OKLAHOMA
State Department
of Health

August 12, 2022

License Number: AL7238

Ms. Trischa Kwiatkowski, Administrator
Colonial Oaks At Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

Survey Event ID: G8KQ11

Dear Ms. Kwiatkowski:

On **July 13, 2022,** representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action will be completed for each violation; and
(6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance

under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 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 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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may <u>not</u> 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.

Sincerely,

Lisa Calvin

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

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Colonial Oaks at Tulsa**
Address: **7807 S. Mingo Rd**
City, State, Zip: **Tulsa, Ok. 74133**
Provider #: **AL 7238**
Complaint #: **OK00059134**
Investigation Date(s): **07/11/22 through 07/13/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure residents were not neglected.	**US**
2. The center failed to ensure residents were administered medications as ordered by the physician and medications were available in the facility.	**S**
3. The center failed to ensure resident's property was not misappropriated.	**US**
4. The center failed to ensure residents were provided timely incontinent care.	**US**
5. The center failed to provide adequate staff for the care of dependent residents.	**US**

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

An unannounced on-site investigation was initiated on Thursday, July 7, 2022 at 11:15 a.m.

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

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was unsubstantiated related to this allegation.
Tours of the facility were conducted throughout the survey. Residents were observed to receive timely assistance with activities of daily living and be engaged in multiple activities throughout the day.

Residents were interviewed and stated they received timely assistance with activities of daily living and social activities. Staff were interviewed and stated they strived to provide timely care.

The sampled residents' clinical records were reviewed and documented residents received assistance with activities of daily living and assistance.

Facility incident reports and state reportable incident reports were reviewed. There was no documentation of allegations of neglect.

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.
Tours of the facility were conducted throughout the survey.

Residents were interviewed and denied any misappropriation of property. Facility staff were interviewed and denied any knowledge of misappropriation of property. Facility staff stated in the event a resident on hospice was low on supplies, the hospice would sometimes give instruction to pull supplies provided to the facility and set a time for delivery of the supplies from hospice.

The sampled residents' clinical records were reviewed. There was no documentation of misappropriation of property. Facility incident reports and state reportable incident reports were reviewed. There was no documentation of misappropriation of property.

Allegation #4: Deficient practice was unsubstantiated related to this allegation.
See allegation #1

Allegation #5: Deficient practice was unsubstantiated related to this allegation.
See allegation #1

A sample period of time was reviewed for census and staffing ratios. The facility exceeded state minimum staffing requirements for the sampled time period.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation two. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation one, three, four, and five. 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

B. Garrison, R.N.

B. Garrison, R.N.

Date report completed: 07/14/2022

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 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL OAKS AT 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 complaint investigation (#OK00059134) was conducted on 07/11/22 through 07/13/22.	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 interview and record review, it was determined the facility failed to maintain an accurate written record of medication administration for three (#1, 2, and #3) of three sampled residents and failed to administer medications as ordered for one (#1) of three sampled residents. The facility administrator identified 35 residents residing in the facility.	C1923		

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 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL OAKS AT 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
C1923	Continued From page 1 Findings: 1. Resident #1 had diagnoses which included congestive heart failure and Alzheimer's dementia. The physician's orders, dated June 2022, documented the resident was to receive donepezil (Aricept - a medication to aid in the slowing of the progression of dementia) 10mg at bedtime and furosemide (a diuretic) 40mg daily. The medication administration, dated June 2022, record documented the resident did not receive donepezil 10mg on 06/05/22. A note on the MAR documented the medication was on order and not given to the resident. The medication administration record documented the resident did not receive donepezil 10mg on 06/06/22 through 06/15/22, 06/22/22, and 06/30/22. There was no documentation as to why the resident had not received the medication. The medication administration record did not document the resident had received furosemide 40mg from 06/18/22 through 06/22/22. 2. Resident #2 had diagnoses which included gastro-esophogeal reflux disease. The physician's orders, dated January 2022, documented the resident was to receive acetylcysteine 600mg daily. The medication administration record, dated January 2022, documented the resident had not received acetylcysteine 600mg from 01/10/22	C1923		

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 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL OAKS AT 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
C1923	Continued From page 2	C1923		

through 01/13/22. Review of the clinical record did not reveal an explanation as to why the resident had not received the medication.

