., the administrator stated, October or November 2020 a staff (not named) reported to her resident #2 was in resident #1's room with his hands down her pants. She stated when she got to the room the residents were fully clothed, sitting side by side on the bed and his hands were not down her	C1971		

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 _____	06/04/2021

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

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C1971	Continued From page 10	C1971		

pants. When she was asked if there was any documentation she stated, "I don't think I documented it. No." There was no documentation about the sexual contact. She stated the residents were independent and could make those decisions.

On 06/04/21 at 11:58 a.m., the administrator was asked if there were any other time resident #2 was in resident #1's room or had sexual contact with her. She stated, "No other time. That was the only time anyone said anything." She was asked if there was any reason it wasn't investigated. She stated, no, when I went down (to her room) they weren't doing anything. I just assumed they were consenting adults. They were of sound mind. They knew what they were doing. She stated she did ask her if she was okay and she stated she was fine. She further stated we just re-directed them both and went to dinner (the dining room.)

The administrator further stated she did not feel it was her job to interrupt or tell them they can't. She stated she did'nt want to take away their right to do something they're okay with.

No documentation was provided to indicate a complete investigation had been conducted to determine if there was involvement with other residents and no incident report was provided.

A facility policy, dated reviewed 03/22/2021 "Abuse & Neglect Reporting Policy" Including suspected/confirmed Resident-Resident Abuse, documented, this policy will ensure that proper reporting procedures are followed when a case of abuse, neglect or exploitation is reported. All cases of confirmed or suspected cases of resident abuse will be immediately reported to the

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 _____	06/04/2021

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

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C1971	Continued From page 11	C1971		

corporate office via Significant Event Call Line and Incident Reporting policies and procedures.

Sexual Abuse----the infliction of sexual contact upon a person by forcible compulsion, or the engaging in sexual contact with a person who is below a specific age or who is incapable of giving consent because of age or mental or physical incapacity.

The act of alleged abuse, neglect or exploitation must be reported within the first 24-hours or the next business day, either written or orally, to the local Long Term Care Ombudsman Program Office and the appropriate state office which will investigate reports of alleged abuse, neglect, and exploitation. It is recommended by the Long Term Care Ombudsman Program that statements be taken from residents, caregivers or witnesses.

Procedure:
1. Immediately notify the Executive Director (ED) of the issue and/or incident.
2. Notification to the Significant Event Line immediately upon learning of issue/concern. The Risk team will establish a group call which may include: ED, Business Office Manager (BOM)/Human Resources (HR), Regional HR, Divisional Director of Health and Wellness (DDHW), Regional Director of Operations (RDO), Vice President of Operations (VPO), Vice President Clinical Services (VPCS), Corporate Director of Risk Management, and others as needed.

The investigation of any act of abuse, neglect or exploitation should include the following:
*Notification of the incident to the ED, including the date and time the notification occurred.
*The date the investigation of the incident began.

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 _____	06/04/2021

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

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C1971	Continued From page 12 *Record of statements or interviews of all involved. May include: residents, staff and family members, etc. *Any documentation pertaining to the incident. *If an injury was sustained due to the incident and the examination report of the resident. *Documentation of any follow-up examinations. *Documentation of steps taken to protect a resident from further harm. *Action plan and correctives action taken, such as notification of the Long Term Care Ombudsman, State licensure authorities and other agencies. * Report suspected and/or confirmed case of resident abuse, neglect or financial exploitation to the corporate office by call the Significant Event Call Line for your region and submitting an incident report. Resident-To-Resident Incidents: 1. The attending physician of both residents must be notified of the incident, and an order for a psychological or psychiatric evaluation and treatment will be requested as appropriate for both residents involved. 2. The family member/responsible party of both residents must be notified. 3. Both residents should be monitored closely for an appropriate length of time necessary to determine if the abusive resident presents a risk of causing/inflicting further harm or abuse. 4. If necessary, steps will be taken to discharge the abusive resident to a different care setting. Prevention-Protection The abuse policies and procedures of this community are developed to promote a safe living environment for all residents. Residents must not be subjected to abuse, neglect, or mistreatment by anyone, including, but not limited to facility or agency staff, other residents, family members or	C1971		

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 _____	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERWOOD ASSISTED LIVING & MEMORY CARE	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
C1971	Continued From page 13 other visitors. Prevention of abuse/neglect requires the involvement of all staff to monitor, observe, intervene, and report any behaviors/situations that may lead to conflict or neglect.	C1971		

