



Oklahoma State Department of Health
Creating a State of Health

March 6, 2020

License Number: AL7238

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

Survey Event ID: PHDM11

Dear Ms. Wise:

On **February 4, 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.

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (President)
Edward A Legako, MD (Vice-President)
Becky Payton (Secretary)

Jenny Alexopoulos, DO
Terry R Gerard II, DO
Charles W Grim, DDS, MHA

R Murali Krishna, MD
Ronald D Osterhout
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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

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Autumn Leaves of Tulsa
Address: 7807 S. Mingo Rd
City, State, Zip: Tulsa, OK, 74133
Provider #: AL7238
Complaint #: OK#54940
Investigation Date(s): 02/03/20 through 02/04/20

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The center failed to ensure a refund was issued as contracted.	US

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

An unannounced on-site investigation was initiated on Monday, February 3, 2020 at 1:00 p.m.

A sample of 7 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 unsubstantiated related to this allegation.

An investigation specific to contract refunds was conducted. A review of records documented the resident identified in the complaint's power of attorney (POA) had given the center a 30 day notice, in writing on 10/31/19. The center stopped billing on 11/30/19. The center does not refund if the resident/family chooses to move the resident out of the center a few days early from the 30 day notice deadline. The center cannot use/rent the bed space until after the 30 day notice is completed.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation 1. 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.

A handwritten signature in black ink, appearing to read 'J. Leach', with a long horizontal line extending to the right.

Justina Leach RN/CHFS

Date report completed: 02/07/2020

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Autumn Leaves of Tulsa
Address: 7807 S. Mingo Rd
City, State, Zip: Tulsa, OK, 74133
Provider #: AL7238
Complaint #: OK#54970
Investigation Date(s): 02/03/20 through 02/04/20

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The center failed to have and/or implement their abuse policy.	US
2. The center failed to administer medications according to physician's orders.	S
3. The center failed to ensure residents' contracted services were provided.	US

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

An unannounced on-site investigation was initiated on Monday, February 3, 2020 at 1:00 p.m.

A sample of 7 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 unsubstantiated related to this allegation.

An investigation specific to resident abuse was conducted. The centers records concerning the resident identified in the complaint, documented and investigation was conducted as per the center's policy/state requirements. All entities were notified per state regulation.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1923 for details.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the center's contracted services/care was conducted. The resident's contract does not specify every 2 hour toileting. Documentation reviewed of activities of daily living (ADLs) documented staff had frequent toileting checks and residents were observed being toileted throughout the investigation. Resident appeared clean and no foul odor was observed. Interviews were conducted with staff, residents and family members at the center during the investigation. All four of the community's shower/bathroom facilities were toured with the assistance of staff and no issues or extreme odors were observed.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation 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 1 & 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.

A handwritten signature in black ink, appearing to read 'Justina Leach', is written over a horizontal line.

Justina Leach RN/CHFS

Date report completed: 02/12/2020

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL7238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/04/2020
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF TULSA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 On 02/03/20 and 02/04/20 an abbreviated survey was conducted to investigate complaints #OK54940 and #OK54970. The census was 33. The following deficient practice was cited.	C 000		
C1923 SS=E	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. 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 identity and signatures of certified medication aide employees, who administered nebulizer treatments to 1 (#4) of 1 sampled resident, was identified on a medication administration record (MAR); and	C1923		

Oklahoma State Department of Health
LABORATORY 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 AL7238	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____		(X3) DATE SURVEY COMPLETED C 02/04/2020
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF TULSA		STREET ADDRESS, CITY, STATE, ZIP CODE 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
C1923	Continued From page 1 b) Certified medication employees, who administered nebulizer treatments routine or as needed to 1 (#4) of 1 sampled resident, recorded the date, time, dose, medication, and administration method on the MAR, as required. These deficient practices had the potential for more than minimal harm at a pattern. Findings: Resident #4 Resident #4's medical record and physician's orders documented the resident was to receive Albuterol (breathing treatment) via nebulizer 2 times a day (BID) and as needed. Resident #4's MAR was reviewed with the assistance of the registered nurse (RN). Four times in the month of January 2020, medication staff had not initialed, signed their names or documented breathing treatments were administered. The RN was asked about the missing initials and signatures of the staff administering breathing treatments for resident #4 on the MAR. The RN stated without the signatures or initials he was not able to determine if the medication (breathing treatment) had been administered. The RN stated staff knew the MAR required initials and signatures and he would be monitoring initials and signatures of the treatments and physician ordered medication.	C1923			

STATE WORKLOAD REPORT

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

Type of Survey (select all that apply)

