



Delivery via email to: adonaldson@autumnleaves.com

June 24, 2021

License Number: AL5598

Ms. Andrea Donaldson, Administrator
Autumn Leaves Of Edmond
1001 S Bryant Ave
Edmond, OK 73034

Survey Event ID: WQO511

Dear Ms. Donaldson:

On **May 26, 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.

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.

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

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

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

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

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

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



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

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

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

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

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

INVESTIGATIVE REPORT

Facility: Autumn Leaves of Edmond
Address: 1001 South Bryant Ave
City, State, Zip: Edmond, OK, 73034
Provider #: AL5598
Complaint #: OK00055262
Investigation Date(s): 05/20/21, 05/21/21, 05/23/21 through 05/26/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to follow resident contract regarding refunds.	US
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☐ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 05/20/2021 at 7:45 a.m.

A sample of 2 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation. Record review and interview was completed, it was determined the resident was reimbursed for the balance of the money.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Mary Cooper By Ed Roe

Mary Cooper RN/CHFS

Date report completed: 05/28/2021

INVESTIGATIVE REPORT

Facility: Autumn Leaves of Edmond
Address: 1001 South Bryant Ave
City, State, Zip: Edmond, OK, 73034
Provider #: AL5598
Complaint #: OK00056468
Investigation Date(s): 05/20/21, 05/21/21, 05/23/21 through 05/26/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate staff to meet the needs of the residents.	US

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 05/20/2021 at 7:45 a.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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation enter text . The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation OK00056468. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Mary Cooper By Edizer

Mary Cooper RN/CHFS

Date report completed: 05/28/2021

INVESTIGATIVE REPORT

Facility: Autumn Leaves of Edmond
Address: 1001 South Bryant Ave
City, State, Zip: Edmond, OK, 73034
Provider #: AL5598
Complaint #: OK00056484
Investigation Date(s): 05/20/21, 05/21/21, 05/23/21 through 05/26/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to provide adequate medical care and services, according to residents' contracts.	S
2. The center failed to have and/or implement their abuse policy.	US
3. The center failed to do assessments as required.	S

☐ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 05/20/2021 at 7:45 a.m.

A sample of 6 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A 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, C-1505 and C-0552 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.
The facility has a policy and procedure in place for abuse and neglect. Direct care staff, administrative staff, maintenance staff and third party providers were interviewed about any incidents of abuse or neglect.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C-0552 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation **OK00056484** . The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation enter number. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Mary Cooper by E & R

Mary Cooper RN/CHFS

Date report completed: 05/28/2021

INVESTIGATIVE REPORT

Facility: Autumn Leaves of Edmond
Address: 1001 South Bryant Ave
City, State, Zip: Edmond, OK, 73034
Provider #: AL5598
Complaint #: OK00057063
Investigation Date(s): 05/20/21, 05/21/21 and 05/23/21 through 05/26/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to provide care according to resident contracts.	S
2. The center failed to have and/or implement their abuse policy.	US
3. The center failed to ensure residents received physician ordered medications from qualified staff.	S

☐ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 05/20/2021 at 7:45 a.m.

A sample of 5 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A 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 C-1505 for details.

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

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 0921 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation OK00057063. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation enter number. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Mary Cooper

By ESK

Mary Cooper RN/CHFS

Date report completed: 05/28/2021

INVESTIGATIVE REPORT

Facility: Autumn Leaves of Edmond
Address: 1001 South Bryant Ave
City, State, Zip: Edmond, OK, 73034
Provider #: AL5598
Complaint #: OK00057068
Investigation Date(s): 05/20/21, 05/21/21, 05/23/21 through 05/26/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide care and services according to resident contracts and physicians' orders.	S

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated 05/20/2021 at 7:45 a.m.

A sample of 4 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 Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

Breakfast and lunch meals were observed for sufficient staffing to assist with feeding and safety measures. Residents food was observed for the correct diet as ordered. Staff were observed interacting with residents during transfers and activities. Medication administration records were reviewed for blood pressure checks as ordered by physician.

