OKLAHOMA
State Department
of Health

**Delivery via email to: bchappell@trinitywoodstulsa.com**

September 4, 2024

License Number: AL7226

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

**Survey Event ID: PIRB11**

Dear Ms. Chappell:

On **August 30, 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: Trinity Woods Assisted Living**
**Address: 3130 South Sandusky Ave**
**City, State, Zip: Tulsa, OK 74135**
**Provider #: Al7226**
**Complaint #: OK00066133**
**Investigation Dates: 08/29/24 and 08/30/24**

| ALLEGATION |
| --- |
| The facility failed to protect resident from physical abuse by employee. |

An unannounced on-site investigation was initiated 08/29/2024 at 1:15 p.m.

A sample of three residents, including any identified residents, 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 Summary of Complaint Investigation:**

Residents were observed relaxing in common areas and in their rooms. Staff were observed attending to residents and assisting with ADLs.

Staff were interviewed regarding abuse, facility policies and education on abuse.

Record reviews included facility policies, incident reports, electronic medical records and abuse investigations.

The attached State form, Statement of Deficiencies, 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: 08/30/2024

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 08/30/2024 |

| 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<br><br>A complaint investigation (#OK00066133) was conducted on 08/29/24 and 08/30/24.<br>Facility Census: 60 | C 000 | | |
| C1512 SS=D | 310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect<br><br>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<br><br>63 O.S. 1-1918.(B)(12)<br>(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;<br><br>Title 43A O.S. 10-103. Definitions<br>8. "Abuse" means causing or permitting:<br>a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or<br>b. the deprivation of nutrition, clothing, shelter, | C1512 | | |

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| C1512 | Continued From page 1<br>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;<br><br>10. "Neglect" means:<br>a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest,<br>b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or<br>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;<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to prevent abuse for one (#1) of three residents sampled for abuse.<br><br>The administrator identified 60 residents resided in the facility.<br><br>Findings:<br><br>A "Preventing Resident Abuse" facility policy read in part "...Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, | C1512 | | |

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| C1512 | Continued From page 2<br>systems, etc., to assist in preventing resident abuse.<br><br>Resident #1 has diagnoses which include unspecified dementia with behavioral disturbances and anxiety.<br><br>An " Incident Report Form" dated 07/27/24 documented Resident #1 hit DA#1 and DA#1 hit the resident back on the shoulder.<br><br>On 08/29/24 at 1:38 p.m., LPN #1 stated that DA#1 self reported the unwitnessed incident to her when it occurred and that they immediately reported the incident to the administrator.<br><br>On 08/29/24 at 2:35 p.m., the administrator stated as soon as the incident was reported, DA#1 was placed on administrative leave and Resident #1 was assessed for injuries. The administrator stated no injuries were found. The administrator stated reports were filed with all required agencies and an investigation was begun. The staff were re-educated on abuse and facility policies on abuse. The administrator stated that at the conclusion of the investigation, it was determined that physical touch did occur between the staff member and the resident, but not to what extent. The abuse was substantiated by the facility and DA#1 was terminated.<br><br>On 08/29/24 at 3:11 p.m., the administrator stated that all staff on the Trinity Woods campus were re-educated on abuse by 08/06/24. | C1512 | | |

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**Delivery via email to: bchappell@trinitywoodstulsa.com**

September 24, 2024

License Number: AL7226

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

**Survey Event ID: PIRB11**

Dear Ms. Chappell:

On **August 30, 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 **August 31, 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<br>Creating a State of Health<br><br>Protective Health Services<br>Long Term Care Service | **OPTIONAL PLAN OF CORRECTION TEMPLATE**<br>**Current Date: 9/13/2024**<br>**Facility Name:** Trinity Woods Inc.<br>**License Number:** AL 7226<br>**Survey Event ID:** PIRB11<br>**Date Survey Completed: 8/30/2024** |
|---|---|

**SUMMARY OF DEFICIENCY CITED BY OSDH**

| | |
|---|---|
| ID Prefix Tag: C1512 | Based on: Based on record review and interview, the facility failed to prevent abuse for one (#1) of three residents sampled for abuse. |

**ASSISTED LIVING CENTER'S PLAN OF CORRECTION**

Assisted Living Center's Comments: Trinity Woods Inc. respectfully submits this plan of correction as its allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies or violations and is submitted at the request of the Oklahoma Department of Health and Human Services. Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.

| **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 employee was immediately placed on administrative leave pending the investigation. The employee is no longer employeed by Trinity Woods. The resident was assessed and no injuries were sustained. |
| 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 resident residing in assisted living were identified as having potential to be affected by this alleged deficient practice. |
| 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? | Staff were educated on abuse and neglect by 8/6/24 and will continue to be educated annually. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:<br>a. How the correction will be evaluated for effectiveness;<br>b. How the correction will be incorporated into the center's quality assurance system; and<br>c. How monitoring records will be kept to evidence the correction. | Enter methods to ensure corrections are sustained:<br><br>All grievances and allegations will be reviewd by the administrator or designee.<br><br>Results will be taken to the quality assurance team that meets quartly for the next 3 meetings or longer as needed.<br><br>The reviews will be documented in the quality assurance minuets. |
| OSDH Response: Element accepted Yes ☐ No ☐ | |
| 5. On what date will corrective action be completed? | 8/31/2024 |
| OSDH Response: Element accepted Yes ☐ No ☐ | |

| **Administrator's Signature** OAC 310:663-25-4(F) | **Date 9/13/2024** |
|---|---|

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: .<br>Facility in Compliance by: . | | | |

OKLAHOMA
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of Health

**Delivery via email to:** Britani Chappell <bchappell@trinitywoodstulsa.com>

September 30, 2024

License Number: AL7226

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

**Survey Event ID: PIRB12**

Dear Ms. Chappell:

On **September 30, 2024,** an offsite/paper complaint revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **August 30, 2024,** have now been corrected effective **August 31, 2024.**

If you have any questions concerning the information in this letter, please contact 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

| 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 _____ | R-C 09/30/2024 |

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

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|---|---|---|---|---|
| {C 000} | INITIAL COMMENTS<br><br>An offsite/paper revisit was conducted on 09/30/24. 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