OKLAHOMA
State Department
of Health

Delivery via email to: vicky@unitedresource.biz

May 17, 2022

License Number: AL6302

Ms. Vicky Anderson, Administrator
Avonlea Cottage Of Shawnee, Llc
789 Country Grove Drive
Shawnee, OK 74804

Survey Event ID: I07R11

Dear Ms. Anderson:

On **May 4, 2022, r**epresentatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action will be completed for each violation; and
(6) Be signed by the administrator.

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

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Avonlea Cottage of Shawnee, LLC**
Address: **789 Country Grove Drive**
City, State, Zip: **Shawnee, OK 74804**
Provider #: **AL6302**
Complaint #: **OK00058696**
Investigation Date(s): **05/04/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to protect resident's right to be free from all types of abuse, including mental abuse.	S

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

An unannounced on-site investigation was initiated on 05/04/2022 at 9:40 a.m.

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

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1512 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (**S**) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

Melissa Swaim RN

Melissa Swaim RN

Date report completed: 05/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6302	A. BUILDING: _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVONLEA COTTAGE OF SHAWNEE, LLC	789 COUNTRY GROVE DRIVE SHAWNEE, OK 74804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A complaint investigation (#OK00058696) was conducted 05/04/22. Listed below are abbreviations used throughout this document. CMA-certified medication aide DHS-department of human services LTCA-long term care aide ODH-Oklahoma Department of Health	C 000		
C1512 SS=D	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect 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)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statues, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;	C1512		

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C1512	Continued From page 1 Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to protect and ensure a vulnerable adult was free from exploitation and abuse for one (#1) of three sampled residents for abuse or neglect. The administrator identified 13 residents who resided at the center.	C1512		

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C1512	Continued From page 2 Findings: The center's abuse and neglect policy, not dated, read in part, "...It is the policy of (name-deleted center) to protect our residents and to allow for the safest environment at all times. (Name-deleted center) prohibits the abuse or neglect of residents...All forms of abuse, exploitation, neglect...of residents...are prohibited and will not be tolerated..." The center's resident rights, not dated, read in part, "...It is the policy of (name-deleted) to perfect and promote the individual and several rights of residents in our homes...actively safeguards resident rights through development of its mission statement and policies and procedures and by carefully screening, selecting and training staff...every resident shall receive respect and privacy in the resident's medical care program...every resident shall have the right to receive courteous and respectful care and treatment...every resident shall be free from mental and physical abuse..." The center's employee abuse and neglect policy procedure, not dated, read in part, "...It is the policy of (name-deleted) that no resident shall be subject to Abuse/or Neglect...Neglect is defined as follows: The failure to provide protection for an elderly or incapacitated adult who is unable to protect his/her own interest...an employee of this facility who had any knowledge of abuse or neglect of a resident is required to report the matter to Administration immediately. This is in harmony with Oklahoma law, which makes reporting mandatory...it is also the policy of the facility to immediately investigate a matter of abuse and/or neglect as soon as the problem is	C1512		

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C1512	Continued From page 3	C1512		

reported. The resident and the involved employee will be interviewed to determine the facts...Any employee of (name-deleted) is subject to immediate dismissal if involved in abuse and/or neglect...This policy shall be made known to each new employee in the orientation procedure. In-service will be held about our policy on abuse and/or neglect..."

The center's policies and procedures manual, dated September 2019, read in part, "...Engaging in the following activities may subject you to disciplinary action, up to and including termination of employment...disclosing confidential company information (resident status)...The following actions are FORBIDDEN (Code of ethics): Breach of the resident's privacy and confidentiality of information...Committing any act of abuse, neglect or exploitation..."

A former LTCA's (former employee #1) employee record documented their first day of employment was 04/23/21 and was terminated 04/18/22.

Resident #1 had diagnoses to include dementia and senile brain degeneration.

A comprehensive assessment, dated 08/18/21, read in part, "...alert and oriented x 1 (self)...confused with poor judgement...poor mobility, strength, gait...one person assist with bathing, eating, dressing, toileting and ambulation...one to two person assist with transfers...incontinent of bladder and bowel..."

Inservice, dated 10/26/21, read in part, "...Resident Rights...Abuse..."

An initial incident report, ODH form 283, dated 04/17/22, read in part, "...Allegations of

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C1512	Continued From page 4	C1512		

Abuse/Mistreatment...Notifications Made...physician, family, resident's legal representative, DHS: Adult Protective Services, Appropriate licensing board (nurse aide registry), ombudsman...at 9:00 p.m. (CMA #1) sent me (Administrator) a disturbing picture..."

An attachment to ODH form 283, read in part, "...The picture showed (Resident #1) and (former employee #1) shooting the middle finger at the side of the bed and wrote across the picture was quote "Can't wait to WAKE her tf up heheh...CMA #1 stated that (former employee #2) sent the picture to her...

