



Oklahoma State Department of Health
Creating a State of Health

July 3, 2019

License Number: AL5543

Mr. Michael Hunter, Administrator
Autumn Leaves Of Southwest Oklahoma City
2232 Southwest 104th Street
Oklahoma City, OK 73159

RE: Survey Event ID: IFPV11

Dear Mr. Hunter:

On **June 11, 2019**, 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.

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;

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- (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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

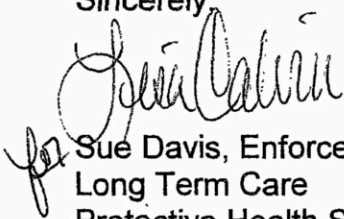
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,



Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure



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FROM:

Oklahoma State Dept. of Health
Protective Health Services - LTC
1000 NE 10th St
Oklahoma City OK 73117-1299

TO:

Mr. Michael Hunter, Administrator
Autumn Leaves Of Southwest Oklahoma City
2232 Southwest 104th Street
Oklahoma City, OK 73159



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5543	(X2) MULTIPLE CONSTRUCTION A BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED 06/11/2019
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF SOUTHWEST OKLAHOM		STREET ADDRESS, CITY, STATE, ZIP CODE 2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159		
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N 000	Initial Comments A re-licensure survey was conducted 06/03/19, 06/04/19, 06/10/19 and 06/11/19. Resident census was 39. Deficient practice was cited as follows.	N 000		
N1405 SS=E	310:677-13-6 (b) Competency and Practice Standards Each certified medication aide shall: (1) Comply with 63 O.S. Section 1-1950.3 (E) and OAC 310:677-13; (2) Perform within authorized duties; (3) Follow written instructions of a licensed nurse or physician; and (4) Accurately record medications administered, withheld or refused.	N1405		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

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N1405	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record it was determined the center failed to ensure edema and the amount of edema was documented daily by qualified staff for 2 (#2 and #5) of 8 residents. This failed practice resulted in the potential for more than minimal harm, at a pattern. Findings: On 06/04/19 at 2:03 p.m. during review of the June medication administration record (MAR) employee #2 was asked about checking for edema and recording the amount. Employee #2 stated, I poke on the ankles and legs. If there's indentions it means edema and resident was carrying fluid. On 06/10/19 at 1:50 p.m. during review of the June MAR employee #6 was asked about checking for edema and recording the amount. Employee #6 stated, we would put a percentage on the MAR. On 06/11/19 at 8:05 a.m. during review of the June MAR employee #1 was asked about checking for edema and recording the amount. Employee #1 stated, they would check to see if any extra fluid was on the body. At 8:52 a.m. during record review, the registered nurse (RN) was asked how the certified medication aids determined the amount of edema. The RN stated, just like anyone would; plus one, plus two, plus three.	N1405		

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N1429	Continued From page 3 more than minimal harm, at a pattern. Findings: Resident #9 Resident #9 had diagnoses to include vascular dementia and hypertension (HTN). The April 2019 physician orders documented, three routine blood pressure medications were discontinued. The clonidine was changed to 1 tablet twice a day prn for systolic b/p greater than 165 or diastolic b/p greater than 100. The April 2019 medication administration record (MAR) documented 24 times resident #9 required the prn clonidine. There were 22 missing follow-up blood pressures. There was no documentation provided the physician had been notified of the 24 elevated blood pressures. The May 2019 MAR documented 35 times resident #9 required the prn clonidine. There were 22 missing follow-up blood pressures. There was no documentation provided the physician had been notified of the 35 elevated blood pressures. The June 2019 MAR documented 8 times resident #9 required the prn clonidine. There were 5 missing follow-up blood pressures. There was no documentation provided the physician had been notified of the 8 elevated blood pressures. On 06/10/19 at 10:13 a.m. the resident stated she was nauseous. Resident #5 Resident #5 had diagnoses to include alzheimer's	N1429		

