OKLAHOMA
State Department
of Health

Delivery via email to: rray@chapterstulsa.com

March 18, 2025

License Number: AL7238

Ms. Rachel Ray, Administrator
Chapters Living of Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

RE: Survey Event ID: W1R411

Dear Ms. Ray:

On **March 6, 2025**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **March 6, 2025**.

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

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

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

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and

compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 calendar days from receipt of the State Form deficiency statement. Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review, conducted in a face-to-face, or virtual meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to: IDRCoordinator@health.ok.gov

or mail to: IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

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

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

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

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Chapters Living of Tulsa
Address: 7807 S Mingo
City, State, Zip: Tulsa, Oklahoma, 74133
Provider #: AL7238
Complaint #: OK00061659
Investigation Date(s):

ALLEGATION(S)
enter text The center failed to ensure residents were not physically, verbally or psychosocially abused or involuntarily secluded.
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 03/05/2025 at 8:15a.m.

A sample of eight residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Throughout the survey residents were observed for signs and symptoms of abuse. Staff was always interacting with the residents. Evidence was obtained through observations; interviews with residents, family members, in-services and staff members and review of electronic records.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/17/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Chapters Living of Tulsa
Address: 7807 S Mingo
City, State, Zip: Tulsa, OK, 74133
Provider #: AL7238
Complaint #: OK00061840
Investigation Date(s): 03/05/25 and 03/06/25

ALLEGATION(S)
The center failed to ensure allegations of abuse were reported to the Oklahoma State Department of Health within 2 hours
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 03/05/2025 at 8:15 a.m.

A sample of eight residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Throughout the survey residents were observed for signs and symptoms of abuse. Staff was always interacting with the residents. Evidence was obtained through observations; interviews with residents, family members, and staff members and review of electronic records.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/17/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Chapters Living of Tulsa
Address: 7807 S Mingo
City, State, Zip: Tulsa, Oklahoma, 74133
Provider #: AL7238
Complaint #: OK00066702
Investigation Date(s): 03/05/25 and 03/06/25

ALLEGATION(S)
The facility failed to ensure exit doors were secured to prevent a resident from elopement.
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 03/05/2025 at 8:15 a.m.

A sample of eight residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Upon entrance into the facility access was gained with assistance of an employee putting in a code for entrance into the facility. Throughout the survey observations of the facility were made for access for elopement by residents and all exit doors were securely locked and accessible by exit or entry by code. State Reportable Incident, facility in-services, facility policies/procedures and investigations were all conducted and the employee involved was suspended and later terminated due to the risk of the residents safety.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/17/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Chapters Living of Tulsa
Address: 7807 S Mingo
City, State, Zip: Tulsa, Oklahoma, 74133
Provider #: AL7238
Complaint #: OK00067412
Investigation Date(s): 03/05/25 and 03/06/25

ALLEGATION(S)
enter text The center failed to notify legal surrogates of a change in residents' medical regimen
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 03/05/2025 at 8:15 a.m.

A sample of eight residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Throughout the survey observations of residents' rights were made. Interviews were conducted with residents and representatives regarding family/legal surrogate access to medical records. Record reviews consisted of resident clinical record and cognitive abilities, POAs and facility policies. Residents representatives stated the facility has notified them with changes in conditions and they have no concern about abuse or neglect.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/17/2025

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT

Facility: Chapters Living of Tulsa
Address: 7807 S Mingo
City, State, Zip: Tulsa, OK, 74133
Provider #: AL7238
Complaint #: OK0006718
Investigation Date(s): 03/05/25 and 03/06/25

ALLEGATION(S)
The facility failed to provide family/legal surrogate access to medical records.
enter text
enter text
enter text
enter text

An unannounced on-site investigation was initiated 03/05/2025 at 8:15 a.m.

A sample of eight residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

Throughout the survey observations of residents' rights were made. Interviews were conducted with residents and representatives regarding family/legal surrogate access to medical records. Record reviews consisted of resident clinical record and cognitive abilities, POAs and facility policies.