The Administrator contacted (former employee #2) and asked where (they) got the picture. (Former employee #2) said (they) saw it on (former employee #2's) snap chat (a multimedia instant messaging app, pictures and messages are usually only available for a short time before they become inaccessible to their recipients) two weeks ago and screenshot it. (They) were asked why (they) waited this long to report it and (former employee #2) said (they) told (former employee #1) not to post that and take it down. Then it started bothering (them) and so (they) reported it...

The Administrator attempted to contact former employee #1 via phone call and text, but no answer to suspend (former employee #1) while under investigation. The Administrator had reported the incident to all four daughters. Facility nurse and hospice nurse both assessed resident for any injuries, none were noted. Resident was calm and smiling...

The Administrator recognized and confirmed the hand and finger of the employee (former

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C1512	Continued From page 5 employee #1), the resident and the location. The Administrator had interviewed the resident and stated (former employee #1) never touched (them) inappropriately and never had caused (them) harm... The (name-deleted) police department, Administrator, and (former employee #1) had a meeting. (Former employee #1) stated the picture had been taken six months or more ago while working...playing on their phone...joking with their roommate while in the resident's room... (former employee #1) stated they did not write the statement across the picture...had never placed the picture on snap chat...never placed the picture on social media...the police investigator asked to see the (former employee #1's) phone and there were no resident's pictures saved...a report was filed... The corrective measures implemented to prevent reoccurrence were the facility fired (former employee #1) for taking the picture...explained to (former employee #1) the picture was exploitation and abuse of a resident...not allowed...had been trained and knew not to take pictures of residents...joke was disturbing in nature and would be further investigated by the police department...explained was reported to nurse aide registry for further review...had been trained phone was not to be in the facility except while on break and not ever in a resident's room... A camera was placed in the resident's room by the family...signs posted camera in use..." On 05/04/22 at 10:12 a.m., attempted to interview Resident #1, but was not interviewable. Resident #1 was observed sitting up in a mechanical wheelchair, awake, alert, watching a western. She spoke of the flowers her children had brought	C1512		

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C1512	Continued From page 6 her on the table in front of her and the actors on TV. At 10:39 a.m., a family member, of Resident #1 was contacted. When asked about the staff, the family stated, "As far as health care, hospice, aides, they're really good." The family member was asked how staff responded to requests for assistance. The family stated, "Mom is not where she can ask. So, she's kind of on a schedule." She stated the staff responds good and they placed a camera in the room now. At 10:50 a.m., CMA #1 stated, "I had been shown a picture." CMA #1 asked for the picture to be sent to them and contacted the Administrator about it. CMA #1 stated, "It wasn't appropriate." At 11:40 a.m., LPN #1 stated they would call the Administrator if someone had reported an allegation. At 11:46 a.m., the Administrator discussed the allegation of abuse, incident report, thorough investigation with the resident assessments, interview of resident(s) and staff, notifications, documentation, policy and procedures, abuse training during orientation, and inservice. At 2:51 p.m., CMA #2 stated they did not see any signs or adverse reactions of any of the residents.	C1512		

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May 20, 2022

License Number: AL6302

Ms. Vicky Anderson, Administrator
Avonlea Cottage Of Shawnee, Llc
789 Country Grove Drive
Shawnee, OK 74804

Survey Event ID: I07R11

Dear Ms. Anderson:

On **May 4, 2022**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1512** -There is no indication on how long the facility will monitor its performance to ensure solutions are sustained.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 5/19/2022** **Facility Name:** AVONLEA COTTAGE OF SHAWNEE **License Number:** AL6302 **Survey Event ID:** 107R11 **Date Survey Completed: 5/4/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1512	Based on: Based on record review and interview, the center failed to protect and ensure a vulnerable adult was free from exploitation and abuse for one (#1) of three sampled residents for abuse or neglect.

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	**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?	* Employee #1 who was employed by Avonlea Cottage during the time period of this deficient practice no longer works at the facility. Employee #1 was terminated on 4/18/22 and is not eligible for re-hire per Avonlea Cottage policy and procedure. * Resident #1 was interviewed and indicated that she felt safe. Resident #1 Representative was interviewed and notified on the alleged deficient practice and Employee #1 termination. * Avonlea Cottage Nurse and Hospice Nurse conducted a assessment of Resident #1 for signs of abuse with no signs of abuse noted. *All residents of Avonlea Cottage have potential to be affected by this deficiency practice and were interviewed and indicated that no similar findings and/or negative affects have been identified in regards to abuse, neglect, exploitation, or any violation of their rights. *Avonlea Cottage employees were interviewed and indicated that no similar findings were identified in regards to abuse, neglect, expoitation, or any violation of Resident Rights.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	*All residents of Avonlea Cottage have potential to be affected by stated deficiency of abuse and exploitation. *All other residents of Avonlea Cottage were interviewed with no similar findings and/or negative affect have been identified by this deficient practice and will be monitored continuously.
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?	*Residents, Resident's Representatives, and all Avonlea Cottage staff are educated on Abuse, neglect, and exploitation of a elderly.