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N1429	Continued From page 4 and HTN. The April 2019 physician orders, documented clonidine to be given prn for systolic b/p greater than 180. The April 2019 MAR documented 9 times resident #5 required the prn clonidine. There were 9 missing entries the medication had been given. The June 2019 MAR documented 1 time resident #5 required the prn clonidine. There was a missing entry the medication had been given. On 06/11/19 at 9:02 a.m. during record review with the registered nurse (RN). The RN was asked about the missing documentation. The RN stated the medication was not documented to have been given.	N1429		
C 000	INITIAL COMMENTS A re-licensure survey was conducted 06/03/19, 06/04/19, 06/10/19 and 06/11/19. Resident census was 39. Deficient practice was cited as follows.	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements;	C 391		

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C 391	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview, it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations by not testing the chemical sanitizer concentration of the dish machine utilizing the required test strips. This had the wide spread potential for more than minimal harm for all 39 residents who ate food prepared by the centers kitchen. Findings: 310:257-7-77 Warewashing equipment, determine chemical sanitizer concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. On 06/03/19 at 9:18 a.m. a tour of the kitchen was conducted. During record review, there was no variation of dish machine temperatures or ph for the month of April 2019. They all recorded daily, three times a day the temperature was 130 and the ph 50. The month of June had no recorded temperatures or ph of the dish machine sanitizer. On 06/04/19 at 9:10 a.m. the cook ran the dish machine. The temperature was 120 degrees and there was no result on the test strip. The test strips had expired April 2018. No other test strips were located in the kitchen.	C 391		

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C 391	Continued From page 6 The center's policy, titled, "Cleaning", documented, "Dishes and utensils will be cleaned and sanitized after each use. Dishwasher sanitizer levels will be checked and documented three times daily."	C 391		
C 911 SS=G	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a registered nurse (RN): - assessed, monitored and followed up on 1 (#9) of 1 resident with repeated abnormally high blood pressures from April 2019 to June 2019 - supervised and verified the administration of prn antihypertensive medication used to treat the high blood pressure - reviewed clinical documentation to make certain the staff administered the medication as ordered and required on an as needed basis (prn) - notified the physician of abnormal blood pressure readings repeatedly requiring prn medication. - delegated medication administration to staff	C 911		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AUTUMN LEAVES OF SOUTHWEST OKLAHON

**2232 SOUTHWEST 104TH STREET
OKLAHOMA CITY, OK 73159**

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C 911	Continued From page 7 competent to administer prn medication according to physician orders, document blood pressure readings and rechecking blood pressure after medication administration. This failed practice resulted in isolated actual harm to resident #9 for continued uncontrolled hypertension. Findings: Resident #9 has physician orders (ordered 4/2/19) to monitor blood pressure twice daily at 8 a.m. and 4 p.m. If the systolic blood pressure is more than 165 mm/hg or diastolic blood pressure is more than 100 mm/hg, the resident is to be administered clonidine hcl, 0.1 mg tablet, orally, two times a day, dependent on the blood pressure. April 2019 medication administration record (MAR) documented resident #9 frequently has high blood pressures. Following is only a representative sample of the elevated blood pressure findings documented in April 2019. Clonidine prn was documented as administered 20 times in April 2019. Clonidine was indicated a minimum of 24 times in April for elevated blood pressures. Rechecks after administration of clonidine was only documented 3 times. It was very difficult to read the blood pressure readings on the April MAR or determine if the prn medication was effective: April 02 - 4:00 BP 168/131, recheck after administration of clonidine was 133/110 - no indication physician was notified April 06 - 4:00 BP 157/120, no recheck after administration of clonidine April 08 - 4:00 BP 194/103, no recheck after administration of clonidine April 09 - 8:00 BP 168/96, no recheck after	C 911		

