OKLAHOMA
State Department
of Health

Delivery via Email: tkiatkowski@aberdeenmc.com

August 11, 2020

License Number: AL7258

Ms. Trischa Kwiatkowski, Administrator
Aberdeen Memory Care Of Tulsa
7210 South Yale Avenue
Tulsa, OK 74136

Survey Event ID: GZUR11

Dear Ms. Kwiatkowski:

On **January 16, 2020**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

(1) Address how corrective action will be accomplished for affected residents;

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

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

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

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

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may

be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

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

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

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Katie Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner, o=Oklahoma State Department of Health, ou=Long Term Care, email=katies@health.ok.gov, c=US
Date: 2020.08.11 11:14:55 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Aberdeen Memory Care of Tulsa**
Address: **7210 South Yale Avenue**
City, State, Zip: **Tulsa, OK, 74136**
Provider #: **AL7258**
Complaint #: **OK#54911**
Investigation Date(s): **01/14/20 through 01/16/20**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate care, according to residents' contract.	US

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

An unannounced on-site investigation was initiated on 01/14/2020 at 10:05 a.m.

A sample of 8 residents including any identified resident, was selected for the investigation based on the concerns relevant to the allegation.

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

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

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

An investigation specific to provision of resident care was conducted. Resident contracts were reviewed and "All inclusive" was related to no change in the cost for the room, and the resident's level of care would have not increased throughout resident's stay at the center.

An observation was conducted of a resident with a wound that was covered with a dressing. The dressing was clean, dry and intact.

Medical records were reviewed, to include documentation from the center, hospice, and the hospital. Skin assessments included documentation of a resident's wounds, showing a worsening of one wound and the development of another wound that also worsened. Hospice documented the resident demonstrated a

continuing decline, from initial wound onset, until the resident was hospitalized 21 days later. Hospice records documented the resident had declined with increased edema, decreased nutrition, mobility issues, and the family was aware of the resident's decline. The center was communicating with hospice and there was documentation of coordination of care between hospice, the nursing staff and the family related to the resident's decline. The hospice nurse came to the center to look at the wound(s) prior to the resident's transport to the hospital for evaluation of the wound(s). While hospitalized, the resident was evaluated for continuing care. The family chose to admit the resident to another licensed entity, with services continuing to be provided by the original hospice service to care for the resident through resident's continued decline and death.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation 1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Lisa McAlister, Survey Manager for

Justina Leach RN/CHFS

Date report completed: 01/22/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7258	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN MEMORY CARE OF TULSA	7210 SOUTH YALE AVENUE TULSA, OK 74136

(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 abbreviated survey was conducted on 01/14/20 through 01/16/20 to investigate complaint #OK00054911. The census was 41. The following deficiencies were cited.	C 000		
C 341 SS=D	310:663-3-4(b)(1) APPROPRIATE PLACEMENT (b) The resident shall not be eligible for placement in the assisted living center under one (1) or more of the following circumstances: (1) The resident needs care or services that exceed the care or services available in the assisted living center; This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to deny admission for 1 (#7) of 1 sampled resident who did not meet the center's assistance with daily activities requirement and regular nursing supervision criteria as outlined in the resident service agreement. This deficient practice had the isolated potential for more than minimal harm. Findings: Resident #7 was admitted to the center 08/05/19, with a pre-assessment completed on 07/31/19. The assessment which documented she weighed 89.4 pounds, was not weight bearing, had memory impairment, was chair-fast, had limited range of motion (contractures), was a total assist requiring 2 people, totally dependent on others to	C 341		

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C 341	Continued From page 1 provide grooming and personal hygiene needs, required assistance with feeding, and required nursing services (hospice/palliative care). The resident was also assessed to have contractures of both lower extremities. The resident was assessed as not having any wounds. Another assessment, dated 08/07/19, was conducted and identified the resident as a total care resident. This assessment identified the resident as having no wounds, identified the resident as requiring "daily nursing services" and was a hospice recipient. The center's assessment documented the resident as being bowel and bladder incontinent "at times" but the hospice assessment identified the resident as being fully incontinent. The Resident was identified by hospice as already declining in status and condition at the time admission. According to a skin assessments and monitoring sheets: By nurse aide on 12/03/19, 12/05/19, 12/10/19 and 12/12/19, the resident had no skin breakdown on buttocks. These monitoring sheets were not accurate. By nurse aide on 12/19/19, the resident had a wound identified on the right buttock. By nurse aide on 12/24/19, the resident had a wound identified on the right and left buttock. By nurse aide on 12/31/19, the resident had a wound identified on the right and left buttock that "was open." By DON, on 12/11/19, the resident had a dime size wound on the buttocks. By DON, on 12/18/19, the resident had a nickel size wound on the buttocks with an odor. By Don, on 12/26/19, the resident had a nickel size wound on the buttocks with an odor but was	C 341		