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 C-910 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation **OK00057068** . The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation enter number. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

 

Mary Cooper RN

Date report completed: 05/28/2021

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2021
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An investigative survey was conducted on 05/20/21, 05/21/21 and 05/23/21 through 05/26/21 to investigate complaint # OK00057068, #OK00057063, #OK00056484, #OK00056468, and #OK00055262. Deficient practice was cited.	C 000		
C 552 SS=D	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on interview and record review it was determined the registered nurse failed to complete a 14 day assessment for one (#5) of 3 residents sampled for assessments. This deficient practice had the isolated potential for more than minimal harm. Census was 26. Findings: Resident #5 was admitted to the center on 02/26/2021 with diagnoses of Depression, Atrial Fibrillation, Dementia and Hypertension. On 05/25/21 the registered nurse was asked if there was a 14 day assessment completed for resident #5. He stated "no i don't recall doing it."	C 552		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

AUTUMN LEAVES OF EDMOND

1001 S BRYANT AVE
EDMOND, OK 73034

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: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2021
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 910	Continued From page 2 Findings: On 05/20/2021, at 08:22 a.m., resident #15 was observed in TV room, no shoes on, hair not combed, and was unshaven. At 11:00 a.m. resident # 7 was in the tv room, and observed with food debris to her teeth. At 11:15 a.m, an anonymous family member reported concerns with lack of staff. Her father was moving out of the center due to staff shortage and care. On 05/23/2021, at 7:56 a.m., resident #15 was sitting in he wheelchair in the dining room. His hair was uncombed, neck was unshaven, and only had socks on. The resident was observed with debris at the gumline of their lower teeth. At 9:07 a.m., CMA (ertified medication aide) #2 was asked if the center was short staffed, she replied, some weekends, right now we just have two nursing assistants here today. She was asked how many dependent resident resided in the facility, she replied, nineteen. At 2:00 p.m., resident #7 was observed with a wet area on the front of her blue sweat pants located in the peri area. At 2:22 p.m., resident #16 was observed sitting in her broda chair in the tv room. A wet area was observed on the front of her purple sweats pants in the peri area. At 3:00 p.m., resident #16 was pushed into activities by a staff member. The wet area remained on the front of her purple sweat pants.	C 910		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2021
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 910	Continued From page 3 Two CNA's and one CMA were working in the facility at the time of the observations. On 05/25/21, at 9:03 a.m., resident # 7 was in the tv room, with no shoes on. At 9:07a.m., LTCA (long term care aide) #1 was asked if she had been working short staffed. She replied yes, a bunch of people quit. She was asked why dependent residents did not have any shoes on. She replied, their supposed to have shoes on. On 05/26/21, at 6:05 a.m., resident #15 was observed sitting in his wheelchair in the tv room. His hair was uncombed, and his neck was unshaved. At 6:50 a.m, resident #14 was observed ambulating in the hallway with his walker. He had not been shaved. At 6:53 a.m., resident #7 was observed sitting in her chair in the tv room, with no shoes on. At 6:15 a.m., LTCA #4 and LTCA #5 was observed dressing resident #18, while she was still in bed. The two staff transferred resident #18 to her broda chair. Staff did not provide oral care or comb her hair before taking her to the dining room.	C 910		
C 911 SS=H	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	C 911		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2021
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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
C 911	Continued From page 4 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 implement interventions to prevent or lessen the risk of falls for one (#1) of 4 residents sampled for falls. This deficient practice resulted in harm at a pattern. Census was 26. Findings: Resident #1 was admitted to the center on 01/3/21 with diagnosis to include, acute onset Alzheimers without behavioral disturbance, chronic obstructive pulmonary disease, high blood pressure and psychiatric disorder. Autumn Leave Service plan, dated 01/18/21 documented: "...General Mobility: Resident is independent with mobility, staff will monitor and report any changes in ambulation ...Incidents/Falls: Resident has had more than one fall in the last 3 month ...Family reported resident has had falls prior to move in, will monitor closely to anticipate resident activities	C 911		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2021
