Oklahoma State Department of Health
Creating a State of Health

January 23, 2020

License Number: AL7225

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

Survey Event ID: V66211

Dear Ms. Davidson:

On **January 2, 2020**, 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 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) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

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

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

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Katie Stagner

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kgs

Enclosure

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 #: **OK#54649**
Investigation Date(s): **01/02/20**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure medications were properly administered.	**S**
2. The center failed to ensure staff were qualified to perform their assigned tasks.	**S**
3. The center failed to provide care according to the resident's contract.	**US**

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

An unannounced on-site investigation was initiated on **01/02/2020** at 9:30 a.m.

A sample of 6 residents including any identified resident, 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 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 C1505 for details.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C0911 for details.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.
An investigation specific to residents receiving care according to the contract was conducted.

On 01/02/20 at 9:45 a.m., a tour of the center was conducted. Residents were observed in common areas and in hallways were clean with no odors, interacting with other residents and staff. At 11:00 a.m. the resident identified in the complaint was observed. The resident was sitting on the couch in the common/TV area asleep with no foul odors/urine and well groomed. The shower schedule for the resident was reviewed with staff and documented the resident was observed every 2 hours "eyes on" and toilet checks were completed. Residents had the right to refuse care, showers, change of clothes, toileting/incontinent care. Staff stated attempts were made to shower, toilet or provide incontinent care and change resident clothes, but it was the residents right to refuse and they could not be forced.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 1 & 2. 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.

Deficient practice was unsubstantiated for allegation 3. 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 state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Justina Leach RN/CHFS

Date report completed: 01/13/2020

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 _____	01/02/2020

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 01/02/20, to investigate complaint #OK00054649. The census was 47. The following deficient practice was cited.	C 000		
C 911 SS=D	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review, it was determined the nurse failed to ensure neurological (neuro) checks were monitored, completed, and documented by qualified staff for 1 (#3) of 1 sampled resident who had a physician order for 24 hour neuro checks. This failed practice resulted in the isolated potential for more than minimal harm. Findings: Resident #3 moved into the center on 03/11/19, with diagnoses to include major depressive disorder, pain unspecified, cerebrovascular disease, and hypertension. On 01/02/20 at 9:30 a.m., the medical record was reviewed with the assistance of the licensed practical nurse #1 (LPN#1) and the registered nurse (RN)/ Administrator.	C 911		

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

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 _____	01/02/2020

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 911	Continued From page 1 A nurse's note, dated 11/04/19, documented resident #3 had received the wrong medications. The physician was notified and had ordered neurological checks (neuro checks) and finger stick blood sugars (FSBS). No internal incident report had been completed by the center for the medication error. No head injury log was received for resident #3 for the date of 11/04/19. A head injury log for resident #3, dated 11/13/19, documented CMAs (Employee #3 and Employee #4) had documented staff checked on the resident and questioned the resident on the log. It was standard practice at the center for CMAs to conduct the checks and questions for resident head injury logs (neuro check). It documented, "notify the nurse immediately if the resident answered "Yes" to any of the questions as follows: Are you in pain? Have a headache? Dizzy? Vision change? Loss of balance? Vomiting? Difficulty breathing? Weak in arms or legs?" At 10:10 a.m., LPN #1 was asked who had done neuro checks on resident #3. She stated the CMAs had completed a head injury log and would call the nurse if resident's had issues. She stated they were advanced trained CMAs for FSBS. She stated neuro checks had not been monitored or completed by a nurse. There was no head injury log documentation, dated 11/04/19 for resident #3. There was no documentation of neurological checks completed or monitored by a nurse.	C 911		

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 _____	01/02/2020

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
C1505	Continued From page 2	C1505		
C1505 SS=F	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 incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure the physician ordered medications were administered to the right resident, for 1 (#3) of 3 sampled residents who received medications from the centers staff. This failed practice had the widespread potential for more than minimal harm for all 47 residents receiving medication from the center's staff.	C1505		

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 _____	01/02/2020

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
C1505	Continued From page 3 On 01/02/20 at 9:30 a.m., resident #3's medical record was reviewed with the assistance of the licensed practical nurse#1 (LPN#1), and the registered nurse (RN)/ Administrator. A nurse's note, dated 11/04/13, documented resident #3 had received the wrong medications. No internal incident report had been completed for the the resident who received the wrong medications. At 11:30 a.m., LPN #1 stated resident #3 had not received the correct medications. The long term care aide (LTCA) had two residents medication prepared and adminsistered the other residents' medication to resident #3. The physician was notified and a new order for 24 hour neuro checks and FSBS was ordered. Resident #3 was not harmed by the incorrect medication.	C1505		

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. 323[illegible]	01/02/2020	01/02/2020	0.50	0.00	3.50	0.00	1.50	7.50
2.								
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**