The attached State form, Statement of Deficiencies, will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 03/17/2025

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 03/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS A relicensure survey was conducted from 03/05/25 through 03/06/25. Complaint investigations #OK00061659, OK00061840, OK00066702, OK00067412, and #OK00067618) were conducted in conjunction with the survey. Facility Census: 27 Listed below are abbreviations that will be used throughout this document. CNA- certified nurse aide CMA-certified medication aide OSDH - Oklahoma State Department of Health	C 000		
C 940 SS=E	310:663-9-4 DIETARY CONSULTANT Each assisted living center shall use a licensed dietician or qualified nutritionist to develop the assisted living center's diet plan and address the needs of individuals with special diets. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents received a complete lunch meal approved by the registered dietitian for 6 (#1,2,3,4,5, and #7) of 8 sampled residents who received services from the kitchen. The administrator identified 27 residents receive nutrition from the kitchen. Findings: A facility policy titled "Dietary Services," updated 09/2021, read in part, "The facility will post a	C 940		

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 03/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 940	Continued From page 1 weekly menu, including snacks, that can be viewed by residents and families. Best efforts will be made to follow the posted menu and any substation of menu items will be with and item of equivalent nutritional value and will be recorded on the posted menu." The lunch menu for week 5 showed sliced pork, sweet potato casserole, cauliflower, cream pie, and a beverage. On 03/05/25 at 11:40 a.m., the kitchen culinary director was taking temperatures of food and stated they did not provide a dessert at lunch due to being short on staff. They were asked how long this had been going on they stated ever since they worked at the facility. The kitchen culinary director was asked who made the decision and they stated they did not know. They stated it had been like that since they had been working there. On 03/05/25 at 11:50 a.m., CMA #1 was asked if they helped serve lunch and they stated sometimes. CMA #1 was asked what did they provide for a dessert if resident ask for one. CMA #1 stated they would offer applesauce or pudding. On 03/05/25 at 1:40 p.m., the administrator was asked the reason dessert was not provided with the residents lunch meal and the administrator stated they should prepare a dessert and to follow the menu according to plan. The administrator stated the kitchen culinary director did all of the ordering for the supplies, so they should have everything they need to prepare for each meal.	C 940		
C1915 SS=D	310:663-19-1(e) REPORTS TO THE DEPARTMENT	C1915		

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 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1915	Continued From page 2 (e) Each assisted living center shall report allegations and incidents of resident abuse, neglect, or misappropriation of resident's property by licensed personnel to the appropriate licensing board within five (5) business days. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report allegations of abuse as required for 1 (#6) of 1 sampled residents reviewed for abuse. The administrator identified 27 residents resided in the facility. Findings: A facility policy titled "Abuse, Neglect, Exploitation, or Misappropriation," updated 2021, read in part, "All incidents of suspected abuse, neglect, exploitation, injury of unknown origin, and other reportable incidents must be reported to the Department within twenty-four (24) hours, or by the next business day when the incident occurs on a weekend or holiday. The Director is responsible for (1) informing all staff of the obligation to report suspected incidents of abuse, neglect, exploitation, or other reportable incidents. (2) assuring that the required State notice regarding reporting suspected abuse, neglect, exploitation, or other reportable incidents is posted; and (3) investigating and reporting the alleged abuse or neglect as per State	C1915		

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 03/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1915	Continued From page 3	C1915		

requirements."

An anonymous complainant report, dated 11/08/23, for an allegation of abuse for Resident #6, showed CNA #1 hit Resident #6 in the head with a bottle of water on 11/08/23. The complainant reported CNA #1 laughed and stated they meant to hit the resident. The complainant reported they, the sales and marketing director, and the administrator all viewed the video. The video showed CNA #1 with an almost empty water bottle in their hand. The complainant reported the video showed CNA #1 barely touched Resident #6's cheek with the water bottle and Resident #6 did not have a response. The complainant reported the administrator stated they interviewed residents and staff as part of the investigation. The complainant reported the administrator stated the allegation was unsubstantiated based on results of investigation. The complainant reported the administrator stated they were not required to report allegations of abuse to the OSDH if they were unsubstantiated.

On 03/06/25 at 1:22 p.m., the administrator was asked about the above incident not being reported. The administrator stated, "They have never had to address any abuse about employee to resident". The administrator was asked about the incident involving CNA #1 and Resident #6. The administrator stated CNA #1 placed the water bottle up to Resident #6's face so they could see how cold the bottle of water was because Resident #6 did not like their water too cold. The administrator stated they looked at the video along with the owner of the facility and CNA #1 did not hit Resident #6. The administrator stated no statements were collected due to being an in house investigation and the timing of the