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 911	Continued From page 5 contributing to his falls-staff will ensure residents' room is free of clutters." Physicians' assistant order dated 04/03/21 documented the resident was to have the following lab work completed: Uric acid, CBC (complete blood count) and CMP (comprehensive metabolic profile) TSH (thyroid stimulating hormone) T4 (thyroxine). No results available in chart for the TSH and T4. There was no documentation to indicate the labs had been completed as ordered. Autumn Leave internal incident report. dated 04/11/21, documented, " ...walked in residents room, found him in another residents room, found him on floor he stated he hit his head on floor ..." Autumn Leaves Comprehensive functional assessment change of condition dated, 04/16/21 documentedGeneral mobility: resident requires reminders to use assistive devices. He requires one person for assistance for transfer ..." " ...Incidents/falls: Resident has had more than one fall in the last three months ..."" ...General medical history: resident uses a walker but is not compliant ..." " ...Mobility: Resident ambulates with a walker but regularly walks independently without assistive device and unsteady gait ..." A physicians' assistant progress note, dated 04/19/21 documented, "...History of present illness: The patient is walking and his gait is unsteady but will not use a wheelchair and does not recall to use a walker ...Generalized muscle weakness: The patient has muscle wasting and weakness and needs help throughout the day, he is a fall risk ..."	C 911		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2021
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 911	Continued From page 6 A physicians' assistant progress note, dated 04/21/21 documented, "....History of present illness: this is a 78 year old white male who is walking and is very unsteady today. I have asked the staff to try and put him in a wheelchair ... Diagnosis assessment and plan: Recurrent falls, the patient is encouraged to ask for help but does not recall, he will just walk and fall and cannot be restrained in bed or chair..." An incident report to the Oklahoma State Department of Health, 04/23/21 documented " ...unwitness fall, in the tv room. He was sent to the emergency room. Potential orbital fracture patient remains in the hospital ..." A medical center CT (computerized tomography) scan consultation report, dated 04/23/21 at 4:00 a.m., documented " ...History: trauma, Fall ... Impression: Scattered subacute subarachnoid hemorrhage involving the bilateral high frontal lobes near the vertex. Acute subdural blood along the left tentorial leaflet with extension into the left quadrigeminal cistern. Disproportionate prominence of the ventricles. Normal pressure hydrocephalus if of consideration. Acute comminuted fracture of the right orbital roof with extension into the right frontal calvarium. Acute fractures of the right lamina papyracea, fovea ethmoidalis, cribiform plate. Acute fractures of the right nasal bone. Soft tissue swelling overlying the right orbit and nose. Findings suggestive of possible right superior rectus muscle injury ..." The Resident's, State of Oklahoma Death Certificate Dated May 18, 2021 documented, " ...Date of death 04/28/21 at 12:35 ... A. Immediate Cause: Blunt force head trauma ... Sequentially list conditions, if any, leading to the cause listed on line a. B. Fall ..."	C 911		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL5598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/26/2021
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF EDMOND		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S BRYANT AVE EDMOND, OK 73034		
(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 911	Continued From page 7 On 05/23/21 at 5:20 p.m., a family member was interviewed regarding resident #1. It was reported resident # 1 did not sleep in his bed for five nights, staff would bring him out of his room to keep an eye on him. She reports the facility was short staffed. She stated "we had a camera in his room, but they took him off camera to supervise him, but they didn't." On 05/24/21 at 11:15 a.m., LPN #1 (Licensed practical nurse) was asked what action was taken after resident #1 had fallen on 04/11/2021. She stated, "I can't tell, I didn't see any notes in the documentation to transfer him out." She was asked if there was any assessment completed or any neurological checks completed by a skilled nurse after resident #1's fall upon return to the facility. She stated "I didn't see anything." LPN #1 was asked if there was any documentation by staff why resident #1 was sent to the hospital on 03/12/21. She stated "there were no notes to confirm or deny it." LPN#1 was asked if resident #1 returned to the facility on 03/29/21. She stated, "I don't know". She was asked if there was an assessment completed upon return, she replied there were no assessments in the chart. Hospital admission report dated, 03/12/21 was reviewed with LPN #1. Resident #1 was admitted to the hospital with a right hip fracture. Resident underwent a right total hip arthroplasty on 03/13/21. On 03/16/21, he was admitted to skilled nursing and therapy for rehabilitation with diagnosis, " ...displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing and presence of right artificial hip joint ..." Rehabilitation discharge	C 911		