	*All new residents and facility staff will receive education on abuse, neglect, and exploitation of a elderly by the Administrator, Nurse, or designee. *Avonlea Cottage employees will not be allowed to have their phones in the Resident's Rooms or while providing care for a Resident of Avonlea Cottage unless permission is granted by the Administrator. Example where permission maybe granted is if the employee is hearing impaired and uses the phone for hearing aid or Resident request a employee uses phone for virtual doctor visits. *Residents, Resident's Representatives, and all Avonlea Cottage staff will be educated on abuse yearly by the Nurse, Administrator, or designee. *Signage will be posted in the dining room display board and the nurses station on what abuse and neglect mean to help identify and prevent abuse at Avonlea Cottage. *An Abuse Prevention Committee will be initiated and will consist of the Administrator, Nurse, and Aide. The committee will be held monthly and esure ongoing and sustained compliance of this deficiency practice and to ensure that the deficient practice will not recur. *Care Plans completed by the nurse for all Residents will provide for yearly training and monthly monitoring for abuse. *Avonlea Cottage Residents and staff will receive random quality audits performed by the Administrator, Nurse, or designee in the form of interviews and observations on abuse, neglect, and exploitation to prevent this deficient practice from recur. *Avonlea Cottage policy and procedure on Abuse, Exploitation, and Resident Rights was reviewed and revised by the Administrator, QA Committee, and the Abuse Prevention Committee.
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.	*Administrator, nurse, or designee will perform observations; and random audits, in the form of resident and staff interviews weekly to monitor for abuse; monitor for employee phones in Residents rooms; and to ensure Avonlea Cottage responsibility that abuse, neglect, and exploitation are prevented to prevent this deficient practice from recur. *The Abuse Prevention Committee will look for trends and will make and suggest changes to monitoring for abuse. The Committee will check all monitoring records to assure completion is done. The Committee will make sure corrections are sustained; evaluate for effectiveness; and ensure that Avonlea Cottage is monitoring and performing to prevent abuse. The Committee will make recommendations for updated changes to the abuse Avonlea Cottage policy. The Committee will review Care

	Plans; orientation of new employees; all audits; training; and all other documentations on abuse and abuse prevention. The Committee will report immediately to the Administrator if any signs of abuse are evident. *The correction action for this deficiency practice will be incorporated into Avonlea Cottage Quality Assurance quarterly meetings. The Quality assurance Committee will review the Abuse Prevention Committee monthly findings and reports. The QA committee will follow OK State Department of Health guidelines and Avonlea Cottage policy and procedure to ensure that all Residents are protected from abuse. The QA Committee will report immediately to the Administrator if any signs of abuse are evident. *Monitoring records for Inservice records of staff training on abuse, Care Plans, Employee orientation on abuse; and Administrator or representative audits; will be kept in the Avonlea Cottage Abuse Prevention Committee book.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/30/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature VICKY ANDERSON, ADM. OAC 310:663-25-4(F)	**Date 5/20/2022**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable **Date:** Click here to enter a date. **Surveyor:** Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department
of Health

Delivery via email to: vicky@unitedresource.biz

May 23, 2022

License Number: AL6302

Ms. Vicky Anderson, Administrator
Avonlea Cottage of Shawnee, Llc
789 Country Grove Drive
Shawnee, OK 74804

Survey Event ID: I07R11

Dear Ms. Anderson:

On **May 4, 2022,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **May 30, 2022**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2022.05.23 08:52:00 -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: 5/19/2022** **Facility Name:** AVONLEA COTTAGE OF SHAWNEE **License Number:** AL6302 **Survey Event ID:** 107R11 **Date Survey Completed: 5/4/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1512	Based on: Based on record review and interview, the center failed to protect and ensure a vulnerable adult was free from exploitation and abuse for one (#1) of three sampled residents for abuse or neglect.