OKLAHOMA
State Department
of Health

Delivery via email to: kbolino@seniorlifestyle.com

July 26, 2021

License Number: AL5520

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

Survey Event ID: EFK011

Dear Ms. Bolino:

On **June 4, 2021,** a complaint investigation and a COVID focus 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 **August 31, 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: 2021.07.26 12:20:57 -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: 7/21/2021** **Facility Name:** Timberwood **License Number:** AL 5520 **Survey Event ID:** EFK011 **Date Survey Completed: 6/4/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1951	Based on: interview and record review, it was determined the facility failed to ensure organized and accurate clinical records, with updated assessments and care plans for three (# 1, 2 and 3) of three sampled residents who exhibited sexual behaviors or decline in cognition or health.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community regarding the alleged statements or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared soley as a matter of compliance with State and/or Federal Law.

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?	Care plans for residents # 2 & 3 have been updated to reflect that these residents exhibited sexual behaviors and or a decline in cognition or health. Resident # 1 no longer resides in the community, therefore an updated care plan for resident # 1 is no longer needed.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Care plan meeting to be held monthly with HWD and Administrator to discuss all care plans that are due for the upcoming month. In addition, HWD and Administrator will review and discuss all other residents to assess if there is a need for any changes to their Care Plan given they have had a change in condition.
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?	Care plan meeting to be held monthly with HWD and Administrator to discuss all care plans that are due for the upcoming month. In addition, HWD and Administrator will review and discuss all other residents to assess if there is a need for any changes to their Care Plan given they have had a change in condition.
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.	Enter methods to ensure corrections are sustained: a. HWD will report in QA meeting status updates for each month's residents scheduled assessments. b. QA committee will discuss under Clincial and Resident Care Issues from QA meeting Minutes. c. QA committee will document on QA meeting minutes agenda. Completed QA meeting minutes are kept in the Administrator's office for review.

OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/31/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Kara Bolino	**Date 7/21/2021**

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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/21/2021** **Facility Name:** Timberwood **License Number:** AL 5520 **Survey Event ID:** EFK011 **Date Survey Completed: 6/4/2021**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1971	Based on: interview and record review, it was determined the administrator failed to identify, investigate and report to the OSDH (Oklahoma State Department of Health) allegations of sexual abuse, including suspected resident to resident abuse for two (#1 and # 2) of two sampled residents after being aware of sexual contact/allegation of sexual abuse.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Responses to the cited deficiencies do not constitute an admission or agreement by the community regarding the alleged statements or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared soley as a matter of compliance with State and/or Federal Law.

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 #1 is no longer a resident of the community and therefore will no longer be affected by this deficient practice. Resident # 2 will be monitored and staff will be interviewed radomally to inquire if they have seen any signs/actions of a sexual nature. Resident # 2 recently had a significant change of condition and any signs/actions of a sexual nature that were previously displayed/witnessed appear to have ceased.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Training to be held with staff to discuss the reporting of any witnessed behaviors being exhibited/displaying any type of sexual behavior, either through their words or actions. In addition, Administrator to review and re-train on Abuse & Neglect Reporting Policy Including suspected/confirmed Resident-Resident Abuse.
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?	QA committee will discuss under Clincial and Resident Care Issues any issues/concerns that have been witnessed and reported to ensure the abuse & neglect reporting policy including suspected/confirmed resident-resident abuse was followed correctly and all reporting practices executed.
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;	Enter methods to ensure corrections are sustained: a. QA committee will review and discuss and concerns that have been witnessed and reported and will discuss that the required policy and procedures regarding such matters was followed. b. QA committee will discuss any witnessed and reported

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.	incidents with the policy and procedure in hand to ensure all requirements were executed. c. QA committee will document on QA meeting minutes agenda. Completed QA meeting minutes are kept in the Administrator's office for review.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	8/31/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Kara Bolin	**Date 7/21/2021**

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: mshrum@homesteadofdelcity.com

December 19, 2022

License Number: AL5520

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

RE: Survey Event EFK012

Dear Ms. Shrum:

On **December 14, 2022,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **June 4, 2021,** have now been corrected effective **August 31, 2021.**

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

Sincerely,

Lisa Calvin

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL5520	A. BUILDING: _____ B. WING _____	R-C 12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD OF DEL CITY	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 revisit was conducted on 12/14/22. The facility was in compliance.	{C 000}		

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