OKLAHOMA
State Department
of Health

Delivery via email to: bchappell@trinitywoodstulsa.com

February 21, 2024

License Number: AL7226

Ms. Britani Chappell, Administrator
Trinity Woods, Inc
3130 South Sandusky Ave
Tulsa, OK 74135

RE: Survey Event ID: WB3Z11

Dear Ms. Chappell:

Enclosed is a report of the inspection with complaint investigations conducted at your Assisted Living Center on **February 14, 2024.** No deficiencies were cited. Oklahoma Statutes 63-1-1910 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) 426-8200.

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:	**Trinity Woods, INC**
Address:	**3130 South Sandusky Ave**
City, State, Zip:	**Tulsa, OK. 74135**
Provider #:	**AL7226**
Complaint #:	**OK00061554**
Investigation Date:	**02/12/24 through 02/15/24**

ALLEGATION(S)

1. The center failed to ensure meals were served according to schedule and food was provided according to residents' requests.	
2. The center failed to ensure residents were treated with dignity and respect	
3. The center failed to ensure care was provided according to the assessment, plan of care, contract and the residents acuity of care.	

An unannounced on-site investigation was initiated 02/12/2024 at 11:00 a.m.

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

A Summary of Complaint Investigation:
A tour of the facility was conducted upon entrance, at other various times throughout the survey, and across multiple shifts. Observations were made of staff washing hands, wear gloves if needed, and using hand sanitizers. Observations were made of staff assisting residents in main dining room of assisted living and nurse and personal sitters assisting residents with meals in memory care assisted living. Observations made of staff transferring residents, toileting residents and assisting them to walk if needed.

Residents were interviewed related to going to the dining room to eat meals, did staff sit with residents while the resident was eating, was there certain times that the dining rooms where open to residents and if the residents could go into dining room without staff being in attendance.

Resident records were reviewed including service contract, resident assessments, physician orders, care/service plan, progress notes.

Staff members were interviewed regarding the facility policy on staff eating with residents in either dining room, the procedure/policy to determine if a resident has reached the highest level of care for assisted living, and can a resident come into either dining room before the times that are posted.

The attached CMS 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: 02/16/2024

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
	AL7226	A. BUILDING: _____ B. WING _____	C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY WOODS, INC	3130 SOUTH SANDUSKY AVE TULSA, OK 74135

(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 relicensure survey was conducted from 02/12/24 through 02/14/24. A complaint investigation (#OK00061554) was conducted in conjunction with the survey. No deficiencies were cited. Facility Census: 62	C 000		

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