Oklahoma State Department of Health

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C 911	Continued From page 8 orders dated, 03/26/21 documented "...may DC (discharge) home with medications on 03/29/21. Home health to evaluate for physical therapy/occupational therapy/ speech therapy nursing and aid..." He was discharged back to Autumn Leaves on 03/29/21. "Oklahoma State Department of Health Incident Report" initial form, dated 04/23/21 documented "...Unwitness fall in tv room, Family and Physician notified. He was sent to the ER. Potential orbital fracture, pt remains in hospital..." On 05/23/21a request was made to LPN #1 for the ordered labs dated 04/03/21. No lab results were provided. On 05/25/21 at 9:07 a.m., LTCA #1 (long term care aide) was asked if she was working the night resident #1 had his fall in the TV room. She stated, "I was working that night, I came out of the laundry room he was on the floor in the TV room, I called hospice and his wife. At 10:00 a.m., the executive director said the staff reported the family of resident #1 had called and said the resident was agitated and asked the staff to take him out to the TV room. At 10:30 a.m., RN (registered nurse) said he discussed the need for a bed alarm for the resident with the family on 04/15/21. The family agreed to provide the bed alarm. No bed alarm was in place the night of the fall on 04/23/21. Change of condition assessment was completed on 04/16/21. The RN was asked if the resident always slept in his room, he replied he would get up early. There was a nanny cam and the wife would call the staff to let them know he was awake. The RN was asked what the policy was	C 911		

Oklahoma State Department of Health

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C 911	Continued From page 9 on a head injuries. No comment was made. At 1:35 p.m., the RN was asked what it meant in the care plan/assessment for staff to monitor resident. He stated, "His unpredictability to anticipate his falls, sometimes there is no person around him, it can result in a fall." At 1:54 p.m., LTCA #2 confirmed she was working when resident #1 fell in the tv room. She stated, "I was called by the medication aide, she{medication aide}had found him on the floor." LTCA #2 identified four staff were on duty that night. She recalled her and another staff member were in the opposite TV room. I asked her how resident #1 got into the TV room and did he have his walker with him. She replied, he walked to the tv room and she was uncertain if the resident had his walker. LTCA #1 was asked if resident #1 had his walker with him. She stated, "I just saw him on the floor." On 05/26/21 at 08:25 a.m., home health physical therapist was asked about resident #1. He stated resident #1 "was a "wanderer" and had a right hip fracture during the time when no nurse was here, there was no coordination of care." The PT (physical therapist) also stated the resident "fell the day he got here." Requested physical therapy notes from PT, no documentation provided.	C 911		
C 921 SS=E	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse	C 921		

Oklahoma State Department of Health

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C 921	Continued From page 10 or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on interview and record review it was determined the center failed to ensure three medication administration aides had a current certification to administer medications. This had the widespread potential for more than minimal harm. The facility census was 26. Findings: ACMA #1 certification expired on 02/28/2021. CMA #2 had no current medication certification on file with the Nurse Aide Registry. CMA #3 certification had expired 04/30/2020. On 05/23/2021 at 9:07 a.m., CMA #2 (Certified Medication Aide) was asked if she had been working as a CMA. She replied yes, I have been passing medications. She was hired as a CMA in February 2021. She was asked who hired her, she replied the current ED (executive director). The ED notified CMA #2 her certification was expired, and was still scheduled to work as a CMA. At 1:35 p.m., the executive director was asked what her understanding about staff working when waiting on recertification. She replied if they had submitted the paperwork they could still work.	C 921		