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 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
C1915	Continued From page 4 incident. The administrator stated CNA #1 was never suspended and was currently working at facility. The administrator was asked if anyone asked the resident whom was no longer a resident at the facility what happened. The administrator stated, "No." The administrator stated they did not think it was an allegation that was why it was not submitted. The administrator stated a former disgruntled employee was the one that made the complaint. The administrator stated there was never a incident report with allegations of abuse regarding Resident #6.	C1915		
C1916 SS=D	310:663-19-1(f) REPORTS TO THE DEPARTMENT (f) Each continuum of care facility and assisted living center shall report allegations and occurrences of resident abuse, neglect, or misappropriation of resident's property by a nurse aide to the Nurse Aide Registry by submitting a completed "Notification of Nurse Aide Abuse, Neglect, Mistreatment or Misappropriation of Property" form (ODH Form 718), which requires the following: (1) facility/center name, address and telephone; (2) facility type; (3) date; (4) reporting party name or administrator name; (5) employee name and address; (6) employee certification number; (7) employee social security number; (8) employee telephone number; (9) termination action and date (if applicable); (10) other contact person name and address; and (11) the details of the allegation or occurrence of abuse, neglect, or misappropriation of resident property.	C1916		

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 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1916	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notifiy the nurse aide registry of an allegation of abuse involving CNA #1 for 1 (#6) of 1 sampled resident reviewed for an allegation of abuse. The administrator idenfified 27 residents resided at the facility. Findings: An anonymous complainant report, dated 11/08/23, for an allegation of abuse for Resident #6, showed CNA #1 hit Resident #6 in the head with a bottle of water on 11/08/23. The complainant reported CNA #1 laughed and stated they meant to hit the resident. The complainant reported they, the sales and marketing director, and the administrator all viewed the video. The video showed CNA #1 with an almost empty water bottle in their hand. The complainant reported the video showed CNA #1 barely touched Resident #6's cheek with the water bottle and Resident #6 did not have a response. The complainant reported the administrator stated they interviewed residents and staff as part of the investigation. The complainant reported the administrator stated the allegation was unsubstantiated based on results of investigation. The complainant reported the administrator stated they were not required to report allegations of abuse to the OSDH if they were unsubstantiated.	C1916		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C1916	Continued From page 6 On 03/06/25 at 1:22 p.m., the administrator was asked about the above incident not being reported. The administrator stated, "They have never had to address any abuse about employee to resident". The administrator was asked about the incident involving CNA #1 and Resident #6. The administrator stated CNA #1 placed the water bottle up to Resident #6's face so they could see how cold the bottle of water was because Resident #6 did not like their water too cold. The administrator stated they looked at the video along with the owner of the facility and CNA #1 did not hit Resident #6. The administrator stated no statements were collected due to being an in house investigation and the timing of the incident. The administrator stated CNA #1 was never suspended and was currently working at facility. The administrator was asked if anyone asked the resident whom was no longer a resident at the facility what happened. The administrator stated, "No." The administrator stated they did not think it was an allegation that was why it was not submitted. The administrator stated a former disgruntled employee was the one that made the complaint. The administrator stated there was never a incident report with allegations of abuse regarding Resident #6.	C1916		

OKLAHOMA
State Department
of Health

Delivery via email to: rray@chapterstulsa.com

March 27, 2025

License Number: AL7238

Ms. Rachel Ray, Administrator
Chapters Living of Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

RE: Survey Event W1R411

Dear Ms. Ray:

On **March 6, 2025**, a Licensure inspection with a complaint investigation was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and in a timely manner. **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 **May 2, 2025**.

We will conduct a revisit to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 3/25/2025
	Facility Name: Chaptersliving of Tulsa
	License Number: AL 7238
	Survey Event ID: W1R411
	Date Survey Completed: 3/6/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 940 SS=E	Based on: the record review and interview, the facility failed to ensure residents received a complete lunch meal approved by the registered dietitian for 6 of 8 sampled residents who received services from the kitchen. (#1,2,3,4,5,6,7)

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Dietary Manager failed to follow the Registered Dieticians lunch menu menu. Deserts will be served at lunch per the menu.

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?	A complete lunch including deserts and approved by the RD, will be served per the menu daily
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 not served desert per the RD approved menu have been identified by Administrator.
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?	Admistrator, Don and the Dietary Manager and persons designated will QA and monitor each meal..
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.	A. Dietary Manager and designee: person will complete a QA checkoff list for each meal daily X 2 weeks then 3 times a week x 2 weeks then monthly x 6 months to ensure that the meal is served per the RD approved menu. Dietary Manager will meet with Administrator to QA weekly to ensure menu being followed per the RD approved menu. Administraro when present will be in dining room to ensure menu followed. Enter methods to evaluate for effectiveness: b. Next quarterly QA meeting Administrator with Directors will discuss the importance of following approved menu, QA will be looked over to ensure RD approved menu being followed . Deserts will be served per the menu. c. A. Dietary Manager and designee: person will complete a QA checkoff list for each meal daily X 2 weeks then 3 times a week x 2 weeks then monthly x 6 months to ensure that the meal is served per the RD approved menu. Dietary Manager will meet with Administrator to QA weekly to ensure menu being followed per the RD