☒ 3 ☐ ☐ ☐ ☐

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

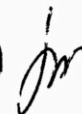
Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 32888	02/03/2020	02/04/2020	1.00	0.00	6.75	0.00	3.75	13.00
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
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Total SA Clerical/Data Entry Hours....	0.00	Total RO Clerical/Data Entry Hours.....	0.00
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Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

MAR 08 2020





Oklahoma State Department of Health
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March 16, 2020

License Number: AL7238

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

Survey Event ID: PHDM11

Dear Ms. Wise:

On February 4, 2020, 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 **February 21, 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,

Sue Davis
Long Term Care Enforcement Coordinator
Oklahoma State Department of Health

SD/tk

Board of Health

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Commissioner of Health

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Edward A Legako, MD (*Vice-President*)
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7238	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/04/2020
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF TULSA		STREET ADDRESS, CITY, STATE, ZIP CODE 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
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Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

0159

PHDM11

If continuation sheet 1 of 2

D. Ulise Executive Director 3-11-202

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7238	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/04/2020
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF TULSA			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
C1923	Continued From page 1 b) Certified medication employees, who administered nebulizer treatments routine or as needed to 1 (#4) of 1 sampled resident, recorded the date, time, dose, medication, and administration method on the MAR, as required. These deficient practices had the potential for more than minimal harm at a pattern. Findings: Resident #4 Resident #4's medical record and physician's orders documented the resident was to receive Albuterol (breathing treatment) via nebulizer 2 times a day (BID) and as needed. Resident #4's MAR was reviewed with the assistance of the registered nurse (RN). Four times in the month of January 2020, medication staff had not initialed, signed their names or documented breathing treatments were administered. The RN was asked about the missing initials and signatures of the staff administering breathing treatments for resident #4 on the MAR. The RN stated without the signatures or initials he was not able to determine if the medication (breathing treatment) had been administered. The RN stated staff knew the MAR required initials and signatures and he would be monitoring initials and signatures of the treatments and physician ordered medication.	C1923			



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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 3/11/2020

Facility Name: Autumn Leaves of Tulsa

License Number: AL7238

Survey Event ID: PHDM11

Date Survey Completed: 2/4/2020

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923

Based on: a) The identity and signatures of certified medication aid employees, who administered nebulizer treatments to 1 (#4) of 1 sampled resident, was not identified on a medication administration record and b) Certified medication employees, who administered nebulizer treatments routine or as needed to 1 (#4) of 1 sampled resident, did not record the date, time, dose, medication, and administration method on the MAR, as required.

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

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

ASSISTED LIVING CENTER'S PLAN ELEMENTS

All required signatures will be present on the MAR. A master signature page has been placed back on each MAR.
All Certified Medication Aides have been in-serviced on the importance of their signature and the importance of recording the date, time, dose, medication and administration method on the MAR.

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 signatures and date, time, dose, medication and administration method are complete.

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?

A master signature page has been placed back on each MAR.
All Certified Medication Aides have been in-serviced on the importance of their signature and the importance of recording the date, time, dose, medication and administration method on the MAR.
Director of Healthcare will complete a weekly audit of the MARS to ensure signatures and date, time, dose, medication and administration method are complete.

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

Results from the 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 missing signatures or date,

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.	time, dose, medication and administration method are not complete. Results from the audits will be discussed at each quarterly QA meeting. An investigation will be conducted by the Executive Director, the Director of Healthcare an/or designee if an audit reveals missing signatures or date, time, dose, medication and administration method are not complete. Results from the audits will be discussed at each quarterly QA meeting. An investigation will be conducted by the Executive Director, the Director of Healthcare an/or designee if an audit reveals missing signatures or date, time, dose, medication and administration method are not complete. Results from the audits will be discussed at each quarterly QA meeting. An investigation will be conducted by the Executive Director, the Director of Healthcare an/or designee if an audit reveals missing signatures or date, time, dose, medication and administration method are not complete.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	2/21/2020
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature Danna Wise <i>D. Wise</i> OAC 310:663-25-4(F)	Date 3/11/2020
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.	