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C 911	Continued From page 8 administration of clonidine April 09 - 4:00 BP 190/94, no recheck after administration of clonidine April 11 - 8:00 BP 192/79, no medication documented as administered April 11 - 4:00 BP 148/101, no medication documented as administered April 12 - 8:00 BP 160/97, medication administered and not indicated by blood pressure reading, no recheck April 15 - 4:00 BP 191/137, no medication documented as administered April 16 - 8:00 BP 187/128, no recheck after administration of clonidine April 17 - 8:00 BP 146/106, no recheck after administration of clonidine April 25 - 8:00 BP 212/102, no recheck after administration of clonidine April 28 - 4:00 BP 146/106, no medication documented as administered May 2019 MAR: Resident #9 required clonidine prn a minimum of 35 times in May 2019 for elevated blood pressure readings. Clonidine was only documented as administered 25 times. The residents blood pressure was rechecked after the clonidine was administered only 14 times. It was difficult to read the documentation and the majority of blood pressure readings could not be determined. Clonidine was administered on 5/7/19 when it was not indicated. June 2019 MAR: Resident #9 required Clonidine prn a minimum of 8 times from June 1 through June 10th. It was documented as administered only 7 times. Blood pressures were rechecked 5 times and 2 times it was not effective. On June 6, no blood pressure was recorded, but the resident was administered	C 911		

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C 911	Continued From page 9 another prn medication because the resident was vomiting. On June 9 the 8a.m. blood pressure was 236/132; the blood pressure recheck was recorded as 217/109. The resident was administered a prn medication for vomiting because the resident was again vomiting. The 4:00 blood pressure was 215/109. The recheck was 177/102. There was no indication the physician was notified of the continued hypertension and ineffective prn medication. On 06/04/19 at 1:30 p.m. the resident stated blood pressures ran high and he would wake up with headaches. On 06/10/19 at 10:13 a.m. the resident stated he had nausea and hadn't been feeling well throughout the weekend On 06/11/19 at 8:31 a.m. during record review with the registered nurse (RN), the RN stated blood pressures were reported to the physician, but there was no documentation. It was noted in the clinical record the last physicians order change for the hypertensive medication was 4/2/19 and the residents blood pressure readings continue to be above the physician ordered parameters. It was documented the RN completed a monthly medication review of medications, but the RN failed to document the continued abnormal blood pressure reading or notify the physician of the continued hypertension for over two months.	C 911		
C1505 SS=G	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be	C1505		

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C1505	Continued From page 10 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		

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C1505	Continued From page 12 The April 2019 medication administration record (MAR) documented 24 times resident #9 required the prn clonidine. There were 22 missing follow-up blood pressures. Resident #9's b/p ranged from 157/120 to 219/100 throughout the month of April. There was no documentation provided by the center the physician had been notified of the 24 elevated blood pressures. The May 2019 MAR documented 35 times resident #9 required the prn clonidine. There were 22 missing follow-up blood pressures. Resident #9's b/p ranged from 149/102 to 219/111 throughout the month of May. There was no documentation provided by the center the physician had been notified of the 35 elevated blood pressures. The June 2019 MAR documented 8 times resident #9 required the prn clonidine. There were 5 missing follow-up blood pressures. Resident #9's b/p ranged from 170/113 to 236/132 throughout the month of June. There was no documentation provided by the center the physician had been notified of the 8 elevated blood pressures. The June 2019 MAR documented the resident received an anti-nausea medication twice for vomiting. On 06/04/19 at 1:30 p.m. the resident stated blood pressures ran high and he would wake up with headaches. On 06/10/19 at 10:13 a.m. the resident stated he had nausea and hadn't been feeling well throughout the weekend.	C1505		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5543	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/11/2019
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF SOUTHWEST OKLAHON		STREET ADDRESS, CITY, STATE, ZIP CODE 2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159		
(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 13 On 06/11/19 at 8:38 a.m. during record review with the registered nurse (RN), the RN was asked about the elevated blood pressures. She stated there should have been documentation the physician was notified.	C1505		
C5010 SS=E	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of the Home Care Act. D. The assisted living center shall monitor and assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident.	C5010		

