OKLAHOMA
State Department
of Health

Delivery via email to: TrischaD@knownmemorycare.com

March 29, 2023

License Number: AL7238

Ms. Trischa DeAguero, Administrator
Known Memory Care
7807 S Mingo Rd
Tulsa, OK 74133

Survey Event ID: V3BS11

Dear Ms. DeAguero:

On **March 14, 2023,** 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 not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Known Memory Care**
Address: **7807 South Mingo Rd.**
City, State, Zip: **Tulsa, OK 74133**
Provider #: **AL7238**
Complaint #: **#OK00060222**
Investigation Dates: **03/14/23**

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure heat was available in all resident rooms and temperatures kept between 71 degrees Fahrenheit and 81 degrees(F) and electrical outlets were working.	**S**
2. The facility failed to communicate facility to facility to provide the best practical care for the resident.	**US**

☒ **Violations unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on Click to enter a date at 03/14/23.

A sample of three residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the 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 L1304 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

The facility was observed to be clean, without orders and clutter free. A restoration company was on site conducting repairs after a fire. Residents were observed ambulating in the hallways, in the common room

watching T.V. and resting in their rooms. Staff was observed helping residents with activities of daily living, administering medication and offer fluids. Staff was observed interacting with residents in a kind and respectful manner. The residents were observed to be dressed, groomed and without odors. The administration team was in their office working on their daily duties.

The administrator was asked to explain the policy for sharing medical records with another facility after a resident has discharged. The administrator stated after they receive a medical records request form from a facility, they send the records as soon as possible to facilitate resident care. When asked if they had received a request concerning a recently discharged resident the administrated replied no.

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.

Deficient practice was unsubstantiated for allegation #2. 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.

Anita Newman, LPN

Date report completed: 03/15/2023

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 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOWN MEMORY CARE	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 (#OK00060222) was conducted on 03/14/23. Listed below are abbreviations that will be used throughout this document. CNA - Certified Nurse Aide DON - Director of Nursing	C 000		
C1304 SS=D	310:663-13-1(d) RESIDENT SERVICE CONTRACT (d) The assisted living center shall provide all services that are specified in the resident's current service contract. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure all services that are specified in the resident's current service contract were provided for two (#1 and #3) of three sampled residents. The administrator identified 26 residents living in the facility.	C1304		

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C1304	Continued From page 1 Findings: The "Residency Agreement" contract states in part...Your apartment will be furnished with basic cable TV hook up, water and electricity...We will perform all necessary maintenance and repairs of the apartment at our expense... 1. The POA for resident #1 stated they did not have working outlets in their room from 01/24/23 unitl his discharge on 03/01/23. On 03/14/23 at 10:45 a.m., CNA #1 was asked how the fire affected the electrical system in the building. The CNA replied some rooms were without electricity for a while. They were then asked if those residents without electricity were moved to other rooms. They stated no they weren't. On 03/14/23 at 11:00 a.m., the temperature of the west hallway measured 72.2 degrees Fahrenheit (F). The temperature of room 122 measured 76.2 degrees F, and the temperature of room 123 measured 73.9 degrees (F). Room 124 had an extension cord from the TV to the electrical outlet in the bathroom. On 03/14/23 at 11:00 a.m., the DON obtained a pair of electric hair clippers and tested the electrical outlets in rooms 122, room 123 and room 124. The only working outlets in rooms 122, 123 and 124 were the bathroom outlets. On 03/14/23 at 2:17 p.m., family member #3 stated resident #3's electrical outlets have not been working for several weeks and that is why there is an extension cord from the TV to the only working outlet, which is in the bathroom. When asked if another room was offered to the resident	C1304		

