Oklahoma State Department of Health
Creating a State of Health

January 9, 2020

License Number: AL7238

Ms. Danna Wise, Administrator
Autumn Leaves Of Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

RE: Survey Event ID: S8IT11

Dear Ms. Wise:

On **December 20, 2019**, agents from our office concluded a State Licensure survey with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on December 20, 2019.

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 (attached). 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 and monitoring will be completed for each violation;
(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

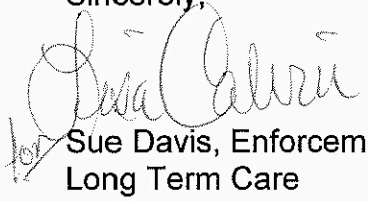
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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,



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

SD/ldc

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Autumn Leaves of Tulsa**
Address: **7807 S. Mingo RD**
City, State, Zip: **Tulsa, OK, 74133**
Provider #: **AL7238**
Complaint #: **OK# 54430**
Investigation Date(s): **12/18/19 through 12/20/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to refund money as stated in the resident's contract.	S

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

An unannounced on-site investigation was initiated on 12/18/2019 at 9:45 a.m.

A sample of 11 residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegation.

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 1302 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 1. 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.

Thank you for bringing these concerns to our attention.

Justina Leach RN/CHFS

Date report completed: 12/26/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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 re-licensure survey was conducted 12/18/19 through 12/20/19, in conjunction with complaint #OK54430. The census was 23. The following deficient practice was cited.	C 000		
C1302 SS=F	310:663-13-1(b) RESIDENT SERVICE CONTRACT (b) All rights, privileges and assurances guaranteed to residents under these rules or marketing materials are deemed incorporated in any contract between an assisted living center and a resident. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a refund was issued for 1 (#9) of 1 sampled residents as contracted. This failed practice had the widespread potential for more than minimal harm for all 23 residents who resided at the center. Findings: Resident #9 moved into the center 06/04/19 with diagnoses of dementia, behaviors, hypertension, pulmonary fibrosis, and edema. On 12/20/19 at 9:45 a.m. the administrator was asked for a copy of the financial records related to resident #9. Resident #9's contract documented the resident's family was to receive a refund payment 30 days from June 2019. The financial documentation for reimbursement was	C1302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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
C1302	Continued From page 1 dated October 9, 2019. The administrator stated the resident expired 2 days after the moved-in date. The family called about reimbursement and were given the corporate number for financial business because the finances were handled at corprorate not at the center. The administrator stated the family should have been reimbursed within the 30 days per contract. Contract The center's contract dated 06/01/18, documented "In the event of the death of the Resident, This Agreement shall terminate after (10) days. Responsible Party will be given a pro-rated refund for any pre-paid fees based on the day of the Resident's death. All refunds will be provided to Responsible Party within thirty (30) days of the effective date of termination."	C1302		
C1921 SS=E	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to ensure: a. The correct dose of medication was administered for 1 (#11) of 3 sampled residents	C1921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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
C1921	Continued From page 2 who were administered medication by the center's staff; and b. There was a physician's order to apply a topical medication for 1 (#11) of 3 sampled resident who had a cream at bedside. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 12/19/19 at 9:45 a.m. resident #11 was administered a 4 milligram (mg) Risperidone tablet for a diagnosis of dementia related symptoms. Resident #11's physician orders were reviewed and documented the resident was to receive a 2 mg (1/2 tablet) dose one time a day. The resident did not received the correct dose of Risperidone for 19 days. The December 2019 medication administration record (MAR) documented a 4 mg dose was administered to resident #11 rather than the correct dose of 2 mg. An over the counter medication (butt cream) was observed on the bedside table in resident #11's room. Employee #1 was asked if there was a physician order for the over the counter cream. There was no physician order to apply cream to the area. On 12/20/19 at 11:20 a.m. the registered nurse (RN) stated he should have checked the medication each time the resident's spouse provided it from an outside pharmacy (4 mg tablet). The staff was not aware of the over the counter medication at the bedside and had no physician order for it.	C1921		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL7238	AUTUMN LEAVES OF TULSA