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2019
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF SOUTHWEST OKLAHOM		STREET ADDRESS, CITY, STATE, ZIP CODE 2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159		
(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
C5010	Continued From page 15 On 06/10/19 at 10:13 a.m. employee #3 stated the resident hadn't felt well throughout the weekend. On 06/11/19 at 8:31 a.m. during record review with the registered nurse (RN), the RN stated blood pressures were reported to the physician, but there was no documentation. The April 2019 medication administration record (MAR) documented: April 6 b/p 157/120, April 8 b/p 108/101, April 24 b/p 210/100, and April 28 b/p 146/106. The May 2019 MAR documented: May 2 b/p 180/113, May 11 b/p 200/126, May 12 b/p 213/100, and May 26 b/p 214/129. The June 2019 MAR documented: June 2 b/p 142/112, June 6 there was no b/p recorded, but the resident needed a prn medication to prevent vomiting because the resident was vomiting, June 10 b/p 170/113. On 06/04/19 at 1:50 p.m. resident #9 stated, "I've got two sores on my butt that's bothering me." On 06/10/19 at 9:48 a.m. resident #9's room smelled like urine. It could be smelled outside the residents door. The resident was in bed. The resident had a visitor. At 10:13 a.m. resident #9 was in bed and the room still smelled of urine. Employee #3 was	C5010		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5543	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING. _____	(X3) DATE SURVEY COMPLETED 06/11/2019
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF SOUTHWEST OKLAHOM		STREET ADDRESS, CITY, STATE, ZIP CODE 2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159		
(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
C5010	Continued From page 16 asked about the dark ring around the large wet spot on the protective pad between the resident and the bedding, but the employee didn't know why. The resident had a bright red/pink bottom with the larger area on the left buttocks and smaller area on the right buttocks; together about the size of a palm of hand. Resident #4 On 06/03/19 at 2.42 p.m. the resident was sitting in a chair in residents room. She had dark purple skin around the bilateral forearms circumference from elbow to the back of hand and bilateral lower legs circumference from knee to tops of feet. The residents had a bandage on the right forearm. The resident had a swollen right foot. No compression were on the resident. The resident also had a reddened area on her chest with indentation in skin. 06/11/19 at 8:22 a.m. the registered nurse (RN) was asked about any documentation about the residents skin. The RN stated home health did treatments. The RN was asked about the centers documentation. The RN stated normally notes and measurements would be documented, but had not been done. The last skin injury to the resident #4's skin was 05/22/19 and the RN had not assessed it since home health was. The RN was not aware of the reddened area on the residents chest. There were no additional notes or measurements provided by the center for resident #9.	C5010		

STATE WORKLOAD REPORT

Provider/Supplier Number AL5543	Provider/Supplier Name AUTUMN LEAVES OF SOUTHWEST OKLAHOMA CITY
------------------------------------	--

Type of Survey (select all that apply)

☒ 2 ☐ ☐ ☐ ☐

- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | 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. 34460	06/03/2019	06/11/2019	0.50	0.00	24.50	0.00	7.00	7.00
2. 41872	06/03/2019	06/11/2019	0.00	0.00	16.50	0.00	2.50	0.00
3. 42023	06/03/2019	06/11/2019	0.00	0.00	16.50	0.00	2.25	0.00
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

Handwritten signature and date stamp: 10/11/2019



Oklahoma State Department of Health
Creating a State of Health

July 26, 2019

License Number: AL5543

Mr. Michael Hunter, Administrator
Autumn Leaves Of Southwest Oklahoma City
2232 Southwest 104th Street
Oklahoma City, OK 73159

RE: Survey Event IFPV11

Dear Mr. Hunter:

On June 11, 2019, 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 **July 30, 2019**.

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) 271-6868.

Sincerely,

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

LC/jt

Board of Health

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Interim Commissioner of Health

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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/11/2019

Facility Name: Autumn Leaves of SW Oklahoma City

License Number: AL5543

Survey Event ID: IFPV11

Date Survey Completed: 6/11/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1405

Based on: observation, interview, and record, it was determined the center failed to ensure edema and the degree of edema was documented daily by qualified staff for 2 (#2,#5) of 8 residents. This failed practice resulted in the potential for more than minimal harm, at a pattern

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

Administrator's Signature

Administrator signature required.

OAC 310:663-25-4(F)

Date Enter a date of signature.

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The center's RN (or designee) and LPN will identify residents that exhibit edema or has potential to develop edema.

