Oklahoma State Department of Health
Creating a State of Health

October 15, 2019

License Number: AL7225

Ms. Jerilyn Davidson, Administrator
The Homestead Of Owasso
14701 East 86th Street North
Owasso, OK 74055

Survey Event ID: Z6J211

Dear Ms. Davidson:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **September 18, 2019**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

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

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **The Homestead of Owasso**
Address: **14701 East 86th Street North**
City, State, Zip: **Owasso, OK. 74055**
Provider #: **AL7225**
Complaint #: **OK54062**
Investigation Date(s): **09/18/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide accurate accounting according to residents' contract and supplemental advertisement.	S

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

An unannounced on-site investigation was initiated on 09/18/2019 at 2:15 p.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 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: The center failed to provide accurate accounting according to resident's contract and supplemental advertisement.

An investigation specific to the center failing to provide accurate accounting according to the resident's contract and supplemental advertisement was conducted.

Deficient practice was substantiated related to this allegation.
However no citation was cited since the center was processing the resident's refund.
The resident identified in the complaint moved into the center on 08/24/18, and lived there until her the death on 02/28/19 (about 6 months).

On 09/18/19 at 2:45 p.m., a review of contracts, billing records, and emails related to the resident identified in the complaint was conducted. No documentation of any discount was found documented in the resident's records. The resident's spouse signed all paper work related to the cost of the center and the financial responsibility for the resident. The resident's record had no documentation related to a concession/discounted rate on the day the paperwork was signed by the resident's spouse.

However, in the complaint the resident's family had included a flyer with a discount of half price on the first month and the third month's rent. No documentation of the flyer was located in the resident's records.

The corporate office responsible for issuing the concessions/discounts said they were not aware of any discount until 3 months after the resident had moved out (expired) and 8 months after the resident's move-in date. The corporate staff stated no family member had requested a refund or made staff aware until approximately 9 months from the date the resident had moved into the center. Staff was not aware the family was due a refund and had not received a discount until they requested a refund on May 8, 2019 and the center started reviewing documents. The administrator (ADM) responsible for filing a concession/discount no longer worked at the center.

When the corporate staff was questioned about any special pricing which was advertised at the time period the resident moved into the center staff acknowledged the center had advertised a discount. The corporate representative said the ADM at the time could have offered the discount, but she had no documentation a discount was offered to the resident since the resident's representative had signed a contract which did not include a discount and no concession/discount waiver was documented.

The corporate representative said the center would extend the discount to the resident/representative and refund the amount even though it was not obligated in the documentation/contract, it would be the right thing to do.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 1.

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.

Justina Leach RN/CHFS

Date report completed: 09/23/2019

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
	AL7225	A. BUILDING: _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD OF OWASSO	14701 EAST 86TH STREET NORTH OWASSO, OK 74055

(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 abbreviated survey was conducted on 09/18/19. The census was 44. No deficient practice was cited.	C 000		

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

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL7225	THE HOMESTEAD OF OWASSO

Type of Survey (select all that apply)

3								

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 32388	09/18/2019	09/18/2019	0.50	0.00	2.25	0.00	1.50	5.00
2. 18473	09/18/2019	09/18/2019	0.50	0.00	2.25	0.00	1.50	1.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

OCT 16 2019