Oklahoma State Department of Health

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C 921	Continued From page 11 She was asked if she had been given paperwork from the staff showing where they had sent their application in, she stated no. At 9:37 a.m., CMA #3 was asked if she had sent paperwork in to renew her certification, she replied, a month ago. She said the ED was aware her paperwork had been sent in for renewal. She was observed passing medications on the day of the interview. On 05/25/21 at 9:07 a.m., ACMA #1 was asked if she had gotten her certification. She replied, I took my eight hour course and sent all the paperwork to the registry. May 2021 staff schedule documented, ACMA#1 and CMA #2, and CMA #3 were on the schedule for the month. CMA #3 was observed to pass medications during the survey.	C 921		
C1505 SS=H	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 12 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the center failed to implement interventions to prevent or lessen the risk of falls for one (#1) of 4 residents sampled for falls. This deficient practice resulted in harm at a pattern. Additionally the center failed to ensure medications were administered as ordered by the physician for one (#10) of 3 sampled residents for medication administration. This deficient practice resulted in the isolated potential for more than minimal harm. The facility census was 26. Findings: 1. Resident #1 was admitted to the center on 01/3/21 with diagnosis to include, acute onset	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 13 Alzheimers without behavioral disturbance, chronic obstructive pulmonary disease, high blood pressure and psychiatric disorder. Autumn Leave Service plan, dated 01/18/21 documented: " ...General Mobility: Resident is independent with mobility, staff will monitor and report any changes in ambulation ...Incidents/Falls: Resident has had more than one fall in the last 3 month ...Family reported resident has had falls prior to move in, will monitor closely to anticipate resident activities contributing to his falls-staff will ensure residents' room is free of clutter." Physicians' assistant order dated 04/03/21 documented the resident was to have the following lab work completed: Uric acid, CBC (complete blood count) and CMP (comprehensive metabolic profile) TSH (thyroid stimulating hormone) T4 (thyroxine). No results available in chart for the TSH and T4. There was no documentation to indicate the labs had been completed as ordered. Autumn Leave internal incident report. dated 04/11/21, documented, " ...walked in residents room, found him in another residents room, found him on floor he stated he hit his head on floor ..." Autumn Leaves Comprehensive functional assessment change of condition dated, 04/16/21 documentedGeneral mobility: resident requires reminders to use assistive devices. He requires one person for assistance for transfer ..." " ...Incidents/falls: Resident has had more than one fall in the last three months ..."" ...General medical history: resident uses a walker but is not compliant ..." " ...Mobility: Resident ambulates	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 14 with a walker but regularly walks independently without assistive device and unsteady gait ..." A physicians' assistant progress note, dated 04/19/21 documented, "...History of present illness: The patient is walking and his gait is unsteady but will not use a wheelchair and does not recall to use a walker ...Generalized muscle weakness: The patient has muscle wasting and weakness and needs help throughout the day, he is a fall risk ..." A physicians' assistant progress note, dated 04/21/21 documented, "...History of present illness: this is a 78 year old white male who is walking and is very unsteady today. I have asked the staff to try and put him in a wheelchair ... Diagnosis assessment and plan: Recurrent falls, the patient is encouraged to ask for help but does not recall, he will just walk and fall and cannot be restrained in bed or chair..." An incident report to the Oklahoma State Department of Health, 04/23/21 documented " ...unwitness fall, in the tv room. He was sent to the emergency room. Potential orbital fracture patient remains in the hospital ..." A medical center CT (computerized tomography) scan consultation report, dated 04/23/21 at 4:00 a.m., documented " ...History: trauma, Fall ... Impression: Scattered subacute subarachnoid hemorrhage involving the bilateral high frontal lobes near the vertex. Acute subdural blood along the left tentorial leaflet with extension into the left quadrigeminal cistern. Disproportionate prominence of the ventricles. Normal pressure hydrocephalus if of consideration. Acute comminuted fracture of the right orbital roof with extension into the right frontal calvarium. Acute	C1505		

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C1505	Continued From page 15 fractures of the right lamina papyracea, fovea ethmoidalis, cribiform plate. Acute fractures of the right nasal bone. Soft tissue swelling overlying the right orbit and nose. Findings suggestive of possible right superior rectus muscle injury ..." The Resident's, State of Oklahoma Death Certificate Dated May 18, 2021 documented," ...Date of death 04/28/21 at 12:35 ... A. Immediate Cause: Blunt force head trauma ... Sequentially list conditions, if any, leading to the cause listed on line a. B. Fall ..." On 05/23/21 at 5:20 p.m., a family member was interviewed regarding resident #1. It was reported resident # 1 did not sleep in his bed for five nights, staff would bring him out of his room to keep an eye on him. She reports the facility was short staffed. She stated "we had a camera in his room, but they took him off camera to supervise him, but they didn't." On 05/24/21 at 11:15 a.m., LPN #1 (Licensed practical nurse) was asked what action was taken after resident #1 had fallen on 04/11/2021. She stated, "I can't tell, I didn't see any notes in the documentation to transfer him out." She was asked if there was any assessment completed or any neurological checks completed by a skilled nurse after resident #1's fall upon return to the facility. She stated "I didn't see anything." LPN #1 was asked if there was any documentation by staff why resident #1 was sent to the hospital on 03/12/21. She stated "there were no notes to confirm or deny it." LPN#1 was asked if resident #1 returned to the facility on 03/29/21. She stated, "I don't know". She was asked if there was an assessment completed upon return, she replied there were no	C1505		