The center will conduct an audit of residents' charts, assess all residents if there is potential for edema, and review MAR and physician orders for accuracy of documentation regarding the presence and degree of edema.

The center will create a master checklist consisting of all residents identified with edema or potential thereof and the required documentation needed for continued monitoring as determined by MD (or designee).

The RN or licensed nursing staff will monitor for presence and degree of edema as ordered by MD or designee and as documented on the MAR.

The RN or designee will follow the American Heart Association guidelines for assessment of edema of dependent areas unless otherwise indicated by MD or designee as follows: +1 Trace/Mild. +2 Moderate pitting. +3 Deep pitting. +4 Very deep pitting

Monitoring records will be documented onto the master checklist and/or MAR as indicated by MD/designee.

7/30/2019

7-15-19

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 date of addendum

Submitted by Enter name

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Enter date of completion **Surveyor:** Enter name

If Plan of Correction is unacceptable, the reasons are as follows: Enter reasons

Facility in Compliance by:



Oklahoma State
Department of Health
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/11/2019

Facility Name: Autumn Leaves of SW Oklahoma City

License Number: AL5543

Survey Event ID: IFPV11

Date Survey Completed: 6/11/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: N1429

Based on: interview and record review, it was determined the center failed to, a.) obtain and document follow-up blood pressures for 1 (#9) of 1 resident who required PRN BP medication for systolic BP>165 or diastolic BP >100, b.) administer a PRN BP med. (Clonidine) for 1 (#5) of 1 resident who required PRN Clonidine for BP>180. This failed practice resulted in the potential for more than minimal harm, at a pattern.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

OSDH Response: Element accepted Yes ☐ No ☒

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted Yes ☐ No ☒

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☒

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☒

Administrator's Signature

Administrator Signature Required

OAC 310-663-25-4(F)

Date Enter a date of signature.

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		Submitted by	
Items Below Are For OSDH Use Only			
Plan of Correction:	☐ Acceptable	☐ Unacceptable	Date:
		Surveyor:	
If Plan of Correction is unacceptable, the reasons are as follows:			
Facility in Compliance by:			



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Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/11/2019

Facility Name: Autumn Leaves of SW Oklahoma City

License Number: AL5543

Survey Event ID: IFPV11

Date Survey Completed: 6/11/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C391

Based on: Observation and interview it was determined the center failed to ensure compliance with Chapter 257 Food Service Establishment Regulations by not testing the chemical sanitizer concentration of the dish machine utilizing the required test strips. This had the wide spread potential for more than minimal harm for all 39 residents who ate food prepared by the centers kitchen. Findings: 310:257-7-77 Warewashing equipment, determine chemical sanitizer concentration: Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

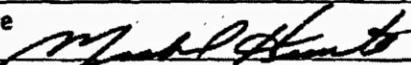
The center immediately purchased new testing strips on 6.4.2019. The center's culinary manager will ensure that the warewashing equipment has proper chemical testing and water temperature testing and done so at the appropriate intervals (3x daily) as determined in company policy and within Ch. 257 Food Service Est. Regulation 310:257-7-77. The culinary manager will ensure the facility has the appropriate, current tests strips on hand to establish proper chemical PH. Additionally, the center's executive director will complete weekly kitchen inspections, which encompasses the review kitchen logs (chemical, temp etc..) which are kept in the kitchen office. If the chemicals are not within the appropriate testing levels, the chemical supply/warewashing company will recalibrate the equipment. Additionally, if temperatures are not to standard, the center's maintenance provider will make the appropriate adjustments in the hot water distribution system.