Master Signature Sheet

Month: February 2020

Initial	Print Name	Signature	Title
W	Jeremy Wilson, RN	[Signature]	RN/DHC
SB	Shoreen Benik-camles	[Signature]	LCMA
GG	Shelly Gleason	[Signature]	CMA
IM	Imelda Miller	[Signature]	CMA
GW	Jim Ward	[Signature]	CMA
JK	John Kahr LPN	[Signature]	LPN
RB	Rhannon Fads CMA	[Signature]	CMA

March 2020

Master Sign Sheet

Initials

Printed Name

Signature

1. TM
2. RB
3. SBC
4. SG
5. SW
6. DW
7. RW
8.

Imecia Miller
Rheannon Fads
Sherona Bonilla
Shelly Gleason
Jimmy Ward
Deleene Washington
Jeremy Wilson, KY

D. Migg
RB
Sherona Bonilla
Shelly Gleason
Jimmy Ward
D. Washington
Imecia

Daily Medication Room Audit

Date Audit Completed	Thursday 2-6-2020
Audit Completed By: Name and Title	Jeremy Wilson, RN DHC

Item Audited	Y / N	Comments
All administered medications addressed on MAR?	Y	
All medications not administered addressed on front and back of MAR?	Y	
All administered narcotics signed for by ACMA in narcotic book?	Y	
All narcotics counts completed and correct?	Y	
All discontinued medications removed from medication room?	Y	
All expired medications removed from medication room?	Y	
Master Signature Sheet initialed and signed by all ACMAs?	Y	
Medication Room clean, tidy, and organized?	Y	
Medication Carts clean and organized and narcotic drawers locked?	Y	

Auditor Signature: _____

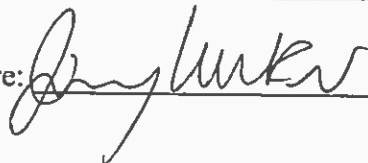
Date: 2-6-2020

Daily Medication Room Audit

Date Audit Completed	2-14-2020
Audit Completed By: Name and Title	Jeremy Wilson, RN, DHC

Item Audited	Y / N	Comments
All administered medications addressed on MAR?	Y	
All medications not administered addressed on front and back of MAR?	Y	
All administered narcotics signed for by ACMA in narcotic book?	Y	
All narcotics counts completed and correct?	Y	
All discontinued medications removed from medication room?	Y	
All expired medications removed from medication room?	Y	
Master Signature Sheet initialed and signed by all ACMAs?	Y	
Medication Room clean, tidy, and organized?	Y	
Medication Carts clean and organized and narcotic drawers locked?	Y	

Auditor Signature:



Date: 2-14-2020

Daily Medication Room Audit

Date Audit Completed	2-21-2020
Audit Completed By: Name and Title	Jeremy Wilson, RN, PICC

Item Audited	Y / N	Comments
All administered medications addressed on MAR?	Y	
All medications not administered addressed on front and back of MAR?	Y	
All administered narcotics signed for by ACMA in narcotic book?	Y	
All narcotics counts completed and correct?	Y	
All discontinued medications removed from medication room?	Y	
All expired medications removed from medication room?	Y	
Master Signature Sheet initialed and signed by all ACMAs?	Y	
Medication Room clean, tidy, and organized?	Y	
Medication Carts clean and organized and narcotic drawers locked?	Y	

Auditor Signature:

Jeremy Wilson

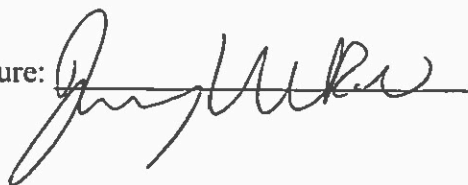
Date: 2-21-2020

Daily Medication Room Audit

Date Audit Completed	2-28-2020
Audit Completed By: Name and Title	Jeremy Wilson, RPh/DIC

Item Audited	Y / N	Comments
All administered medications addressed on MAR?	Y	
All medications not administered addressed on front and back of MAR?	Y	
All administered narcotics signed for by ACMA in narcotic book?	Y	
All narcotics counts completed and correct?	Y	
All discontinued medications removed from medication room?	Y	
All expired medications removed from medication room?	Y	
Master Signature Sheet initialed and signed by all ACMAs?	Y	
Medication Room clean, tidy, and organized?	Y	
Medication Carts clean and organized and narcotic drawers locked?	Y	

Auditor Signature:



Date:

2-28-2020

Daily Medication Room Audit

Date Audit Completed	3-7-2020
Audit Completed By: Name and Title	Jeremy Wilson, RN, DHC

Item Audited	Y / N	Comments
All administered medications addressed on MAR?	Y	
All medications not administered addressed on front and back of MAR?	Y	
All administered narcotics signed for by ACMA in narcotic book?	Y	
All narcotics counts completed and correct?	Y	
All discontinued medications removed from medication room?	Y	
All expired medications removed from medication room?	Y	
Master Signature Sheet initialed and signed by all ACMAs?	Y	
Medication Room clean, tidy, and organized?	Y	
Medication Carts clean and organized and narcotic drawers locked?	Y	

Auditor Signature: _____

Date: 3-7-2020



AUTUMN LEAVES™

BETTER MEMORY CARE. BY DESIGN.