	approved menu. Administraro when present will be in dining room to ensure menu followed.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	5/2/2025		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F)	Administrator Signature Required Rachel Kay CD, LPN	**Date 3/26/2025**	
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 Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 3/25/2025
	Facility Name: Chaptersliving of Tulsa
	License Number: AL 7238
	Survey Event ID: W1R411
	Date Survey Completed: 3/6/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1915	Based on: the record review and interview, the facility failed to report allegations of abuse as required for 1 (#6) of 1 sampled residents reviewed for abuse

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Administrator failed to report allegations of abuse as required

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?	Reports of allegations of abuse, neglect or misappropriation will be reported to the state within 5 busubess days.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Inservice will be conducted to remind and inform staff that the Administrator is the abuse and neglect coordinator and administrator is to be contacted asap to ensure report is made to state.
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?	RN consultant and Administrator will monitor and QA all reportable allegations to ensure that state reportables are completed and reported to state for allegations of abuse, neglect and misappropriation
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.	Enter methods to ensure corrections are sustained: a. Rn consultant will QA along with Administrator with a check off list weekly x 4 then monthly x 6 of all reports of abuse, neglect and misappropriaition of residents property to ensure that all allegations reported to State Dept of Health within 5 business days b. Next quarterly QA meeting Administrator with Directors will discuss the importance of reporting all allegations to Administrator and allegations will be reported within 5 business days. c. Rn consultant will QA along with Administrator with a check off list weekly x 4 then monthly x 6 of all reports of abuse, neglect and misappropriaition of residents property to ensure that all allegations reported to State Dept of Health within 5 business days
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	5/2/2025
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F)	Administrator's Signature Required Rachel Ray ED, LPN		**Date 3/26/2025**
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			
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OKLAHOMA State Department of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE**
	Current Date: 3/25/2025
	Facility Name: Chaptersliving of Tulsa
	License Number: AL 7238
	Survey Event ID: W1R411
	Date Survey Completed: 3/6/2025

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 1916 SS=D	Based on: the record review and interview, the facility failed to notify the nurse aide registry of an allegation of abuse involving CNA #1 for 1 # 6 of 1 sampled resident reviewed for an allegation of abuse

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Administrator will report all allegations of abuse ,neglect and misappropriation of personal property , all allegations will be reported to the state and nurse aide registry.

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?	Reports of allegations of abuse, neglect or misappropriation will be reported to the nurse aide registry
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Inservice will be conducted to remind and inform staff that the Administrator is the abuse and neglect coordinator and administrator is to be contacted to report a allegation of abuse , neglect or misappropriation and ensure form 718 is completed and faxed to nurse aide registry to report any allegation of abuse , neglect or misappropriation.
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?	RN consultant and Administrator will monitor and QA all reportable allegations to ensure that the nurse aide registry is notified form 718 with reported allegations of abuse, neglect and misappropriation.
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.	Enter methods to ensure corrections are sustained: a. Rn consultant will QA along with Administrator with a check off list weekly x 4 then monthly x 6 of all reports of abuse, neglect and misappropriaition of residents property to ensure that all allegations reported to the nurse aide registry with form 718 b. Next quarterly QA meeting Administrator with Directors will discuss the importance of reporting all allegations to Administrator and allegations will be reported within 5 business days to the nurse aide registry c. Rn consultant will QA along with Administrator with a check off list weekly x 4 then monthly x 6 of all reports of abuse, neglect and misappropriaition of residents property to ensure that all allegations are reported to the nurse

	aide registry with form 718 within 5 business days of reported allegation.		
OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?	5/2/2025		
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature Administrator signature received OAC 310:663-25-4(F)	Rachel Ray RN, CPM	**Date 3/26/2025**	
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.
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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: rray@chapterstulsa.com

May 7, 2025

License Number: AL7238

Ms. Rachel Ray, Administrator
Chapters Living Of Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

RE: Survey Event W1R412

Dear Ms. Ray:

On **May 5, 2025,** an off-site paper revisit was conducted for your facility by this agency. The findings indicate that the deficiencies cited during your survey on **March 6, 2025,** have now been corrected effective **May 2, 2025.**

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

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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 05/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 05/05/25. 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