Type of Survey (select all that apply)

2	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	12/18/2019	12/20/2019	1.00	0.00	13.50	0.00	4.50	6.50
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**

JAN 10 2020

Oklahoma State Department of Health
Creating a State of Health

January 22, 2020

License Number: AL7238

Ms. Danna Wise, Administrator
Autumn Leaves Of Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

RE: Survey Event S8IT11

Dear Ms. Wise:

On December 20, 2019, a Licensure inspection was conducted at your Assisted Living Center facility. 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 17, 2020**.

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) 271-6868.

Sincerely,

Katie Stagner

for Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

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
	AL7238	A. BUILDING: _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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 re-licensure survey was conducted 12/18/19 through 12/20/19, in conjunction with complaint #OK54430. The census was 23. The following deficient practice was cited.	C 000		
C1302 SS=F	310:663-13-1(b) RESIDENT SERVICE CONTRACT (b) All rights, privileges and assurances guaranteed to residents under these rules or marketing materials are deemed incorporated in any contract between an assisted living center and a resident. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a refund was issued for 1 (#9) of 1 sampled residents as contracted. This failed practice had the widespread potential for more than minimal harm for all 23 residents who resided at the center. Findings: Resident #9 moved into the center 06/04/19 with diagnoses of dementia, behaviors, hypertension, pulmonary fibrosis, and edema. On 12/20/19 at 9:45 a.m. the administrator was asked for a copy of the financial records related to resident #9. Resident #9's contract documented the resident's family was to receive a refund payment 30 days from June 2019. The financial documentation for reimbursement was dated October 9, 2019.	C1302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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
C1302	Continued From page 1 The administrator stated the resident expired 2 days after the moved-in date. The family called about reimbursement and were given the corporate number for financial business because the finances were handled at corprorate not at the center. The administrator stated the family should have been reimbursed within the 30 days per contract. Contract The center's contract dated 06/01/18, documented "In the event of the death of the Resident, This Agreement shall terminate after (10) days. Responsible Party will be given a pro-rated refund for any pre-paid fees based on the day of the Resident's death. All refunds will be provided to Responsible Party within thirty (30) days of the effective date of termination."	C1302		
C1921 SS=E	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to ensure: a. The correct dose of medication was administered for 1 (#11) of 3 sampled residents who were administered medication by the	C1921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	C 12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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
C1921	Continued From page 2 center's staff; and b. There was a physician's order to apply a topical medication for 1 (#11) of 3 sampled resident who had a cream at bedside. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 12/19/19 at 9:45 a.m. resident #11 was administered a 4 milligram (mg) Risperidone tablet for a diagnosis of dementia related symptoms. Resident #11's physician orders were reviewed and documented the resident was to receive a 2 mg (1/2 tablet) dose one time a day. The resident did not received the correct dose of Risperidone for 19 days. The December 2019 medication administration record (MAR) documented a 4 mg dose was administered to resident #11 rather than the correct dose of 2 mg. An over the counter medication (butt cream) was observed on the bedside table in resident #11's room. Employee #1 was asked if there was a physician order for the over the counter cream. There was no physician order to apply cream to the area. On 12/20/19 at 11:20 a.m. the registered nurse (RN) stated he should have checked the medication each time the resident's spouse provided it from an outside pharmacy (4 mg tablet). The staff was not aware of the over the counter medication at the bedside and had no physician order for it.	C1921		

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/13/2020** **Facility Name:** Autumn Leaves of Tulsa **License Number:** 7238 **Survey Event ID:** S8IT11 **Date Survey Completed: 12/20/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1302	Based on: The center failed to ensure a refund for 1 of 1 sampled residents as contracted.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction constitutes Autumn Leaves of Tulsa's written allegations of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. This Plan of Correction shall not be considered a waiver of Autumn Leaves of Tulsa's appeal rights.