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C1505	Continued From page 16 assessments in the chart. Hospital admission report dated, 03/12/21 was reviewed with LPN #1. Resident #1 was admitted to the hospital with a right hip fracture. Resident underwent a right total hip arthroplasty on 03/13/21. On 03/16/21, he was admitted to skilled nursing and therapy for rehabilitation with diagnosis, "...displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with routine healing and presence of right artificial hip joint ..." Rehabilitation discharge orders dated, 03/26/21 documented "...may DC (discharge) home with medications on 03/29/21. Home health to evaluate for physical therapy/occupational therapy/ speech therapy nursing and aid..." He was discharged back to Autumn Leaves on 03/29/21. "Oklahoma State Department of Health Incident Report" initial form, dated 04/23/21 documented "...Unwitness fall in tv room, Family and Physician notified. He was sent to the ER. Potential orbital fracture, pt remains in hospital..." On 05/23/21a request was made to LPN #1 for the ordered labs dated 04/03/21. No lab results were provided. On 05/25/21 at 9:07 a.m., LTCA #1 (long term care aide) was asked if she was working the night resident #1 had his fall in the TV room. She stated, "I was working that night, I came out of the laundry room he was on the floor in the TV room, I called hospice and his wife. At 10:00 a.m., the executive director said the staff reported the family of resident #1 had called and said the resident was agitated and asked the staff to take him out to the TV room.	C1505		

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C1505	Continued From page 17 At 10:30 a.m., RN (registered nurse) said he discussed the need for a bed alarm for the resident with the family on 04/15/21. The family agreed to provide the bed alarm. No bed alarm was in place the night of the fall on 04/23/21. Change of condition assessment was completed on 04/16/21. The RN was asked if the resident always slept in his room, he replied he would get up early. There was a nanny cam and the wife would call the staff to let them know he was awake. The RN was asked what the policy was on a head injuries. No comment was made. At 1:35 p.m., the RN was asked what it meant in the care plan/assessment for staff to monitor resident. He stated, "His unpredictability to anticipate his falls, sometimes there is no person around him, it can result in a fall." At 1:54 p.m., LTCA #2 confirmed she was working when resident #1 fell in the tv room. She stated, "I was called by the medication aide, she{medication aide}had found him on the floor." LTCA #2 identified four staff were on duty that night. She recalled her and another staff member were in the opposite TV room. I asked her how resident #1 got into the TV room and did he have his walker with him. She replied, he walked to the tv room and she was uncertain if the resident had his walker. LTCA #1 was asked if resident #1 had his walker with him. She stated, "I just saw him on the floor." On 05/26/21 at 08:25 a.m., home health physical therapist was asked about resident #1. He stated resident #1 "was a "wanderer" and had a right hip fracture during the time when no nurse was here,	C1505		

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C1505	Continued From page 18 there was no coordination of care." The PT (physical therapist) also stated the resident "fell the day he got here." Requested physical therapy notes from PT, no documentation provided. 2. Resident #10 was admitted to the facility on 06/10/20 with diagnosis which included Anxiety, Hypertension and Vascular Dementia. The resident had an order for Lorazepam 0.5 MG (milligram) three times a day. On 05/20/2021 at 1:35 p.m., resident #10's MAR (medication administration record) and narcotic count sheets were reviewed. The MAR documented resident #10 did not have her medication administered on 01/09/21. The Nurse's medication notes documented "...1/9 8p lorazepam 0.5 po med out..." There were blanks on the MAR on 01/04, 01/11, and 01/24. At 2:30 p.m., Resident #10's MAR and narcotic count sheets were reviewed with the Licensed Nurse. She acknowledged the missed doses.	C1505		



OKLAHOMA
State Department
of Health

Delivery via email to: jsjones@autumnleaves.com

July 26, 2021

License Number: AL5598

Rishell Milton, Administrator
Autumn Leaves Of Edmond
1001 S Bryant Ave
Edmond, OK 73034

Survey Event ID: WQO511

Dear Ms. Milton:

On **May 26, 2021**, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **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 12:09:38 -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: 7/19/2021

Facility Name: Autumn Leaves of Edmond

License Number: AL 5598

Survey Event ID: WQ0511

Date Survey Completed: 5/26/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 552

Based on: interview and record review it was determined the registered nurse failed to complete a 14 day assessment for one (#5) of 3 residents sampled for assessments.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: In response to your letter dated June 24, 2021 regarding the Complaint Survey visit at Autumn Leaves of Edmond, the community submits the following Plan of Correction: This Plan of Correction constitutes Autumn Leaves of Edmond written plan of compliance for the alleged deficiencies cited, Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state law. This Plan of Correction shall not be considered a waiver of Autumn Leaves of Edmond informal dispute resolution or appeal rights.