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C1304	Continued From page 2 until the outlets were repaired, they stated no. It was asked if there was issues with the temperature of the room and they stated there was not. On 03/14/23 at 2:30 p.m., family member #1 was asked if there were issues with the electrical outlets in residents #1's room. They stated for the entire stay of resident #1's stay, which was about three weeks, the outlets did not work When asked if another room was offered to the resident until the repairs were made, they stated yes but it would cost another 1,000.00 dollars per month because the room would be an upgrade so they declined the offer. On 03/14/23 at 3:30 p.m., the Administrator was asked when a resident discharges what is sent with them. They replied a face sheet, history and physical, their medications and personal belongings. What is the process used when a facility requested medical records on a resident. They answered, we send the records as soon as possible. How did you accommodate the residents who's room were affected by the fire. We offered to move them to other rooms with working electrical outlets but they declined. Did they all decline. Yes.	C1304		
C1911 SS=D	310:663-19-1(a) INCIDENT REPORT TIMELINES (a) All reports to the Department shall be made via facsimile or by telephone within one (1) Department business day of the reportable incident's discovery. A follow-up report of the incident shall be submitted via facsimile or mail to the Department within five (5) Department business days after the incident. The final report	C1911		

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C1911	Continued From page 3 shall be filed with the Department when the full investigation is complete, not to exceed ten (10) Department business days after the incident. Notifications to the Nurse Aide Registry using the ODH Form 718 must be made within one (1) Department business day of the reportable incident's discovery. This Rule is not met as evidenced by: Based on record review and interview the facility failed to report to the Oklahoma State Department of Health within one business day a reportable incident. The administrator identified 26 residents living in the facility. Findings: 1. Review of an incident report faxed to the Oklahoma State Department of Health on 03/03/23, stated on 12/25/22 at approximately 11:00 a.m., the fire department was notified of a small fire in rooms 125 and 126. The fire department determined there was an electrical	C1911		

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C1911	Continued From page 4 fire in the attic of the facility. A fire suppression pipe also ruptured causing a flood on the east side of the building. On 03/14/23 at 4:00 p.m., the administrator was asked why the incident was not reported with the required timeline of one business day. The administrator replied, "Because I was too busy making sure the residents were safe."	C1911		
C1912 SS=D	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515	C1912		

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 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOWN MEMORY CARE	7807 S MINGO RD TULSA, OK 74133

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C1912	Continued From page 5 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure they reported an electrical fire to the Oklahoma State Department of Health. A fire in the facility's attic on 12/25/22 was reported 68 days after the incident. The administrator identified 26 residents living in the facility Findings: 1. An incident report faxed to the Oklahoma State Department of Health on 03/03/23, documented an electrical fire in the attic and also a rupture of a fire suppression pipe in the facility causing a flood on 12/25/22. On 03/14/23 at 4:00 p.m., the administrator was asked why the electrical fire and the flood had not been reported to the Oklahoma State Department of Health. The administrator stated, "Because I was too busy making sure the residents were	C1912		

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 03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOWN MEMORY CARE	7807 S MINGO RD TULSA, OK 74133

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C1912	Continued From page 6 safe."	C1912		

OKLAHOMA
State Department
of Health

Delivery via email to: MichelleN@knownmemorycare.com

April 25, 2023

License Number: AL7238

Ms. Michelle Netters, Administrator
Known Memory Care
7807 S Mingo Rd
Tulsa, OK 74133

Survey Event ID: V3BS11

Dear Ms. Netters:

On **March 14, 2023,** 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 have been corrected and you were in substantial compliance by **April 15, 2023**.

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: 2023.04.25 14:23:17 -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: 3/29/2023** **Facility Name:** Known Memory Care **License Number:** AL7238 **Survey Event ID:** V3BS11 **Date Survey Completed: 3/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1304	Based on: review, observation and interview facility failed to ensure all services that are specified in the residents current service contract were provided two of three sampled 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?	Residency Agreement has been updated. All electrical outlets have been fixed.
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. Electrical outlets have been fix and are operational in all units.
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?	weekly checks of outlets in the building for three months then quarterly there after to ensure the outlets are operational and a log will be kept in ED ofiice
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.	Maintenance will do weekly for three months then quarterly checks to ensure outlets are functioning properly. ED will review checklist for accuracy. ED will keep a binder that will include audits of outlets done weekly for three months then quarterly there after. All records will be kept in a binder in the ED office Signed by both the maintenance technician and the ED Binder will be kept in ED office and included in quarterly quality meeting binders
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Michelle Letter	**Date** Enter a date of signature. 4/13/2023

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: 3/29/2023** **Facility Name:** Known Memory Care **License Number:** AL7238 **Survey Event ID:** V3BS11 **Date Survey Completed: 3/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1911	Based on: record review and interview the facility failed to report to the Oklahoma State Department Health within 1 business day a reportable incident report.

