OKLAHOMA
State Department
of Health

Delivery via email to: vicky@unitedresource.biz

January 23, 2024

License Number: AL6701

Ms. Vicky Anderson, Administrator
Avonlea Cottage Of Seminole
2207 West Wrangler
Seminole, OK 74868

Survey Event ID: U5WM11

Dear Ms. Anderson:

On **January 17, 2024,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: **http://www.ok.gov/health**. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care**. 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 calendar days from receipt of the State Form deficiency statement. 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, conducted in a face to face, or a virtual 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.

Respectfully,

Lisa Calvin

Lisa Calvin, Enforcement Analyst II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA State Department of Health

INVESTIGATIVE REPORT

Facility: **Avonlea Cottage of Seminole**
Address: **2207 West Wrangler**
City, State, Zip: **Seminole, OK, 74868**
Provider #: **AL6701**
Complaint #: **OK000**
Investigation Dates: **01/16/24 through 01/17/24**

ALLEGATIONS

1.The center failed to have/or implement an effective infection control program.
2.The center failed to ensure fluids were served in a sanitary manner, failed to ensure adequate food portions were served according to the residents' preferences, and failed to ensure accommodations were made for a comfortable dining experience.
3.The center failed to ensure assistance with activities of daily living was provided in a timely manner according to the contract and the plan of care.
4.The center failed to ensure adequate staff to meet the needs of the residents.
5.The center failed to ensure mechanical lifts were provided and used in a safe manner.

An unannounced on-site investigation was initiated 01/16/2024 at 9:42 a.m.

A sample of three residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

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

A Summary of Complaint Investigation:

Tours of the center were conducted upon entrance and throughout the survey. The center was observed for adequate staff. Staff were observed for providing timely assistance to residents with activities of daily living, implementing effective infection control practices, providing adequate food portions, providing a comfortable dining experience, and providing safe transfers.

Resident records were reviewed including service plans, care plans, assessments, physician orders, weight reports, nurses progress notes, and incident reports. Resident grievances, dietary reports, food menus, maintenance logs, policy and procedures, user manuals, and staff time records were reviewed.

Residents and staff were interviewed and asked about adequate staff, timely assistance with activities of daily living, infection control practices, dietary services, and accidents.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/18/2024

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: **Avonlea Cottage of Seminole**
Address: **2207 West Wrangler**
City, State, Zip: **Seminole, OK, 74868**
Provider #: **AL6701**
Complaint #: **OK000**
Investigation Dates: **01/16/24 through 01/17/24**

ALLEGATION

The center failed to ensure adequate staff to meet the needs of the residents.

An unannounced on-site investigation was initiated 01/16/2024 at 9:42 a.m.

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A Summary of Complaint Investigation:

Tours of the center were conducted upon entrance and throughout the survey. The center was observed for adequate staff and staff were observed for providing timely assistance to residents with activities of daily living.

Resident records were reviewed including service plans, care plans, and assessments. Resident grievances and staff time records were reviewed.

Residents and staff were interviewed and asked about adequate staff and timely assistance with activities of daily living.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6701	A. BUILDING: _____ B. WING _____	C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVONLEA COTTAGE OF SEMINOLE	2207 WEST WRANGLER SEMINOLE, OK 74868

(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 Complaint investigations (#OK00061573 and #OK00061646) were conducted on 01/16/24 and 01/17/24. Facility Census: 24 Listed below are abbreviations that will be used throughout this document. CNA - certified nurse aide Res - resident	C 000		
C1505 SS=D	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 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	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AVONLEA COTTAGE OF SEMINOLE	2207 WEST WRANGLER SEMINOLE, OK 74868

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C1505	Continued From page 1 incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the center failed to ensure a mechanical lift was used in a safe manner for one (#3) of three sampled residents reviewed for accidents. The administrator identified four residents who utilized a mechanical lift for transfers. Findings: An undated "Patient Lift" center policy, read in part, "...At all times in using the Patient Lift there will be two trained staff members..." Res #3 had diagnoses which included peripheral neuropathy. A hospice aide sheet, dated 12/08/23, documented the resident required the use of a mechanical lift for transfers. On 01/16/24 at 1:20 p.m., CNA #1 was observed transferring Res #3 from their wheelchair to their bed using a mechanical lift. There were not two	C1505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6701	A. BUILDING: _____ B. WING _____	C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVONLEA COTTAGE OF SEMINOLE	2207 WEST WRANGLER SEMINOLE, OK 74868

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1505	Continued From page 2 staff members present during the transfer. On 01/16/24 at 1:33 p.m., CNA #1 was asked what was the protocol for using a mechanical lift to transfer residents. They stated most of the time there were two staff members to transfer the resident. On 01/16/24 at 1:36 p.m., the administrator was asked what was the protocol for using a mechanical lift to transfer residents. They stated there should be two staff members when using the mechanical lift. They were made aware of the above observation.	C1505		

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Delivery via email to: vicky@unitedresource.biz

February 7, 2024

License Number: AL6701

Ms. Vicky Anderson, Administrator
Avonlea Cottage Of Seminole
2207 West Wrangler
Seminole, OK 74868

Survey Event ID: U5WM11

Dear Ms. Anderson:

On **January 17, 2024,** 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 **January 30, 2024**.