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 # 5 Service plan updated

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 DHC/Designee will ensure all current residents have updated corresponding Individualized service plan (ISP) addressing their Clinical need (for move in, at 14 days, at 90 days, for annual and for significant change of 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?

- The DHC/Designee will complete ISP for all new residents upon move in, at 14 days, at 90 days, annually, with any significant change in condition to reflect the resident's current need and ensure resident's care meets his/her needs.
- The DHC/Designee and ED will develop a tracking tool to ensure residents assessments are completed when required.

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.

- The community will adhere to the section 310:663-5-5 (2) governing use of Assessment to develop a care plan for the resident in consultation with the resident.

DHC/Designee and ED will review the self-created tracking tool to ensure residents individual assessments are completed and reflective of their current state of health. Staff will be educated with any new assessment to incorporate changes into the resident's care and individual plan of care will be discussed with residents if possible and

		resident's responsible party to ensure all aspects of resident's needs/care are incorporated. DHC/Designee and ED will conduct a monthly audit of the wellness site to ensure all required assessments are completed as required to meet the resident's individual need. Regional Nurse will conduct random audit of the wellness site to ensure compliance and any identified concerns will be discussed with DHC/Designee and ED for correction and compliance.	
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 Rishell Palmer OAC 310:663-25-4(F)		Date 7/22/2021	
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	Jillian Jones
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: 7/19/2021

Facility Name: Autumn Leaves of Edmond

License Number: AL 5598

Survey Event ID: WQ0511

Date Survey Completed: 5/26/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 910

Based on: observation, interview and record review it was determined the center failed to ensure sufficient staffing to meet the needs of residents dependent upon staff for activities of daily living (grooming, oral care, shoes, toileting) for five (#14, 15, 16 18 and #7) of five sampled residents reviewed for activities of daily living.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: In response to your letter dated June 24, 2021 regarding the Complaint Survey visit at Autumn Leaves of Edmond, the community submits the following Plan of Correction: This Plan of Correction constitutes Autumn Leaves of Edmond written plan of compliance for the alleged deficiencies cited, Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state law. This Plan of Correction shall not be considered a waiver of Autumn Leaves of Edmond informal dispute resolution or appeal 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?

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?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident # 14, 15, 16, 18 and 7 are properly groomed, received oral care, wear appropriate shoes and toileted.

- The community has reviewed its daily staffing of personnel to ensure it's aligned with the Alzheimer's Disclosure Statement and to meet scheduled and unscheduled residents needs (Activities of Daily Living).
- The DHC/ED will ensure facility has sufficient personnel to meet the needs of each resident, including 24 hours scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis per the Alzheimer's Disclosure Statement.
- The DHC/ED will ensure all current employees are educated on the attendance policy and the need to be notified by staff immediately if staffing concerns arise for resident care.

- Current staffing reviewed and position posted for additional employees to ensure adequate staffing is readily available for the resident's needs.
- All community's staff educated on the importance of promptly reporting to the Director of Healthcare or the Executive Director any staffing concerns and adjustment will be made timely to meet the resident's needs.
- Educate staff on importance of providing ADL care as scheduled and as needed.

		In the event any staffing challenge occurs and community leader are unable to adequately staff the facility for resident's care, temporary staffing agency will be utilized as needed.
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 community will adhere to the section 310:663-9-1 governing Nurse to ensure adequate staffing is available to meet the service 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. ED and DHC will develop a Manager on Duty schedule in addition to their routine rounds to ensure all care areas are rounded on and any identified ADL's care concerns are addressed timely and reported to ED/DHC for further correction to ensure consistent compliance. - The Executive Director and/or Director of Healthcare and /or designee will conduct daily huddle during shift change and review staffing as well as any resident care concerns/needs to ensure all assigned personnel are present, knowledgeable of the care concerns/needs and will address any supplemental need immediately. - Regional Director of HealthCare and/or Regional Director of Operation will conduct random audit during site visit of the employee's time card or daily assignments as well as residents observation to ensure compliance and any identified concern will be discussed with ED and DHC.
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 Rishell Palmer OAC 310:663-25-4(F)		Date 7/22/2021
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Addendum Date	Enter a date of addendum.	Submitted by Jillian Jones
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OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 7/19/2021