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?	Previous Ed is no longer Employeed with Known Memory Care. New ED will report and all incidents reports to OSDH with 24 hours of incident and a copy of report will be kept in ED office.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All resident s have the potential to be affected. All state reportable incidents are to be reported within 1 business day. Ed will keep a binder located in her office with all verifications that reports have been sent to OSDH. ED will track and sign all reportable incident reports.
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?	Ed will keep a binder located in her office with all verifications that reports have been sent to OSDH. All state reportables will be included in quarterly quality reports.
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.	Ed will track and sign all reportable incident reports. ED will keep a binder with all state reportable events in the ED office with confirmations that reportables have been sent to OSDH. Ed will Sign and track all state reportable incident reports to ensure they have been reported in a timely manner. All state reportables will be reported in quarterly quality meetings and evaluated for effectiveness. ED will keep a binder with all state reportable events in the ED office with confirmations that reportables have been sent to OSDH.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.
Michelle Potter	4/21/2023

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: 3/29/2023** **Facility Name:** Known Memory Care **License Number:** AL2387 **Survey Event ID:** V3BS11 **Date Survey Completed: 3/14/2023**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1912	Based on: record review and interview the facility failed to report to Oklahoma State Department of Health within 1 business day.

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?	Previous Ed is no longer employeed with community. New ED is knowledgeable about timelines and state regulations on incident reports and timelines for state reportable incidents.
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. ED will track and sign all state reportable and keep confirmation in the ED office as proof and of state reportables being reported.
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?	ED will track and sign all state reportables and will attach confirmation of state notification being completed within 1 business day and binder will be kept in ED office to ensure quality and follow up.
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.	ED will track and sign all incident reports and attach confirmation they have been sent within 1 business day. Ed will do monthly review of all state reportables and will have both ED and Business/HR director sign off on all state reportables. Ed will ensure all state reportables will be included in quarterly qa meeting report. State reportable binder will be kept in ED office with confirmation attached as proof of state reportable being reported within 1 business day.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	4/15/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature.
Michelle Letter	4/02/2023

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@knownmemorycare.com; TrischaD@knownmemorycare.com

REPORT REVISED NOTICE

May 8, 2023

Facility ID: AL7238
Survey Event ID: V3BS11

Ms. Michelle Netters, Administrator
Known Memory Care
7807 S Mingo Rd
Tulsa, OK 74133

Dear Ms. Netters:

On **March 14, 2023**, agents from our office concluded an investigation at your facility. You were advised of the findings of that investigation in our notice of **March 29, 2023**.

The original investigative report #OK00060222 has been revised to include an allegation previously not included on the investigative report. A copy of the amended investigation report is included. Deficiencies identified during the investigation are not affected by these corrections and a new plan of correction is not required. The corrected investigation report is being provided for your records and no additional action on your part is required at this time.

If we can be of any further assistance, please contact us at 405-426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Known Memory Care**
Address: **7807 South Mingo Rd.**
City, State, Zip: **Tulsa, OK 74133**
Provider #: **AL7238**
Complaint #: **#OK00060222**
Investigation Dates: **03/14/23**

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure heat was available in all resident rooms and temperatures kept between 17 degrees Fahrenheit and 81 degrees Fahrenheit and electrical outlets were working.	**S**
2. The facility failed to communicate facility to facility to provide the best practical care for the resident.	**US**
3. The facility failed to report a fire, heat and electrical outages to the State Agency.	**S**

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

An unannounced on-site investigation was initiated on 03/14/2023 at 9:45a.m.