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C 341	Continued From page 2 25% black/brown (possibly eschar.) The resident agreement for resident #7, dated 08/05/19, documented, "Feeding assistance will be provided only on an interim basis for reasons of temporary mobility impairment. Residents requiring regular or scheduled nursing supervision are not eligible to move in unless need is temporary or due to a brief, recoverable illness..." On 01/14/20 at 1:25 p.m., the director of nursing was asked if resident #7 was above the center's level of care at the time she was admitted. She stated resident #7 was above level of care, and the resident was placed on hospice immediately.	C 341		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the Registered Nurse (RN) failed to complete a significant change assessment for 1 (#7) of 1 sampled resident who had mentally and physically declined after admission, even though the resident was already total care at admission. Because no significant change of condition assessment was completed, no additional	C 522		

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C 522	Continued From page 3 interventions were documented as developed and implemented to meet the resident's needs. This deficient practice resulted in more than minimal harm at a pattern. Findings: Resident #7 was admitted to the center on 08/07/19, with diagnoses which included vascular dementia, diabetes type II, stage 3 kidney disease, heart disease, congestive heart failure, malnutrition, peripheral vascular disease, and hypertension. According to the admission assessment, Resident #7 was alert and oriented x 1 (self), confused at times, forgetful with good judgement, poor mobility, fair strength, poor gait with limited contractures and limited range of motion in right leg. The resident was not weight bearing and was only ambulatory with staff assistance via wheelchair and a two person transfer. The resident had contractures of both lower extremities. The resident was assisted by two staff with activities of daily living for bathing, dressing, transferring, toileting and ambulation. The resident was assessed to be totally dependent on staff for all care at the time of admission. The center and hospice continued to document the resident's physical and mental decline. The center failed to complete a significant change of condition assessment identifying the residents currents need, which were identified in all areas including communication, dietary and skin integrity. Hospice documented care but the center provided no documentation of interventions that were implemented to prevent skin breakdown or prevent worsening of the wounds or even to facilitate healing if possible. The center provided no documentation of comfort	C 522		

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C 522	Continued From page 4 measures to minimize or alleviate pain and according to the documentation provided, all care was being provided by hospice. On 09/03/19, a hospice note documented the resident developed a new onset of significant left lower extremity edema which began having redness and warmth a couple of days later. On 09/11/19, a hospice note documented the resident was unable to express any needs. The wheelchair was replaced with a broda chair due to the resident needing more support and elevation of bilateral lower extremities. On 10/04/19, a home health visit note documented the resident was in a broda chair and intake was minimal. On 12/02/19, a social worker/case manager for resident #7 documented, "...seems to have had a decline...patient did not open her eyes...slumped over in her Broda..." On 12/05/19, a hospice registered nurse (RN) note documented, "...She is nonverbal and appears to be sleeping...will not answer or open her eyes with verbal or tactile stimuli...Sleeping 20-22 hours...SN (skilled nurse) will continue to monitor decline..." On 12/10/19, a Hospice RN note documented, "...Non verbal...non pitting edema BLES (bilateral lower extremities)...skin is tenting...staff report decreased fluid intake..." On 12/11/19, the director of nursing (DON) documented on a skin flowsheet for resident #7, "...small yellow dime size...buttock wound...".	C 522		

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C 522	Continued From page 5 On 12/15/19, a physician's order documented, "...Cleanse wounds to coccyx and RT (right) lower buttock area with cleanser...Apply Medi Honey and cover with optifoam. Secure with suresite..." On 12/18/19, the DON documented, "...Wound buttocks...nickel size...with odor" On 12/26/19 a licensed practical nurse (LPN/DON) documented, buttocks, wound base 25% pink, 50% tan/yellow, 25% black/brown with a large amount of yellow, brown drainage with an odor, the surrounding skin was red, nickel sized. On 01/01/20, due to the residents worsening condition, the resident was transferred to the hospital emergency room (ER) after a discussion between the resident's spouse and hospice nurse. Within the past month, the resident had developed a very large sacral decubitus ulcer which was draining purulent material, developed tachycardia and decreased mental status consistent with probable sepsis. The physician documented sepis, infected stage IV (4) sacral decubitus ulcer. At this time, the patient is lethargic and not verbally responsive. The patient presented to the ER with an altered mental status and wound check, pressure ulcers. During the physical exam the physician documented: chronically ill appearing, cachetic and large purulent unstageable pressure ulcers to bilateral ischial areas. The physician documented the patient was meeting sepsis criteria and believed the nidus (a place in which bacteria have multiplied or may	C 522		