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

Improper maintenance/checks of the warewashing equipment holds the potential for broad and non specific risk of the population. Therefore, the Executive Director or designee will complete daily checks of the log, for the first two weeks to ensure completed and proper testing (3x daily) of the warewashing machine chemicals, confirm sufficient numbers of within date test strips remain available, and review of log to ensure temperatures are at the regulatory standard. Following two weeks of daily compliance, the executive director will complete the standard weekly kitchen review

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?	Consistent and proper audits, as outlined above by the executive director will ensure compliance, should any deficits be noted by the culinary manger or any other part of the kitchen staff, will be held accountable with disciplinary action. Records of all test will be kept in the kitchen office	
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.	The culinary manager and kitchen staff will complete the required testing of the warewashing machine's chemicals and operation temperature, proper testing will be completed and verified by within date test strips.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	7/30/2019	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature 	Date 7-15-19	
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	Submitted by	
Items Below Are For OSDH Use Only		
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date:		Surveyor:
If Plan of Correction is unacceptable, the reasons are as follows: Facility in Compliance by:		



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/15/2019

Facility Name: Autumn Leaves of SW Oklahoma City

License Number: AL5543

Survey Event ID: IFPV11

Date Survey Completed: 6/11/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C911

Based on: interview and record review, it was determined the center failed to ensure a registered nurse assessed, monitored and followed up on 1 (#9) of 1 resident with repeated abnormally high BP from April to June 2019, supervised and verified the administration of PRN antihypertensive med. used to treat high BP, reviewed clinical documentation to make certain staff administered the medication as ordered and required prn, notified the physician of abnormal BP readings repeatedly requiring PRN med., delegated med. administration to staff competent to administer prn medication according to MD orders, document BP readings and rechecking BP after med. administration. This failed practice resulted in isolated actual harm to resident #9 for continued uncontrolled HTN.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This POC constitutes Autumn Leaves of SW OKC's written POC for alleged deficiencies cited. Submission of this POC is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet the requirements established by state law. This POC shall not be considered a waiver of Autumn Leaves' IDR or appeals rights.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The center's RN (or designee) and LPN will review record of affected resident (#9), supervise and verify administration of PRN BP meds (& other meds), review and make certain staff administer medication as ordered and required (PRN), notify MD of abnormal BP readings, delegate med. administration to competent staff according to MD orders, document BP readings and rechecking BP after med. administration. and update service plan.

OSDH Response: Element accepted Yes ☒ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

The center will conduct an audit of residents' charts, and physician orders to ensure PRN BP medication orders are followed through. The center will provide in-service to CMA/ACMA to ensure staff competency on med administration, documentation, follow-up required (especially after administering PRN meds) and proper notification.

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?

The center will create a master checklist consisting of all residents identified with PRN BP medication orders with indication of accurate parameters.

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

The CMAs will notify nurse if a PRN BP needs to be administered and will document on MAR when med. is administered. The CMAs will notify nurse again 30min-1hr

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.	(or as indicated by MD/designee) of PRN BP med administration of follow-up BP reading and will record on MAR as ordered.	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	7/30/2019	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature DAC 310 663-25-4(F)	Date 7-15-19	
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	Submitted by	
Items Below Are For OSDH Use Only		
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Surveyor:		
If Plan of Correction is unacceptable, the reasons are as follows: Facility in Compliance by:		



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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/15/2019

Facility Name: Autumn Leaves of SW Oklahoma City

License Number: AL5543

Survey Event ID: IFPV11

Date Survey Completed: 6/11/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505

Based on: interview and record review, it was determined the center failed to administer PRN BP med based on blood pressures obtained & MD ordered parameters. The center also failed to document follow-up BP for 1 (#9) of 1 resident who required PRN BP med (Clonidine) for SBP>165 or DBP>100. The failed practice resulted in isolated actual harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This POC constitutes Autumn Leaves of SW OKC's written POC for alleged deficiencies cited. Submission of this POC is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet the requirements established by state law. This POC shall not be considered a waiver of Autumn Leaves' IDR or appeals rights.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The center's RN (or designee) and LPN will review record of affected resident (#9), supervise and verify administration of PRN BP meds (& other meds), review and make certain staff administer medication as ordered and required (PRN), notify MD of abnormal BP readings, delegate med. administration to competent staff according to MD orders, document BP readings and rechecking BP after med. administration. and update service plan.

OSDH Response: Element accepted Yes ☐ No ☒

2. How will other residents having the potential to be affected by the same deficient practice be identified?

The center will conduct an audit of residents' charts, and physician orders to ensure PRN BP medication orders are followed through. The center will provide in-service to CMA/ACMA to ensure staff competency on med administration, documentation, follow-up required (especially after administering PRN meds) and proper notification.