A sample of three residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the 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 L1304 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

The facility was observed to be clean, without orders and clutter free. A restoration company was on site conducting repairs after a fire. Residents were observed ambulating in the hallways, in the common room watching T.V. and resting in their rooms. Staff was observed helping residents with activities of daily living, administering medication and offer fluids. Staff was observed interacting with residents in a kind and respectful manner. The residents were observed to be dressed, groomed and without odors. The administration team was in their office working on their daily duties.

The administrator was asked to explain the policy for sharing medical records with another facility after a resident has discharged. The administrator stated after they receive a medical records request form from a facility, they send the records as soon as possible to facilitate resident care. When asked if they had received a request concerning a recently discharged resident the administrated replied no.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag L1812 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegations #1 and #3. 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 #2. 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.

Anita Newman

Anita Newman, LPN, CHFS

Date report completed: 03/15/2023

OKLAHOMA
State Department
of Health

Delivery via email to: MichelleN@knownmemorycare.com

REPORT REVISED NOTICE - CORRECTED INV RPT

May 9, 2023

Facility ID: AL7238
Survey Event ID: V3BS11

Ms. Michelle Netters, Administrator
Known Memory Care
7807 S Mingo Rd
Tulsa, OK 74133

Dear Ms. Netters:

On **March 14, 2023**, agents from our office concluded an investigation at your facility. You were advised of the findings of that investigation in our notice of **March 29, 2023**. On **May 8, 2023**, a report revised notice was issued and tthe original investigative report #OK0006022 was amended. The amended investigative report #OK00060222 was sent along with that notice via email yesterday.

The amended investigative report #OK00060222 has now been CORRECTED to include the appropriate tag reference on the investigative report. A copy of the CORRECTED amended investigation report is included. Deficiencies identified during the investigation are not affected by these corrections and a new plan of correction is not required. The corrected investigation report is being provided for your records and no additional action on your part is required at this time.

If we can be of any further assistance, please contact us at 405-426-8200.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Known Memory Care**
Address: **7807 South Mingo Rd.**
City, State, Zip: **Tulsa, OK 74133**
Provider #: **AL7238**
Complaint #: **#OK00060222**
Investigation Dates: **03/14/23**

ALLEGATIONS	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure heat was available in all resident rooms and temperatures kept between 17 degrees Fahrenheit and 81 degrees Fahrenheit and electrical outlets were working.	**S**
2. The facility failed to communicate facility to facility to provide the best practical care for the resident.	**US**
3. The facility failed to report a fire, heat and electrical outages to the State Agency.	**S**

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

An unannounced on-site investigation was initiated on 03/14/2023 at 9:45a.m.

A sample of three residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the 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 L1304 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

The facility was observed to be clean, without orders and clutter free. A restoration company was on site conducting repairs after a fire. Residents were observed ambulating in the hallways, in the common room watching T.V. and resting in their rooms. Staff was observed helping residents with activities of daily living, administering medication and offer fluids. Staff was observed interacting with residents in a kind and respectful manner. The residents were observed to be dressed, groomed and without odors. The administration team was in their office working on their daily duties.

The administrator was asked to explain the policy for sharing medical records with another facility after a resident has discharged. The administrator stated after they receive a medical records request form from a facility, they send the records as soon as possible to facilitate resident care. When asked if they had received a request concerning a recently discharged resident the administrated replied no.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag L1912 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegations #1 and #3. 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 #2. 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.

Anita Newman

Anita Newman, LPN, CHFS

Date report completed: 03/15/2023

OKLAHOMA
State Department of Health

Delivery via email to: MichelleN@knownmemorycare.com

May 30, 2023

License Number: AL7238

Ms. Michelle Netters, Administrator
Known Memory Care
7807 S Mingo Rd
Tulsa, OK 74133

Survey Event ID: V3BS12

Dear Ms. Netters:

On **May 26, 2023,** an offsite/paper complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **March 14, 2023,** have now been corrected effective **April 15, 2023.**

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7238	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOWN MEMORY CARE	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 conducted on 05/26/23. The facility was in substantial compliance.	{C 000}		

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