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C 522	Continued From page 6 multiply; a focus of infection) of infection was decubitus ulcers which were very severe in nature. The patient was administered a liter of normal saline and began broad-spectrum antibiotics for decubitus ulcers covering for methicillin-resistant staphylococcus aureus (MRSA). The physician documented he did not believe the patient was a surgical candidate due to her overall physical exam and baseline mentation. Patient admitted for further intravenous (IV) antibiotics and for further evaluation and management. The physician also documented the following: Pressure injury of contiguous region involving left buttock and hip, stage 4. Pressure injury of contiguous region involving right buttock and hip, stage 4. Severe sepsis. Diffuse moderate muscle wasting in all extremities and trunk. Large 5 or 6 centimeter (cm) diameter sacral pressure wound extending to the bone with purulent foul-smelling material draining and some surrounding erythema. There could even be some tunneling of the ulceration beneath the existing size of the opening. Skin was thin, easily broken with fragile paperlike quality. On 01/14/20 at 1:30 p.m., the DON stated no significant change assessment had been completed for the residents declines .	C 522		
C5015 SS=D	63 O.S. 1-890.8(F)(1-2) Care and Services - Plan of Accommodation If a resident of an assisted living center develops	C5015		

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C5015	Continued From page 7 a disability or a condition that is consistent with the facility's discharge criteria: 1. The personal or attending physician of a resident, a representative of the assisted living center, and the resident or the designated representative of the resident shall determine by and through a consensus of the foregoing persons any reasonable and necessary accommodations, in accordance with the current building codes, the rules of the State Fire Marshal, and the requirements of the local fire jurisdiction, and additional services required to permit the resident to remain in place in the assisted living center as the least restrictive environment and with privacy and dignity; 2. All accommodations or additional services shall be described in a written plan of accommodation, signed by the personal or attending physician of the resident, a representative of the assisted living center and the resident or the designated representative of the resident; This REQUIREMENT is not met as evidenced by:	C5015		

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C5015	Continued From page 8 Based on interview and record review, it was determined the center failed to develop, complete and implement a Plan of Accommodation for 1 (#7) of 1 sampled resident who met discharge criteria and was dependent on staff for total care. This failed practice resulted in the isolated potential for more than minimal harm. Findings: Resident #7 was admitted to the center on 08/07/19 with diagnoses to include vascular dementia, hypertension, chronic kidney disease stage 3 with heart failure, type II diabetes, anemia, dysphagia, and moderate protein calorie malnutrition. Resident #7 was oriented to person, was bedfast/chairfast, incontinent of bowel and bladder, and required two-person assistance for all activities of daily living. Resident #7 could not bear weight, had contractures, and required to be repositioned. Resident #7 was totally dependent on staff for all care. Resident #7 was on hospice services for palliative care on the day she moved into the center. On 01/14/20 at 1:30 p.m., the director of nursing (DON) stated she was not aware of a Plan of Accommodation for any resident who exceeded the center's discharge criteria and required increased care and services. On 01/15/20 at 11:30 a.m., there was no Plan of Accommodation found in resident #7's records. The DON stated the center was not aware of plans of accommodations for residents. She further stated the center met with the family and reviewed the residents' care plan, but no plan of accommodation was completed.	C5015		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL7258	ABERDEEN MEMORY CARE OF TULSA

Type of Survey (select all that apply)

3

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

Extent of Survey (select all that apply)

A

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 32788	01/14/2020	01/16/2020	1.00	0.00	14.50	0.00	6.50	16.00
2.								
3.								
4.								
5.								
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7.								
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9.								
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11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

AUG 13 2020

OKLAHOMA
State Department
of Health

Delivery via email: tkwiatkowski@aberdeenmc.com

August 18, 2020

License Number: AL7258

Ms.Trischa Kwiatkowski, Administrator
Aberdeen Memory Care Of Tulsa
7210 South Yale Avenue
Tulsa, OK 74136

Survey Event ID: GZUR11

Dear Ms. Kwiatkowski:

On January 16, 2020, a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **September 1, 2020**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 271-6868.

Sincerely,

Users, V. Sue Davis
Digitally signed by Users, V. Sue Davis
Date: 2020.08.18 09:55:32 -05'00'

Sue Davis
Long Term Care EnforcementCoordinator
Oklahoma State Department of Health

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 8/12/2020** **Facility Name:** Aberdeen Memory Care **License Number:** AL7258 **Survey Event ID:** GZUR11 **Date Survey Completed: 1/16/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C341 ss=D	Based on: This Rule is not met as evidenced by: C 341Based on interview and record review, it was determined the center failed to deny admission for 1 (#7) of 1 sampled resident who did not meetthe center's assistance with daily activities requirement and regular nursing supervision criteria as outlined in the resident service agreement. This deficient practice had the isolated potential for more than minimal harm.