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?	Resident's will receive a refund as contracted. Resident agreements to be updated to clarify timeline for refunds.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Random audits will be completed for the first 30 days and at each quarterly QA meeting thereafter. The Executive Director will review the audits and assure all refunds are given in a timely manner.
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?	Random audits will be completed for the first 30 days and at each quarterly QA meeting thereafter. The Executive Director will review the audits and assure all refunds are given in a timely manner.
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.	Random audits will be completed for the first 30 days and at each quarterly QA meeting thereafter. The Executive Director will review the audits and assure all refunds are given in a timely manner. Random audits will be completed for the first 30 days and at each quarterly QA meeting thereafter. The Executive Director will review the audits and assure all refunds are given in a timely manner. Random audits will be completed for the first 30 days and at each quarterly QA meeting thereafter. The

	Executive Director will review the audits and assure all refunds are given in a timely manner. Random audits will be completed for the first 30 days and at each quarterly QA meeting thereafter. The Executive Director will review the audits and assure all refunds are given in a timely manner.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/17/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Danna Wise** OAC 310:663-25-4(F)	**Date 1/13/2020**

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: 1/13/2020** **Facility Name:** Autumn Leaves of Tulsa **License Number: 7238** **Survey Event ID:** S8IT11 **Date Survey Completed: 12/20/2019**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1921	Based on: The center failed to ensure the correct dose of medication was administered for 1 of 3 sampled residents. There was not a physician order for a topical medication for 1 of 3 sampled residents who had cream at bedside.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: This Plan of Correction constitutes Autumn Leaves of Tulsa's written allegations of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. This Plan of Correction shall not be considered a waiver of Autumn Leaves of Tulsa's appeal rights.

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?	Medications will be administered only on a Physician's order. All Certified Medication Aides will be in-serviced on ensuring that the proper dosage of medication is given to each resident per the Physician's order. All employees will be in-serviced that ALL over-the counter medications are to be stored in the medication room and should never be in a resident's room without a specific Physician's order. All resident family members will be re-educated on the medications policy that is signed upon admission.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Director of Healthcare will complete a weekly audit of the MARS to ensure medication dosages are consistent with Physician's orders. A weekly sweep of resident's rooms will be completed by a member of the leadership team to ensure no over the counter medications are being stored in the resident's rooms.
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 Certified Medication Aides will be in-serviced on ensuring that the proper dosage of medication is given to each resident per the Physician's order. Director of Healthcare will complete a weekly audit of the MARS to ensure medication dosages are consistent with Physician's orders.

	All employees will be in-serviced that ALL over-the counter medications are to be stored in the medication room and should never be in a resident's room without a specific Physician's order. A weekly sweep of resident's rooms will be completed by a member of the leadership team to ensure no over the counter medications are being stored in the resident's rooms. All resident family members will be re-educated on the medications policy that is signed upon admission.
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.	Results from audits will be discussed at each quarterly QA meeting. An investigation will be conducted by the Executive Director, the Director of Healthcare and/or designee if an audit reveals Physician's orders are not being followed or medications are found in residents rooms. Results from audits will be discussed at each quarterly QA meeting. An investigation will be conducted by the Executive Director, the Director of Healthcare and/or designee if an audit reveals Physician's orders are not being followed or medications are found in residents rooms. Results from audits will be discussed at each quarterly QA meeting. An investigation will be conducted by the Executive Director, the Director of Healthcare and/or designee if an audit reveals Physician's orders are not being followed or medications are found in residents rooms. Results from audits will be discussed at each quarterly QA meeting. An investigation will be conducted by the Executive Director, the Director of Healthcare and/or designee if an audit reveals Physician's orders are not being followed or medications are found in residents rooms.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/17/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Danna Wise OAC 310:663-25-4(F)	**Date** 1/13/2020

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.