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 _____	R 02/26/2020

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 A follow-up survey was conducted on 02/26/20. The census was 45. All deficient practice was cleared.	{C 000}		

klahoma State Department of Health
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7225	A. BUILDING: _____ B. WING _____	C 01/02/2020

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 01/02/20, to investigate complaint #OK00054649. The census was 47. The following deficient practice was cited.	C 000		
C 911 SS=D	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review, it was determined the nurse failed to ensure neurological (neuro) checks were monitored, completed, and documented by qualified staff for 1 (#3) of 1 sampled resident who had a physician order for 24 hour neuro checks. This failed practice resulted in the isolated potential for more than minimal harm. Findings: Resident #3 moved into the center on 03/11/19, with diagnoses to include major depressive disorder, pain unspecified, cerebrovascular disease, and hypertension. On 01/02/20 at 9:30 a.m., the medical record was reviewed with the assistance of the licensed practical nurse #1 (LPN#1) and the registered nurse (RN)/ Administrator.	C 911		

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 _____	C 01/02/2020

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 911	Continued From page 1 A nurse's note, dated 11/04/19, documented resident #3 had received the wrong medications. The physician was notified and had ordered neurological checks (neuro checks) and finger stick blood sugars (FSBS). No internal incident report had been completed by the center for the medication error. No head injury log was received for resident #3 for the date of 11/04/19. A head injury log for resident #3, dated 11/13/19, documented CMAs (Employee #3 and Employee #4) had documented staff checked on the resident and questioned the resident on the log. It was standard practice at the center for CMAs to conduct the checks and questions for resident head injury logs (neuro check). It documented, "notify the nurse immediately if the resident answered "Yes" to any of the questions as follows: Are you in pain? Have a headache? Dizzy? Vision change? Loss of balance? Vomiting? Difficulty breathing? Weak in arms or legs?" At 10:10 a.m., LPN #1 was asked who had done neuro checks on resident #3. She stated the CMAs had completed a head injury log and would call the nurse if resident's had issues. She stated they were advanced trained CMAs for FSBS. She stated neuro checks had not been monitored or completed by a nurse. There was no head injury log documentation, dated 11/04/19 for resident #3. There was no documentation of neurological checks completed or monitored by a nurse.	C 911		

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 _____	C 01/02/2020

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
C1505	Continued From page 2	C1505		
C1505 SS=F	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 incapacitated. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure the physician ordered medications were administered to the right resident, for 1 (#3) of 3 sampled residents who received medications from the centers staff. This failed practice had the widespread potential for more than minimal harm for all 47 residents receiving medication from the center's staff.	C1505		

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 _____	C 01/02/2020

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
C1505	Continued From page 3 On 01/02/20 at 9:30 a.m., resident #3's medical record was reviewed with the assistance of the licensed practical nurse#1 (LPN#1), and the registered nurse (RN)/ Administrator. A nurse's note, dated 11/04/13, documented resident #3 had received the wrong medications. No internal incident report had been completed for the the resident who received the wrong medications. At 11:30 a.m., LPN #1 stated resident #3 had not received the correct medications. The long term care aide (LTCA) had two residents medication prepared and adminsistered the other residents' medication to resident #3. The physician was notified and a new order for 24 hour neuro checks and FSBS was ordered. Resident #3 was not harmed by the incorrect medication.	C1505		

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/27/2020** **Facility Name:** Homestead of Owasso **License Number:** AL7225 **Survey Event ID:** V66211 **Date Survey Completed: 1/2/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C911	Based on: interview and record review, it was determined the nurse failed to ensure neurological (neuro) checks were monitored,completed, and documented by qualified staff for1 (#3) of 1 sampled resident who had a physician order for 24 hour neuro checks. This failed practice resulted in the isolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: It is the policy of our facility to implement a "Head Injury Log" for nursing staff to complete upon actual or suspected head injury. This is not a neurological check form designed to be completed only by nurses. It is our intention to always follow physician orders and will review our policy and procedures regarding the use of this form and neurological check form. All incidents or events that require monitoring will be discussed in the daily stand up meeting and any issues of non-compliance will be immediately addressed by the facility Resident Care Coordinator (RCC) and the Executive Director and disciplinary action will be conducted including but not limited to suspension and/or termination.