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?	Resident 7 no longer resides in community. Current ED/RSD are aware of acceptable level of care in accordance with Oklahoma regulation310:663-3-49(b)(1) and company policy. ED/RSD will inservice any future Sales and Marketing Directors.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	Audit of medical records will be done by ED/RSD. Audits will be conducted weekly on up to four residents for six weeks to identify any potential residents. Reports will be kept in a binder in ED's office.
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?	RSD/ED will review all initial assessments to ensure that potential residents level of care does not exceed services available in the community. Sales and Marketing director when hired will be in serviced on acceptable level of care in accordance with Oklahoma regulation 310:663-3-49(b)(1). Appropriate Placement.
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/ED will document and track all audits of medical records and keep in the ED office in a binder and will be reviewed monthly for effectiveness. Any potential residents not meeting criteria for placement will be evaluated for discharge. All audits will be included in the Quarterly QAA and will be reviewed quarterly by both ED/RSD and kept in a binder along with appropriate documentation signed by ED/RSD. ED/RSD will determine if any additional interventions need to be implemented. A copy of all medical audits will be stored in a binder in the ED's office.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		9/1/2020	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required. Tracie Nail		**Date** Enter a date of signature. 8-14-20	
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: 8/12/2020

Facility Name: Aberdeen Memory Care

License Number: AL7258

Survey Event ID: GZUR11

Date Survey Completed: 1/16/2020

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C522 SS=E	Based on: Based on interview and record review, it wasdetermined the Registered Nurse (RN) failed tocomplete a significant change assessment for 1(#7) of 1 sampled resident who had mentally and physically declined after admission, even though the resident was already total care at admission. Because no significant change of condition assessment was completed, no additional interventions were documented as developed and implemented to meet the resident's needs. This deficient practice resulted in more than minimal harm at a pattern.

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?	Resident 7 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.
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?	RSD will notify ED and RN consultant for any change of condition and RN will assess. All assessments will be conducted in a timely manner within the 14 day time frame and reviewed by RSD/ED/RN Consultant
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/RSD will review four medical records each week for six weeks to check for any change of condition. Any change of conditions identified by RSD/ED will be reported to RN consult for RN to assess. Any identified change of conditions identified by RSD/ED will be noted in quarterly QAA meetings and kept in QAA binder in ED office. Any identified Change of condition assessments will be Reviewed by RSD/ED and kept in a binder in the RSD office for 30 days. RN consultant will review all Binders monthly.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/1/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. Aiden Hall

OAC 310:663-25-4(F)

Date Enter a date of signature. 8/14/20

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: 8/12/2020** **Facility Name:** Aberdeen Memory Care **License Number:** AL7258 **Survey Event ID:** GZUR11 **Date Survey Completed: 1/16/2020**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C5015	Based on: Based on interview and record review, it was determined the center failed to develop, complete and implement a Plan of Accommodation for 1(#7) of 1 sampled resident who met discharge criteria and was dependent on staff for total care.This failed practice resulted in the isolated potential for more than minimal harm.

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?	Resident 7 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.
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?	RSD/RN consultant will develop, complete, and implement a Plan of Accommodation for any resident who potentially meets discharge criteria.
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/RSD/RN consultant will review all home health and hospice Plans of Accommodations weekly for four weeks and Quarterly there after for continued review. RSD/ RN consultant will review Plan of accommodation binder monthly. Any potential residents not meeting criteria will be reassed and evaluated for discharge to an appropriate facility. All audits will be included in Quarterly QAA and will be reviewed by both ED/RSD and kept in the QAA binber in the ED office. All documented Plans of Accommodation will be kept in a binder in the RSD office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	9/1/2020
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Administrator signature required. OAC 310:663-25-4(F)	**Date** Enter a date of signature. 8/14/20

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: tkwiatkowski@aberdeenmc.com

November 16, 2020

License Number: AL7258

Ms. Trischa Kwiatkowski , Administrator
Aberdeen Memory Care Of Tulsa
7210 South Yale Avenue
Tulsa, OK 74136

Survey Event ID: GZUR12

Dear Ms. Kwiatkowski:

On **November 12, 2020,** a complaint desk audit/paper revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 16, 2020,** have now been corrected effective **September 1, 2020.**

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

Sincerely,

Users, Lisa D Calvin
Digitally signed by Users, Lisa D Calvin
Date: 2020.11.16 14:09:02 -06'00'

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

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7258	A. BUILDING: _____ B. WING _____	R-C 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN MEMORY CARE OF TULSA	7210 SOUTH YALE AVENUE TULSA, OK 74136

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS A desk audit was completed on 11/12/2020. Evidence of correction was submitted for all deficiencies.	{C 000}		

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