The pharmacy consultation report, dated 01/17/22, read in part, "...[Resident's name omitted] order for a medication was not documented as given on 1/10, 1/11, 1/12, and 1/13 but no reason was documented...Please make sure the this [sic] resident does not miss a medication dose unless it is documented on the MAR [medication administration record] with a reason, (i.e. refused or out of the facility)..."

The monthly physician's orders, dated June 2022, documented the resident was to receive L-serine (dietary supplement) 2000mg twice daily and famotidine (Pepcid - a medication for reflux/heart burn) 20mg twice daily.

The medication administration record, dated June 2022, documented the resident did not receive L-serine 2000mg on the evenings of 06/06/22, 06/07/22, and 06/08/22. The clinical record did not document an explanation why the resident had not received the medication.

The medication administration record, dated June 2022, documented the resident did not receive famotidine 20mg on the day shift for 06/07/22 though 06/09/22, and 06/19/22; and on the evenings of 06/05/22 through 06/09/22 and 06/18/22. There was no documentation as to why the resident had not received the medication.

3. Resident #3 had diagnoses which included neurocognitive disorder and chronic kidney disease.

The monthly physician's orders, date June 2022

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 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL OAKS AT 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
C1923	Continued From page 3	C1923		

documented the resident was to receive a vitamin B complex capsule daily and Trazodone 100mg at bedtime.

The medication administration record, dated June 2022, documented the resident did not receive a vitamin B complex capsule on 06/01/22 through 06/03/22. There was no documentation as to why the resident had not received the medication.

The medication administration record documented the resident did not receive Trazodone (antidepressant and sedative used to treat both depression and insomnia) 100mg at bedtime on 06/19/22 through 06/23/22, and 06/25/22. The clinical record did not document why the resident had not received the medication.

On 07/13/22 at 3:00 p.m., the DON and administrator were interviewed related to the missed dosages of medication for resident #1, #2, and #3.

The DON stated they were not an employee of the facility during the time of the missed medication. The DON reviewed the resident records and stated the record did not document why the residents had not received their ordered medications.

The administrator stated they were not made aware the residents had not received the medications as ordered. The administrator stated they did not know why the residents had not received their medications.

OKLAHOMA
State Department
of Health

Delivery via email to: trischad@colonialoaks.com

August 23, 2022

License Number: AL7238

Ms. Trischa Kwiatkowski, Administrator
Colonial Oaks At Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

Survey Event ID: G8KQ11

Dear Ms. Kwiatkowski:

On **July 13, 2022**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C1923**: The POC does not address the root cause of the problem. How will the ordering issue be addressed?

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 8/15/2022
	Facility Name: Colonial Oaks at Tulsa
	License Number: AL2387
	Survey Event ID: G8kQ11
	Date Survey Completed: 7/13/2022

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1923	Based on: Facility failed to maintain an accurate record of medication administration for three residents and failed to administer medictions as ordered to one of the three residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Residents no longer resides in community.
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 residents have the potential to be affected. CMA's are required to give all medications as ordered. MARS will be audited two times a week by CMA shift supervisors and weekly by RSD.
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?	Audit Binders binders have been provided for CMA's on both medication carts. RSD will audit MARS to ensure all medication administration orders are being followed while also ensuring all medications that are not given have a reason noted. RSD will review MARS for accuracy weekly for three months. RSD will then audit MARS monthly there after.
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.	RSD will audit MARS for accuracy. RSD will monthly audits on all CMA's for three months. ED will include copies of monthly audits on quarterly quality assurance meeting forms to be evaluated for effectiveness. All quality assurance meeting forms will be kept in the ED's office in a binder for quality along with copies of monthly audits from RSD. RSD will keep a binder of Monthly audits in the RSD's office as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/30/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.
J. Smith Tuck	8/15/2022

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

Delivery via email to: trischad@colonialoaks.com

September 14, 2022

License Number: AL7238

Ms. Trischa Kwiatkowski, Administrator
Colonial Oaks At Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

Survey Event ID: G8KQ11

Dear Ms. Kwiatkowski:

On **July 13, 2022,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **September 30, 2022**.