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?	The RN will educate nursing staff that only nurses can take orders from physicians, physician's nurses, etc. The nurse will then implement the order as given. The nursing staff will be informed of the order and proper care to be given. The nursing staff will be inserviced on proper completion of incident reporting and documentation, who completes the head injury log and the neurocheck log, reporting of signs and symptoms, and ongoing monitoring and every suspected fall with or without injury, will be reported to a nurse immediately. The inservice will be 1/29, 1/30 and 1/31.
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 practice has the potential to affect all 47 residents. Reviewing and educating staff on procedure for reporting incidents, accepting orders, and implementing interventions will positively affect all resident care and outcomes.
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 RN will review all logs for quality assurance and will measure implementation and outcomes on head injury logs and neurocheck logs. The RN will provide training and education needs identified with monitoring. All calls from physicians, ancillary care providers, clinics, hospitals, etc. will be directed to a nurse. The nurse will follow the orders received and communicate that information to the appropriate staff.

	The nurse will implement the use of a head injury log or a neurocheck log with instruction to the staff on the proper completion of the log. Any deviations to this practice will be reported to the RN.
OSDH	
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.	A. The RN will monitor compliance in following procedure by monitoring incident reports and tracking with quality assurance measures. B. Monitoring of incidents is ongoing and will include use of head injury log and neurocheck log implementation. C. The RN will maintain incident reports, head injury log and neurocheck logs in the quality assurance performance improvement program documents. Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH	
5. On what date will corrective action be completed?	1/31/2020
OSDH	

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Lindsey Davidson	**Date 1/27/2020**	
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 Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/27/2020** **Facility Name:** Homestead of Owasso **License Number:** AL7225 **Survey Event ID:** V66211 **Date Survey Completed: 1/2/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1505	Based on: interview and record review, it was determined the center failed to ensure the physician ordered medications were administered to the right resident, for 1 (#3) of 3 sampled residents who received medications from the centers staff. This failed practice had the widespread potential for more than minimal harm for all 47 residents receiving medication from the center's staff.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Homestead of Owasso takes this matter of deficient practice seriously and has and will continue to implement training and quality improvement practices. All incidents or events that require monitoring will be discussed in the daily stand up meeting and any issues of non-compliance will be immediately addressed by the facility Resident Care Coordinator (RCC) and the Executive Director and disciplinary action will be conducted including but not limited to suspension and/or termination.

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?	The nurses are performing medication pass observations on all CMA's to ensure proper technique is performed and ensuring the 7 rights are being implemented for each medication pass. The CMA's will complete a review of medication administration inservice materials and will complete a test to show knowledge of materials and proper technique on 1/29, 1/30 and 1/31. The CMA's will not prepour medications. The CMA's will use the "PIG" procedure for administering medications to this and all residents. The CMA's will be inserviced on reporting of medication errors and filling out a medication error report with the nurse on 1/29, 1/30 and 1/31.
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 nurses will perform medication pass observations on all CMA's to ensure proper technique is performed at random times on random residents. An audit of medications, administration times and sign off sheets will be performed routinely. The CMA's will practice the "PIG" procedure for administering medications to all residents.
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 nurses are performing medication pass observations on all CMA's to ensure proper technique is performed and ensuring the 7 rights are being implemented for each medication pass. The CMA's will complete a review of medication administration inservice materials and will complete a test to show knowledge of materials and proper technique on 1/29, 1/30 and 1/31.

	The CMA's will not prepour medications. The CMA's will use the "PIG" procedure for administering medications to this and all residents.
OSDH	
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.	A. The RN will monitor error reports, audit findings, medication administration observation findings and will address need for further education or action. B. QA measures, tracking and plan for improvement will be implemented for medication errors. All incidents or events that require monitoring will be discussed in the daily stand up meeting and any issues of non-compliance will be immediately addressed by the facility Resident Care Coordinator (RCC) and the Executive Director and disciplinary action will be conducted including but not limited to suspension and/or termination. C. The RN will monitor the records and share the findings with the nursing staff as a tool to continue/sustain improvements in the administration of medications, error reporting, and following of policy and procedures Enter methods to evaluate for effectiveness: Enter methods to incorporate into QA system: Enter methods to keep monitoring records:
OSDH	
5. On what date will corrective action be completed?	1/31/2020

Administrator's Signature OAC 310:663-25-4(F)	Administrator signature required. Jessica Davidson	**Date 1/27/2020**	
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 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.			

FEB 10 2020
SJ.

Oklahoma State Department of Health
Creating a State of Health

March 9, 2020

License Number: AL7225

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

Survey Event ID: V66212

Dear Ms. Davidson:

On **February 26, 2020,** 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 2, 2020,** have now been corrected effective **January 31, 2020.**

If you have any questions concerning the information in this letter, please contact the Enforcement Coordinator at (405) 271-6868.

Sincerely,

Lisa Calvin

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL7225	A. BUILDING: _____ B. WING _____	R 02/26/2020

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 A follow-up survey was conducted on 02/26/20. The census was 45. All deficient practice was cleared.	{C 000}		

klahoma State Department of Health
ABORATORY 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	D			

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	02/26/2020	01/26/2020	0.50	0.00	0.50	0.00	0.75	0.50
2.								
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**