PLAN OF CORRECTION
AUTUMN LEAVES OF TULSA
DECEMBER 2019

This Plan of Correction constitutes Autumn Leaves of Tulsa's written allegations of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. This Plan of Correction shall not be considered a waiver of Autumn Leaves of Tulsa's appeal rights.

C1302:

Resident's will receive a refund as contracted.

All residents have the potential to be affected.

Resident agreements to be updated to clarify timeline for refunds.

Random audits will be completed for the first 30 days and at each quarterly QA meeting thereafter. The Executive Director will review the audits and assure all refunds are given in a timely manner.

Completion Date: 1-17-20

C1921:

Medications will be administered only on a Physician's order.

All residents have the potential to be affected.

All Certified Medication Aides will be in-serviced on ensuring that the proper dosage of medication is given to each resident per the Physician's order.

Director of Healthcare will complete a weekly audit of the MARS to ensure medication dosages are consistent with Physician's orders.

All employees will be in-serviced that ALL over-the counter medications are to be stored in the medication room and should never be in a resident's room without a specific Physician's order.

A weekly sweep of resident's rooms will be completed by a member of the leadership team to ensure no over the counter medications are being stored in the resident's rooms.

All resident family members will be re-educated on the medications policy that is signed upon admission.

Results from audits will be discussed at each quarterly QA meeting. An investigation will be conducted by the Executive Director, the Director of Healthcare and/or designee if an audit reveals Physician's orders are not being followed or medications are found in residents rooms.

Completion Date: 1-17-2020

Survey POC Compliance Monitoring Tool

Check Yes or No to indicate complete or present *AUTUMN LEAVES OF TULSA C1302: RESIDENT SERVICE CONTRACT*

Audit Date and sign	*Room #*	*Resident Name*	*Resident has a move in agreement/ contract signed?*		*Resident is currently out of the community?*		*Resident/responsible party has refunds due?*		*Was refunds given to resident/responsible party in a timely manner?*		*Comments*
			Yes	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	

Notes:

Survey POC Compliance Monitoring Tool

Check Yes or No to indicate complete or present *AUTUMN LEAVES OF TULSA C1921A: MEDICATION ADMINISTRATION*

Audit Date and sign	*Room #*	*Resident Name*	*Resident receives medications from community?*		*Resident's dispensed medications follows physician's order?*		*Resident received medications as prescribed by physician?*				*Comments*
			Yes	*No*	*Yes*	*No*	*Yes*	*No*			

Notes:

Survey POC Compliance Monitoring Tool

Check Yes or No to indicate complete or present AUTUMN LEAVES OF TULSA C1921B: OVER THE COUNTER MEDICATION AT BEDSIDE

Audit Date and sign	Room #	Resident Name	Resident receives medications from community?		Over the Counter medications observed at resident's bedside?		Resident has physician's order to keep Over the Counter medication at bedside?		Over the Counter medication observed at resident's bedside removed/order updated?		Comments
			Yes	No	Yes	No	Yes	No	Yes	No	

Notes:

Oklahoma State Department of Health
Creating a State of Health

February 19, 2020

License Number: AL7238

Ms. Danna Wise, Administrator
Autumn Leaves Of Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

RE: Survey Event S8IT12

Dear Ms. Wise:

On **February 4, 2020,** a revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 20, 2019,** have now been corrected effective **January 17, 2020.**

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

Sincerely,

Katie Stagner

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

SD/kgs

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
	AL7238	A. BUILDING. _____ B. WING _____	R-C 02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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 02/03/20 and 02/04/20. The census was 33. Deficient practice for tag C1302 and C1921 was cleared.	{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
AL7238	AUTUMN LEAVES OF TULSA

Type of Survey (select all that apply)

2	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	02/03/2020	02/04/2020	0.50	0.00	1.00	0.00	1.50	1.00
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**