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 Digitally signed by Tempal Killman
Date: 2022.09.14 08:26:47 -05'00'

Tempal Killman, Administrative Assistant II
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/24/2022** **Facility Name:** Colonial Oaks at Tulsa **License Number:** AL2387 **Survey Event ID:** G8kQ11 **Date Survey Completed: 7/13/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1923	Based on: Facility failed to maintain an accurate record of medication administration for three residents and failed to administer medictions as ordered to one of the three residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Residents no longer resides in community.
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 residents have the potential to be affected. CMA's are required to give all medications as ordered. MARS will be audited two times a week by CMA shift supervisors and weekly by RSD. All medications ordered will be verified by signed order from doctor and placed in residents file. Any clarifications on orders will be verified by RSD and documented on Audit sheets and placed in audit binders.
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?	Audit Binders binders have been provided for CMA's on both medication carts. RSD will audit MARS to ensure all medication administration orders are being followed while also ensuring all medications that are not given have a reason noted. RSD will review MARS for accuracy weekly for three months. RSD will then audit MARS monthly there after. All medications ordered will be verified by signed order from doctor and placed in residents file. Any clarifications on orders will be verified by RSD and documented on Audit sheets and placed in audit binders.
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.	RSD will audit MARS for accuracy. RSD will monthly audits on all CMA's for three months. ED will include copies of monthly audits on quarterly quality assurance meeting forms to be evaluated for effectiveness. All quality assurance meeting forms will be kept in the ED's office in a binder for quality along with copies of monthly audits from RSD. RSD will keep a binder of Monthly audits in the RSD's

		office as evidence of correction.	
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		9/30/2022	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Kimberly A. DeSpain			**Date** Enter a date of signature. 8/24/2022
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: 8/24/2022** **Facility Name:** Colonial Oaks at Tulsa **License Number:** AL2387 **Survey Event ID:** G8kQ11 **Date Survey Completed: 7/13/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1923	Based on: Facility failed to maintain an accurate record of medication administration for three residents and failed to administer medictions as ordered to one of the three residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

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?	Residents no longer resides in community.
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 residents have the potential to be affected. CMA's are required to give all medications as ordered. MARS will be audited two times a week by CMA shift supervisors and weekly by RSD. All medications ordered will be verified by signed order from doctor and placed in residents file. Any clarifications on orders will be verified by RSD and documented on Audit sheets and placed in audit binders.
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?	Audit Binders binders have been provided for CMA's on both medication carts. RSD will audit MARS to ensure all medication administration orders are being followed while also ensuring all medications that are not given have a reason noted. RSD will review MARS for accuracy weekly for three months. RSD will then audit MARS monthly there after. All medications ordered will be verified by signed order from doctor and placed in residents file. Any clarifications on orders will be verified by RSD and documented on Audit sheets and placed in audit binders.
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.	RSD will audit MARS for accuracy. RSD will monthly audits on all CMA's for three months. ED will include copies of monthly audits on quarterly quality assurance meeting forms to be evaluated for effectiveness. All quality assurance meeting forms will be kept in the ED's office in a binder for quality along with copies of monthly audits from RSD. RSD will keep a binder of Monthly audits in the RSD's

	office as evidence of correction.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/30/2022
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F) Kimberly DeAgan	**Date** Enter a date of signature. 9/24/2022

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

Delivery via email to: MichelleN@colonialoaks.com

December 19, 2022

License Number: AL7238

Ms. Michelle Netter, Administrator
Colonial Oaks At Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

RE: Survey Event G8KQ12

Dear Ms Netter:

On **December 14, 2022,** an offsite/paper revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your complaint survey on **July 13, 2022,** have now been corrected effective **October 21, 2022.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

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 12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL OAKS AT 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 An offsite/paper revisit was completed on 12/14/22. Credible 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