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

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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: January 26, 2024
	Facility Name: Avonlea Cottage of Seminole
	License Number AL 6701
	Survey Event ID: Event USWM11
	Date Survey Completed: 1-17-2024

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1505	**Based on the observation, record review, and interview, the center failed to ensure a mechanical lift was used in a safe manner for one (#3) of three sampled residents reviewed for accidents.**

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?	***On 1-16-2024 CNA #1 was observed transferring Res #3 from their wheelchair to their bed using a mechanical lift. There were not two staff members present during the transfer. CNA #1 was re-trained on the proper protocol in utilizing a Mechanical Lift on Residents. This was completed on 1-25-2024.** *** At Avonlea Cottage protocol will be followed and no one will transfer a Resident with a Mechanical Lift unless two staff members are present during the transfer and all employees were trained on this policy on 1-26-2024.** ***Four Residents of Avonlea Cottage were identified to have potential to be affected by this deficiency practice. Avonlea Cottage Administrator and nurse conducted a review on all Resident's required to use a Mechanical Lift as needed to assure that all employees trained to use the Mechanical Lift were utilizing two staff members present during the transfer and safety measures were provided on these Residents. This was completed on 1-25-2024.**
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	**Four Residents, Res #3, Res #1, Res #13, and Res #18 have the potential to be affected by the same deficient practice as identified by the Administrator and the nurse. These four Residents were identified through their Avonlea Resident Record to have a need assessed by a licensed nurse to need at times a Mechanical Lift. These Residents were identified on 1-24-2024.**
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 Avonlea Cottage nursing staff that use a Mechanical Lift are trained on the protocol of proper use and safety of a Mechanical Lift before they are allowed to use the Mechanical Lift.**

	***All Avonlea Cottage staff that uses the Mechanical Lift will receive additional information training on the protocol, Avonlea Cottage Policy, and safety of using a Mechanical Lift. This was completed on 1-26-2024.** ***Avonlea Cottage will post a note up in each Resident Room that has a Mechanical Lift that two people will assist in the transfer of the Resident. This was completed on 1-26-2024.** ***All Avonlea Cottage staff will be trained in In-Service training on the protocol and policies of using a Mechanical Lift on a Resident. This was completed on 1-26-2024.**
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 twice weekly audit reviews and monitoring for one month; and then monthly for one year on Residents that have a Mechanical Lift to prevent this deficient practice from recur. This audit and monitoring will check to assure that two people are assisting with a Mechanical Lift and proper protocol is being followed for safety of Residents. This audit was initiated on 1-26-2024.** ***A record will be used with a list of all Residents that use a Mechanical Lift showing evidence and effectiveness the Mechanical Lift Protocol and Policy has been evaluated by the Adminstrator, Nurse, or Designee to prevent this deficient practice from recur. This was completed on 1-26-2024.** ***This corrective action for this deficiency practice will be incorporated into Avonlea Cottage Quality Assurance quarterly meetings. The Quality Assurance Committee will review the audits and monitoring records. The Quality Assurance Committee will check to make sure all Avonlea Cottage Protocols and Policy regarding a Mechanical Lift are being followed. The Quality Control Committee will report any findings to the Administrator. This was incorporated into Avonlea Cottage Quality Assurance meeting on 1-26-24 and will be reviewed each quarterly meeting for one year.** ***Monitoring Records will be kept in a binder in the Administrators Office to show evidence of the deficient practice with performed audits with monitoring and reviews to make sure corrections are sustained. This was initiated on 1-26-2024.**
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	**1-30-2024**
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Vicky Anderson, Adm. OAC 310:663-25-4(F) Vicky Anderson			**Date** 1-26-2024
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
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February 23, 2024

License Number: AL6701

Ms. Vicky Anderson, Administrator
Avonlea Cottage Of Seminole
2207 West Wrangler
Seminole, OK 74868

Survey Event ID: U5WM12

Dear Ms. Anderson:

On **February 22, 2024,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 17, 2024,** have now been corrected effective **January 30, 2024.**

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

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
	AL6701	A. BUILDING: _____ B. WING _____	R-C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVONLEA COTTAGE OF SEMINOLE	2207 WEST WRANGLER SEMINOLE, OK 74868

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{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 02/22/24. The facility was in substantial compliance.	{C 000}		

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