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?

The center will create a master checklist consisting of all residents identified with PRN BP medication orders with indication of accurate parameters.

OSDH Response: Element accepted Yes ☒ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and

The CMAs will notify nurse if a PRN BP needs to be administered and will document on MAR when med. is administered. The CMAs will notify nurse again 30min-1hr (or as indicated by MD/designee) of PRN BP med administration of follow-up BP reading and will record on MAR as ordered.

c. How monitoring records will be kept to evidence the correction.			
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		7/30/2019	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature <i>Michael H. Harte</i> OAC 310:663-25-4(F)		Date <i>7-15-19</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		Submitted by	
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable		Date:	Surveyor:
If Plan of Correction is unacceptable, the reasons are as follows:			
Facility in Compliance by:			



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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/15/2019

Facility Name: Autumn Leaves of SW Oklahoma City

License Number: AL5543

Survey Event ID: IFPV11

Date Survey Completed: 6/11/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C5010

Based on: interview and record review, it was determined the center failed to coordinate care with third-party providers to monitor and ensure delivery of services to include: a.) physician notification of abnormal BP for 49 days of 1(#9) of 5 sampled residents with HTN, b.) skin changes for 2 (#4 & #9) of 2 sampled residents was monitored and documented by the center. The failed practice resulted in the potential for more than minimal harm at a pattern.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This POC constitutes Autumn Leaves of SW OKC's written POC for alleged deficiencies cited. Submission of this POC is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet the requirements established by state law. This POC shall not be considered a waiver of Autumn Leaves' IDR or appeals rights.

REQUIRED ELEMENTS OF A PLAN

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The center's RN (or designee) and LPN will review record of affected residents (#9 for abnormal BP & #4 & #9 for skin changes), supervise and verify administration of PRN BP meds (& other meds), review and make certain staff administer medication as ordered and required (PRN), notify MD of abnormal BP readings, delegate med. administration to competent staff according to MD orders, document BP readings and rechecking BP after med. administration., conduct skin assessment, coordinate care with third-party vendors and update service plans as 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?

The center will conduct an audit of residents' charts, and physician orders to ensure PRN BP medication orders are followed through and conduct skin assessment to all residents to identify those with skin issues and coordinate care with third-party as appropriate. The center will provide in-service to CMA/ACMA to ensure staff competency on med administration, documentation, follow-up required (especially after administering PRN meds), notification protocol, coordination of care to third-party vendors and update service plan as appropriate.

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?

The center will create a master checklist consisting of all residents identified with PRN BP medication orders with indication of accurate parameters and those with skin issues for adequate monitoring with coordination of care with third-party vendors as appropriate.

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.	The CMAs will notify nurse if a PRN BP needs to be administered and will document on MAR when med. is administered. The CMAs will notify nurse again 30min-1hr (or as indicated by MD/designee) of PRN BP med administration of follow-up BP reading and will record on MAR as ordered. The nurse will conduct monthly skin assessment at a minimum of all residents. Residents identified with skin issues will be monitored every 3 days at a minimum with coordination of care with third-party vendors as applicable. The center will require copies of third-party vendor assessments weekly.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/30/2019
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature OAC 310-663-25-4(F)	Date 7-15-19
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	Submitted by
Items Below Are For OSDH Use Only	
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date:	Surveyor:
If Plan of Correction is unacceptable, the reasons are as follows: Facility in Compliance by:	