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	**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?	* Employee #1 who was employed by Avonlea Cottage during the time period of this deficient practice no longer works at the facility. Employee #1 was terminated on 4/18/22 and is not eligible for re-hire per Avonlea Cottage policy and procedure. * Resident #1 was interviewed and indicated that she felt safe. Resident #1 Representative was interviewed and notified on the alleged deficient practice and Employee #1 termination. * Avonlea Cottage Nurse and Hospice Nurse conducted a assessment of Resident #1 for signs of abuse with no signs of abuse noted. *All resident's of Avonlea Cottage have potential to be affected by this deficiency practice and were interviewed and indicated that no similar findings and/or negative affects have been identified in regards to abuse, neglect, exploitation, or any violation of their rights. *Avonlea Cottage employee's were interviewed and indicated that no similar findings were identified in regards to abuse, neglect, expoitation, or any violation of Resident Rights.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	*All residents of Avonlea Cottage have potential to be affected by stated deficiency of abuse and exploitation. *All other residents of Avonlea Cottage were interviewed with no similar findings and/or negative affect have been identified by this deficient practice and will be monitored continuously.
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?	*Resident's, Resident's Representatives, and all Avonlea Cottage staff are educated on Abuse, neglect, and exploitation of a elderly.

	*All new residents and facility staff will receive education on abuse, neglect, and exploitation of a elderly by the Administrator, Nurse, or designee. *Avonlea Cottage employees will not be allowed to have their phones in the Resident's Rooms or while providing care for a Resident of Avonlea Cottage unless permission is granted by the Administrator. Example where permission maybe granted is if the employee is hearing impaired and uses the phone for hearing aid or Resident request a employee uses phone for virtual doctor visits. *Resident's, Resident's Representatives, and all Avonlea Cottage staff will be educated on abuse yearly by the Nurse, Administrator, or designee. *Signage will be posted in the dining room display board and the nurses station on what abuse and neglect mean to help identify and prevent abuse at Avonlea Cottage. *A Abuse Prevention Committee will be initiated and will consist of the Administrator, Nurse, and Aide. The committee will be held monthly and esure ongoing and sustained compliance of this deficiency practice and to ensure that the deficient practice will not recur. *Care Plans completed by the nurse for all Residents will provide for yearly training and monthly monitoring for abuse. *Avonlea Cottage Residents and staff will receive random quality audits performed by the Administrator, Nurse, or designee in the form of interviews and observations on abuse, neglect, and exploitation to prevent this deficient practice from recur. *Avonlea Cottage policy and procedure on Abuse, Exploitation, and Resident Rights was reviewed and revised by the Administrator, QA Committee, and the Abuse Prevention Committee.
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.	*Administrator, nurse, or designee will perform observations; and random audits, in the form of resident and staff interviews weekly to monitor for abuse; monitor for employee phones in Residents rooms; and to ensure Avonlea Cottage responsibility that abuse, neglect, and exploitation are prevented to prevent this deficient practice from recur. Monitoring will be done until 5/20/2023. *The Abuse Prevention Committee will look for trends and will make and suggest changes to monitoring for abuse. The Committee will check all monitoring records to assure completion is done. The Committee will make sure corrections are sustained; evaluate for effectiveness; and ensure that Avonlea Cottage is monitoring and performing to prevent abuse. The Committee will make recommendations for updated changes to the abuse

	Avonlea Cottage policy. The Committee will review Care Plans; orientation of new employees; all audits; training; and all other documentations on abuse and abuse prevention. The Committee will report immediately to the Administrator if any signs of abuse are evident. Abuse Prevention Committee will monitor until 5/20/2023. *The correction action for this deficiency practice will be incorporated into Avonlea Cottage Quality Assurance quarterly meetings. The Quality assurance Committee will review the Abuse Prevention Committee monthly findings and reports. The QA committee will follow OK State Department of Health guidelines and Avonlea Cottage policy and procedure to ensure that all Residents are protected from abuse. The QA Committee will report immediately to the Administrator if any signs of abuse are evident. The QA Committee will monitor for one year until 5/20/2023. *Monitoring records for Inservice records of staff training on abuse, Care Plans, Employee orientation on abuse; and Administrator or representative audits; will be kept in the Avonlea Cottage Abuse Prevention Committee book and monitored for one year until 5/20/2023.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/30/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **VICKY ANDERSON, ADM.** OAC 310:663-25-4(F)	**Date 5/20/2022**

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.

Items Below Are For OSDH Use Only

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor

If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.
Facility in Compliance by: Click here to enter a date.

OKLAHOMA
State Department
of Health

Delivery via email to: vicky@unitedresource.biz

August 12, 2022

License Number: AL6302

Ms. Vicky Anderson, Administrator
Avonlea Cottage Of Shawnee, Llc
789 Country Grove Drive
Shawnee, OK 74804

RE: Survey Event I07R12

Dear Ms. Anderson:

On **August 8, 2022,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **May 4, 2022,** have now been corrected effective **May 30, 2022.**

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

Sincerely,

Lisa Calvin

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

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6302	A. BUILDING: _____ B. WING _____	R-C 08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVONLEA COTTAGE OF SHAWNEE, LLC	789 COUNTRY GROVE DRIVE SHAWNEE, OK 74804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS A revisit was conducted on 08/08/22. All deficiencies from the 05/04/22 survey were cleared.	{C 000}		

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