Facility Name: Autumn Leaves of Edmond

License Number: AL 5598

Survey Event ID: WQ0511

Date Survey Completed: 5/26/2021

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 911

Based on: interview and record review it was determined the center failed to implement interventions to prevent or lessen the risk of falls for one (#1) of 4 residents sampled for falls.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: In response to your letter dated June 24, 2021 regarding the Complaint Survey visit at Autumn Leaves of Edmond, the community submits the following Plan of Correction: This Plan of Correction constitutes Autumn Leaves of Edmond written plan of compliance for the alleged deficiencies cited, Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state law. This Plan of Correction shall not be considered a waiver of Autumn Leaves of Edmond informal dispute resolution or appeal 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?

OSDH Response: Element accepted Yes ☐ No ☐

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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Resident # 1 Discharged.

- The DHC/Designee will ensure all residents with fall and subsequent fall incident have updated ISP in a timely manner according to the company's policy to ensure all preventive interventions are documented and in place to prevent similar reoccurrence.
- The DHC/ED will ensure all fall and incidents are thoroughly investigated to ensure root cause of the falls are identified and proper interventions are put in place to prevent fall or fall related injury reoccurrence and ISP to be updated timely.
- The DHC/ED will ensure all current employees are educated on fall investigation protocol to ensure full cooperation and compliance and fall prevention measures and resident safety whenever implemented for new resident or new fall incident.
- The DHC will complete ISP for all new residents upon move in, at 14 days, at 90 days, annually, with any significant change in condition and post incident to reflect the resident's current plan of care as it relates to interventions to prevent fall or fall related injuries.
- The ED will ensure all new employees are trained on fall prevention, reporting requirement, investigation protocol, resident safety and implementation of preventive measures put in place.
- Facility will follow up with all lab orders and maintain sufficient records.

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?	• All residents with fall and subsequent fall incident will have updated ISP in a timely manner according to the company's policy to ensure all preventive interventions are documented and in place to prevent similar reoccurrence. • All falls and incidents will be thoroughly investigated to ensure root cause of the falls are identified and proper interventions put in place to prevent falls or fall related injury reoccurrence and ISP to be updated timely. • All current employees will be educated on fall and fall investigation protocol to ensure full cooperation and compliance and fall prevention measures as well as resident safety whenever implemented for new resident or new fall incident. • The DHC will complete ISP for all new residents upon move in, at 14 days, at 90 days, annually, with any significant change in condition and post incident to reflect the resident's current plan of care as it relates to interventions to prevent fall or fall related injuries. • The ED will ensure all new employees are trained on fall prevention, reporting requirement, investigation protocol, resident safety and implementation of preventive measures put in place.
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 community will adhere to the section 310:663-9-1(1) governing Nurse to ensure adequate staffing is available to meet the service 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: • All community's staff will be educated on the importance of promptly reporting to the Director of Healthcare or the Executive Director or designee any resident fall incident to ensure incident is timely and thoroughly investigated and ISP is updated as well as interventions implemented timely. • All ancillary service providers will be informed of the importance of communicating promptly with the Director of Healthcare or Executive Director or designee any fall incident to ensure incident is timely and thoroughly investigated and ISP is updated as well as interventions implemented timely. • The Executive Director will provide regular communications to family members and responsible parties regarding community and resident safety. Facility will

		monitor lab orders monthly , and resolve any compliance concerns The community's leadership team will meet monthly to review residents incident and compliances with process. In the event any resident has an identified increased number of fall incidents and the community is unable to have an effective intervention for resident to provide safety, the Director of Healthcare and Executive Director will meet with the resident's responsible party to determine appropriate action and appropriate level of care need for the resident, resident's service plan will be updated and staff will be educated as required. • The Executive Director and Director of Healthcare will conduct daily huddle during shift change and review nurse's communication book to ensure all identified incidents/injuries if any are reported in a timely manner to ensure incident is timely and thoroughly investigated and ISP are updated timely and accurately. • Any identified compliance concern during change of shift huddle will be addressed for correction and improvement. • Regional nurse will conduct random audit of the wellness site as well as chart review to ensure compliance and any identified concern will be discussed with ED and DHC.	
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 Rishell Palmer OAC 310:663-25-4(F)		Date 7/22/2021	
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