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5543	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/11/2019
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NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF SOUTHWEST OKLAHON	STREET ADDRESS, CITY, STATE, ZIP CODE 2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159
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(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
N 000	Initial Comments A re-licensure survey was conducted 06/03/19, 06/04/19, 06/10/19 and 06/11/19. Resident census was 39. Deficient practice was cited as follows.	N 000	Refer to POC Template, Event ID IFPV11, ID Tag C391 Refer to POC Template, Event ID IFPV11, ID Tag N1429 Refer to POC Template, Event ID IFPV11, ID Tag C1505 Refer to POC Template, Event ID IFPV11, ID Tag N1405 Refer to POC Template, Event ID IFPV11, ID Tag C911 Refer to POC Template, Event ID IFPV11, ID Tag C5010	
N1405 SS=E	310:677-13-6 (b) Competency and Practice Standards Each certified medication aide shall: (1) Comply with 63 O.S. Section 1-1950.3 (E) and OAC 310:677-13; (2) Perform within authorized duties; (3) Follow written instructions of a licensed nurse or physician; and (4) Accurately record medications administered, withheld or refused.	N1405		

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: AL5543	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/11/2019
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF SOUTHWEST OKLAHON		STREET ADDRESS, CITY, STATE, ZIP CODE 2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159		
(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
N1405	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record it was determined the center failed to ensure edema and the amount of edema was documented daily by qualified staff for 2 (#2 and #5) of 8 residents. This failed practice resulted in the potential for more than minimal harm, at a pattern. Findings: On 06/04/19 at 2:03 p.m. during review of the June medication administration record (MAR) employee #2 was asked about checking for edema and recording the amount. Employee #2 stated, I poke on the ankles and legs. If there's indentions it means edema and resident was carrying fluid. On 06/10/19 at 1:50 p.m. during review of the June MAR employee #6 was asked about checking for edema and recording the amount. Employee #6 stated, we would put a percentage on the MAR. On 06/11/19 at 8:05 a.m. during review of the June MAR employee #1 was asked about checking for edema and recording the amount. Employee #1 stated, they would check to see if any extra fluid was on the body. At 8:52 a.m. during record review, the registered nurse (RN) was asked how the certified medication aids determined the amount of edema. The RN stated, just like anyone would; plus one, plus two, plus three.	N1405		

Oklahoma State Department of Health
STATE FORM

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2019
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF SOUTHWEST OKLAHOM			STREET ADDRESS, CITY, STATE, ZIP CODE 2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159		
(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
N1429	Continued From page 3 more than minimal harm, at a pattern. Findings: Resident #9 Resident #9 had diagnoses to include vascular dementia and hypertension (HTN). The April 2019 physician orders documented, three routine blood pressure medications were discontinued. The clonidine was changed to 1 tablet twice a day pm for systolic b/p greater than 165 or diastolic b/p greater than 100. The April 2019 medication administration record (MAR) documented 24 times resident #9 required the pm clonidine. There were 22 missing follow-up blood pressures. There was no documentation provided the physician had been notified of the 24 elevated blood pressures. The May 2019 MAR documented 35 times resident #9 required the pm clonidine. There were 22 missing follow-up blood pressures. There was no documentation provided the physician had been notified of the 35 elevated blood pressures. The June 2019 MAR documented 8 times resident #9 required the pm clonidine. There were 5 missing follow-up blood pressures. There was no documentation provided the physician had been notified of the 8 elevated blood pressures. On 06/10/19 at 10:13 a.m. the resident stated she was nauseous. Resident #5 Resident #5 had diagnoses to include alzheimer's	N1429			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5543	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2019
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF SOUTHWEST OKLAHOM		STREET ADDRESS, CITY, STATE, ZIP CODE 2232 SOUTHWEST 104TH STREET OKLAHOMA CITY, OK 73159		
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N1429	Continued From page 4 and HTN. The April 2019 physician orders, documented clonidine to be given prn for systolic b/p greater than 180. The April 2019 MAR documented 9 times resident #5 required the prn clonidine. There were 9 missing entries the medication had been given. The June 2019 MAR documented 1 time resident #5 required the prn clonidine. There was a missing entry the medication had been given. On 06/11/19 at 9:02 a.m. during record review with the registered nurse (RN). The RN was asked about the missing documentation. The RN stated the medication was not documented to have been given.	N1429		
C 000	INITIAL COMMENTS A re-licensure survey was conducted 06/03/19, 06/04/19, 06/10/19 and 06/11/19. Resident census was 39. Deficient practice was cited as follows.	C 000		
C 391 SS=F	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements;	C 391		