In Service

Date: 2-12-2020

Topic: Medication Policy and Procedures

(Signing MARS appropriately)

Duration: 2:00-3:00

[illegible]

Medication Room/Administration Guidelines

- A COMPLETE narcotic count MUST occur prior to assuming the responsibility of the keys. You must count EVERY controlled substance and verify on the count sheet that it is correct. This includes ensuring that ALL narcotics that are given are initialed on the MARs and signed by the administering Nurse/ACMA in the narcotic books. This is for ALL routine AND PRN controlled substances.
- ALL medications must be verified that the order on the medication packaging and the order on the Resident's MAR match **EXACTLY**, if there is ANY discrepancy notify the DHC or other member of the management team IMMEDIATELY and DO NOT administer the medication to the Resident.
- Medications may not be carried around the community. If a medication needs to be administered in a Resident's apartment, only THAT Resident's medications are permitted in their apartment. If administering medications outside of the medication room, medication picture book must be taken to the Resident's apartment to verify that Resident's identity prior to administration.
- NO ONE other than an Autumn Leaves Nurse/ACMA may be in the medication room. NO ONE other than an Autumn Leaves Nurse/ACMA may administer medications to Residents.

CNAs MAY NEVER FEED, HAND, OR ADMINISTER A MEDICATION TO ANY RESIDENT AT ANY TIME FOR ANY REASON. VIOLATION OF THIS POLICY IS GROUNDS FOR IMMEDIATE TERMINATION OF THE CNA AND THE ACMA/NURSE!!!

- Medications must be kept in the medication room **THEY ARE NOT ALLOWED IN A RESIDENT'S APARTMENT AT ANY TIME** this includes continuous care medications such as topical creams, ointments, eye drops, ear drops, patches, breathing treatment solutions, inhalers, etc.
- Oral medications must be stored separately from non-oral medications (topical creams, ointments, patches, eye/ear drops, breathing treatment solutions, inhalers, etc.)

Employee Name (Print): Shelly Gleason

Employee Name (Sign): Shelly Gleason Date: 2/12/20

Medication Room/Administration Guidelines

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- NO ONE other than an Autumn Leaves Nurse/ACMA may be in the medication room. NO ONE other than an Autumn Leaves Nurse/ACMA may administer medications to Residents.
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Employee Name (Print): Rhiannon Fads

Employee Name (Sign): R Fads

Date: 2.12.20

Medication Room/Administration Guidelines

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Employee Name (Print): Sissy Ward

Employee Name (Sign): Sissy Ward

Date: 2-11-2020

Medication Room/Administration Guidelines

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Employee Name (Print):

Darlene Washington

Employee Name (Sign):

D. Washington

Date: 1-12-2020

Medication Room/Administration Guidelines

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- Oral medications must be stored separately from non-oral medications (topical creams, ointments, patches, eye/ear drops, breathing treatment solutions, inhalers, etc.)

Employee Name (Print): Donesha Davis

Employee Name (Sign): Donesha Davis

Date: 2-12-2020

Medication Room/Administration Guidelines

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Employee Name (Print): Morgan Eaglin

Employee Name (Sign): M. Eaglin

Date: 2-12-20

Example MAP

Indicate Site With Appropriate Number:

- A. SUGGEST REFUSED / WITHHELD MEDICATION EXPLAINED IN NURSE'S MEDICATION NOTES.**
- B. WHEN PRN MEDICATIONS ARE GIVEN, EXPLAIN IN NURSE'S MEDICATION NOTES.**

16. Upper Chest Right
17. To Right and Above Umbilicus
18. To Left and Above Level of Umbilicus
19. To Right and Below Level of Umbilicus
20. To Left and Below Level of Umbilicus

[illegible]

See Reverse Side

Routine Meds

Example MAE

Tylenol 325 mg
1 tab PO Daily

[illegible][illegible][illegible][illegible][illegible][illegible]

Physician:
Allergies:

Diet:

Diagnosis:

Acm:

ID:

Room:

DOB:

Patient Name: DOE, JANE

Facility:

Date: 8/1/2026



Delivery via email to: ddwise@AutumnLeaves.com

November 16, 2020

License Number: AL7238

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

Survey Event ID: PHDM12

Dear Ms. Wise:

On **November 10, 2020**, an offsite/paper desk audit complaint revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **February 4, 2020**, have now been corrected effective **February 21, 2020**.

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

Sincerely,

Users, Lisa
D Calvin

Digitally signed by
Users, Lisa D Calvin
Date: 2020.11.16
14:25:34 -06'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7238	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/10/2020
NAME OF PROVIDER OR SUPPLIER AUTUMN LEAVES OF TULSA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 desk audit was completed on 11/10/2020. Evidence of correction was submitted for all deficiencies.	{C 000}		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE