



Oklahoma State Department of Health
Creating a State of Health

August 29, 2019

License Number: AL7260

Ms. Tammy Spinazzola, Administrator
Living Rose Christian Assisted Living Home
1108 North Fern Avenue
Broken Arrow, OK 74012

RE: Survey Event ID: FF4311

Dear Ms. Spinazzola:

On **August 20, 2019**, 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 August 20, 2019.

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 (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 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;

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- (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) 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

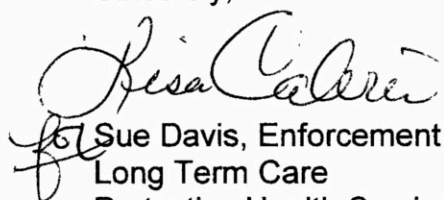
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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,

A handwritten signature in black ink, appearing to read "Sue Davis", is written over a printed name and title.

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7260	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 08/20/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING ROSE CHRISTIAN ASSISTED LIVING H

**1108 NORTH FERN AVENUE
BROKEN ARROW, OK 74012**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS On 08/20/19 a re-licensure survey was conducted. The census was 4. The following deficient practice was cited.	C 000		
C 522 SS=D	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 center failed to complete the comprehensive assessments as required for 1 (# 1) of 4 sampled residents. This resulted in the isolated potential for more than minimal harm. Findings: RESIDENT #1 Resident #1 moved into the center on 07/01/17. There was no annual comprehensive assessment found in the residents records. On 08/20/19 at 12:35 p.m., assessment records were reviewed and there was no annual comprehensive assessment available as required for resident #1. The administrator was asked about the missing assessment and stated it was not done.	C 522		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL7260	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B WING _____	(X3) DATE SURVEY COMPLETED 08/20/2019
NAME OF PROVIDER OR SUPPLIER LIVING ROSE CHRISTIAN ASSISTED LIVING H		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 NORTH FERN AVENUE BROKEN ARROW, OK 74012		
(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
C1301	Continued From page 1	C1301		
C1301 SS=D	310:663-13-1(a) RESIDENT SERVICE CONTRACT (a) Each assisted living center shall furnish to each resident a complete and understandable copy of the resident service contract. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to provide a complete and understandable copy of the resident service contract for 1 (#4) of 4 sampled residents who had signed service contracts with the center. This failed practice had the isolated potential for more than minimal harm. Findings: On 08/20/19 at 12:25 p.m., a review of the sampled residents' service contracts was conducted. There was no documentation resident #4, or the residents' representatives, had been provided with a complete and understandable copy of the service contract. The administrator (ADM) was asked if there was any documentation to show resident #4 or her representatives had been provided with a complete and understandable copy of their service contract. The ADM stated she had filed it somewhere but could not provide documentation.	C1301		

STATE WORKLOAD REPORT

Provider/Supplier Number AL7260	Provider/Supplier Name LIVING ROSE CHRISTIAN ASSISTED LIVING HOME
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Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- 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. 32388	08/20/2019	08/20/2019	0.50	0.00	4.00	0.00	2.00	4.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00 Total RO Supervisory Review Hours..... 0.00

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 30 2019

jm



Oklahoma State Department of Health
Creating a State of Health

September 10, 2019

License Number: AL7260

Ms. Tammy Spinazzola, Administrator
Living Rose Christian Assisted Living Home
1108 North Fern Avenue
Broken Arrow, OK 74012

RE: Survey Event FF4311

Dear Ms. Spinazzola:

On **August 20, 2019**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C0522 & C1301:** Tags C0522 and C1301 along with the AL # were not documented on the Forms submitted. Also, information regarding how monitoring would be done was not submitted.

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

Sincerely,

YD Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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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: 9/5/2019	
	Facility Name: Livingrose Christian Assisted Living Home	
	License Number: Click here to enter assisted living center's license number.	
	Survey Event ID: Click here to enter Survey Event ID from cover letter and STATE FORM.	
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: Enter ID Prefix Tag from Column X4 on STATE FORM.	Based on: Click here to enter "Based On" statement which follows "This REQUIREMENT is not met as evidenced by:" in the Summary of Deficiencies column on the STATE FORM.	
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?	Have the QAteam monitor files for a year.	
OSDH Response: Element accepted Yes ☐ No ☐		
2. How will other residents having the potential to be affected by the same deficient practice be identified?	By room # and bed	
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?	I will have the QA Team monitor files for 1 year	
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.	Administrator and Nurse will monitor files for 1 yr. File is flagged for yearly assessment QA Team will look over all files on the admission date At QA meeting form	
OSDH Response: Element accepted Yes ☐ No ☐		
5. On what date will corrective action be completed?	9/9/2019	
OSDH Response: Element accepted Yes ☐ No ☐		
Administrator's Signature Tammy Spinazzola OAC 310:663-25-4(F)	Date 9/5/2019	
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 9/5/2019	Submitted by	Tammy Spinazzola
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.		

SEP 11 2019
J.P.



Oklahoma State Department of Health
Creating a State of Health

September 16, 2019

License Number: AL7260

Ms. Tammy Spinazzola, Administrator
Living Rose Christian Assisted Living Home
1108 North Fern Avenue
Broken Arrow, OK 74012

RE: Survey Event FF4311

Dear Ms. Spinazzola:

On August 20, 2019, a Licensure inspection 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 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 9, 2019**.

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,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/KS

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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/12/2019

Facility Name: Livingrose Christian Assisted Living Home

License Number: AL7260

Survey Event ID: FF4311

Date Survey Completed: 8/20/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 522

Based on: Assessment Timeframes

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

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

ASSISTED LIVING CENTER'S PLAN ELEMENTS

Monitor for 1yr. all charts monthly and put into place – flags on form pages in charts of residents to draw our attention of timely up-dates.

2. How will other residents having the potential to be affected by the same deficient practice be identified?

Review all residents charts.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

On the first Monday of the month, our QA committee will review all resident charts, looking for timely up-dates.

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

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

On first Monday of each month for the next year QA committee will meet to go through all residents charts.

QA committee meeting monthly for the next year to go over residents charts.

Flag forms in residents charts, that have timeframes.

Timely forms will have flags on them. In each residents charts.

5. On what date will corrective action be completed?

8/21/2019

Administrator's Signature Tammy Spinazzola

OAC 310-663-25-4(F)

Date 9/12/2019

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.

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.



Protective
Health Services
Oklahoma State
Department of Health

Long Term Care
1000 Northeast Tenth Street
Oklahoma City, OK 73117
Phone (405) 271-6868

Recommended Assisted Living
Resident Assessment Form

All Areas Must Be Addressed, "N/A" if not applicable.

* Denotes items required for Admission Assessment.

Admission Date July 21, 2017

Facility Name Living Rose Christian Assisted Living Home Assessment Date July 21, 2017

*Resident Name #1 Room #: A1 Date of Birth: 10-22-1932

Assessment Type (circle one): Preadmission 14 day Annual Significant Change

*Disease Diagnoses and Medically Defined Conditions:

Chronic cough, chronic UTI, HTW, hyperlipidemia,
hyponatremia, hypothyroidism

*History of Infections and Prior Medical History:

chronic cough, pain, depression, colorectal cancer with colectomy, hypothyroidism
CAD with stents x1 2015, chronic diarrhea, UTI, glaucoma, HTW, hyperlipidemia, respiratory
hypotension, Allergies, constipation

*List All Current Medications and dosages (list additional medications on separate page if needed):

sodium chloride 1/2 tablet PO TID latanoprost ophthalmic 125mcg/1ml Montelukast tab 10mg (1 tab PO QPM)
Vitamin D 2000 UT PO (2 tabs Daily) (1 drop each eye HS) Donepezil 10mg tab (1 tab PO QPM)
Loratadine 10mg tab (1 tab PO Daily) refresh tear Drops 0.52OP
Levothyroxine 125mcg (1 tab PO Daily) (instill 2 Drops in each eye once Daily)
SMZ/TMP DS tab 800-160mg (1 tab PO M-W-F) Flonase 50mcg (1 spray each nostril Daily)

*Mental / Cognitive Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe) (circle one):

Alert / Non-Alert / Oriented x 4 Confused / Confused at Times / Forgetful Judgment: G (F) P

*Mental Health History / Mental Retardation or Developmental Disabilities:

None

*Physical Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Mobility: G (F) P Strength: G (F) P Gait: G (F) P
Range of Motion: (Full) Limited / Contractures (describe) Can move all extremities without difficulty
Weight Bearing: (Yes) No (describe) Full weight bearing to all extremities

Ambulatory Without Assistance / With Staff Assistance (describe)

Standby assistance needed only

Bedfast / Chair fast / Geri-chair (Walker) Wheelchair per Self (With Staff Assistance)

*List Number of Persons Required to Assist Resident with Activities of Daily Living to include:

Bathing 1 Eating 0 Dressing 0 Transferring 0 Toileting 0 Ambulation 0

Devices/Restraints (Describe):

Side rails used? Yes (No)

Restraint Devices (Describe) N/A Utilized When and Why (describe) N/A

Assisted Living Resident Assessment Form

Oral / Nutritional Status:

Diet Order: Regular Height: 5'10" ~~125lb~~ Weight: 125lb Weight Changes (loss or gain) Stable

Abnormalities: Swallowing Problems Yes (No) Nausea / Vomiting (describe) None

Ability to Eat: (Independent) Meal Set Up & Cueing / Assistance to Use Utensils/ Supervision / Must be Fed

Oral Status: (Own Teeth) / Partial Teeth / Dentures / No Teeth / Condition of Teeth (describe) _____

Tube Feeding: Gastrostomy / Nasogastric (describe) None

Toileting Ability/Elimination:

Bladder: Continent / Incontinent / (Incontinent at times (describe)) / Urinary Catheter - Indwelling / Other

Bowel: (Continent) ~~(Incontinent)~~ / Incontinent at times (describe) Bowel training every day with scheduled toileting

Toileting Ability: Independent (Assist) / Total Assist / Adult Briefs / B&B Restoration / (Toileting Schedule)

Customary Routine (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Sleep habits: (G) / F / P How Many Hours in 24? 12 Sleep Problems (describe) None

Meals: (In Dining Room) / In Room / Other Location / Eats Out (describe frequency) TID

Bathing: Prefers bath (Prefers shower) Preferred schedule (describe) Morning

Usual time to rise 0700 Usual bedtime 1900 Naps during day? Frequent

Psychosocial Status: (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Ability to communicate: (G) / F / P Interviewable (Yes) / No. If No describe: _____

Usual Mood: (Calm) / Fearful / Agitated / Anxious

History of Mood Disorder: (Depression) Depression history

History of Abnormal Behaviors: Agitation / Anger Outburst / Crying / Aggressive / Combative / Elopement Risk

Family / Friends Involvement: (Yes) / No (describe) Daughter, son

Skin Condition (G=Good, F=Fair, P=Poor, if fair or poor, describe):

General Condition: (G) / F / P Turgor: (G) / F / P

Describe Color, Texture and Appearance: Normal for age and ethnicity

Describe Abnormalities: None

Wounds (Describe All: location, size, color, drainage, treatment): None

Special Treatments and Procedures (i.e. wound care, respiratory therapy, physical therapy, restorative, etc.):

None

Sensory and Physical Impairments (i.e. vision, hearing, etc.):

None

Signature of Resident or Representative Interviewed

Melinda McWhitt RN July 21, 2019

*Signature (R.N. or Physician), Title Date

Participating Health Professional

Date

Participating Health Professional

Date



Oklahoma State
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Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 9/12/2019

Facility Name: Livingrose Christian Assisted Living Home

License Number: AL7260

Survey Event ID: FF4311

Date Survey Completed: 8/20/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C1301

Based on: Service Contact

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

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

OSDH Response: Element accepted: YES ☐ NO ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

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?

OSDH Response: Element accepted: YES ☐ NO ☐

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

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted: YES ☐ NO ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted: YES ☐ NO ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

New resident contract filled out day of admission and forms that need [Notarized] ,needs to be returned 1 week of date, chart needs to be flagged. And ALL contract forms kept in residents charts.

New resident contracts will be filed in the new residents chart and flagged noting a form needs to be returned.

New resident contract will be filed in residents charts and not filed under any other chart. And new residents chart will be flagged.

QA committee will meet for the next year each month to review residents charts.

File new residents contract in residents chart and flag it showing Notarized form needs returned.

QA committee will meet once a month for the next year to insure that New resident contracts are filed in New residents charts and chart is flagged for Notarized form to be returned within week of admission.

New residents contracts will be filed in residents chart and chart flagged for notarized forms to be returned.

Administrator's Signature Tammy Spinazzola
OAC 310:663-25-4(F)

Date 9/12/2019

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

Living Rose Christian Assisted Living Home

Medical Authorization Form

I, #4 (resident or responsible party) authorize Living Rose Christian Assisted Living Home to secure immediate medical or dental services in the event of an accident or illness at their discretion.

I accept full responsibility for any necessary expense(s) incurred for the emergency medical or dental treatment which is not covered by the following Health Care Insurance:

Insurance Company: CLARK County Self-Funded Plan

Policy Number: C00612288

Resident's Known Allergies or Physical Condition:

N/A

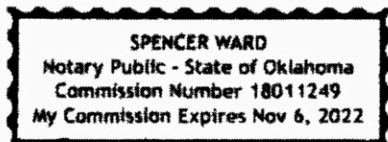
#4 9/9/19
Resident (or Responsible Party) Signature Date

State of OKLAHOMA County of WAGONER TULSA

Signed and sworn to (or affirmed) before me on this 9th day of SEPTEMBER, 2019.

#4
Name(s) of person(s) making statement.

[Signature]
Signature of Notary Public



My Commission Expires: 11 / 06 / 2022
My Commission Number is: 18011249

**Living Rose Christian Assisted Living Home
Resident Agreement**

This Agreement is made between the Living Rose Christian Assisted Living Home ("Living Rose") and # 4 (referred to singly or collectively as "You"). Living Rose is located at 1108 N. Fern Ave, Broken Arrow, OK 74012. You have applied for accommodations at Living Rose, and Living Rose has accepted your application. Living Rose Christian Assisted Living Home is licensed by the Oklahoma State Department of Health as an Assisted Living Facility. This Agreement is a month to month arrangement that can be terminated at any time as provided in Section VIII.

I. ACCOMADATIONS and SERVICES

Beginning on Oct 21, 2018, Living Rose shall provide the following accommodations and services to You, subject to the other terms, limitations, and conditions contained in the Agreement.

A. Accommodations

1. **Your Semi-Private Room.** You may occupy and use a semi-private room. Your semi-private room is subject to the terms of this agreement. Living Rose encourages You to personalize Your semi-private room by providing personal items. Living Rose will provide basic furnishings for Your semi-private room.
2. **Decoration and Alterations.** You are free to decorate Your portion of Your semi-private room as You wish, provided that You comply with the safety rules of Living Rose. You may not make any structural or physical changes to Your semi-private room, unless expressly approved in writing by Living Rose. Any such alterations or improvements shall become the property of Living Rose.

B. Basic Services

1. **Meals and Snacks.** Three nutritional (almost all organic), well-balanced meals per day are included in Your monthly rent. Modified diets will be available to You if prescribed by Your physician as a medical necessity, or if otherwise requested by You. Special dietary arrangements, other than those which are medically required, must be negotiated in advance between You and Living Rose and will be described in Exhibit #3 of this Agreement. Two snacks will be served per day, and in addition, snacks will be available upon request and include fruit, cheese, crackers, cookies etc.
2. **Activities.** Living Rose will provide a program of planned activities, opportunities for community participation, and services in an attempt to help meet Your physical, social and spiritual needs.
3. **Common Areas.** Living Rose offers several common areas (Living room, dining area, backyard, etc.) which are available to You daily.
4. **Transportation.** Living Rose will arrange transportation for Your medical and dental appointments. Living Rose will also arrange regularly scheduled transportation for outings. All other transportation is Your responsibility.

- A. Monthly Service Rate.** The monthly rent includes room, meals, snacks, personal care, monthly hair appointments at Volume Salon, and all utilities, excluding personal cell phones. A common phone is available for all residents use, at no additional monthly charge. Before move-in, Living Rose Administration will conduct an assessment of resident needs. Ongoing resident assessments are scheduled according to the Oklahoma Assisted Living Regulations. An additional assessment is completed fourteen (14) days after move-in, and annually thereafter, unless there is a significant change in Your condition which would warrant an assessment at time of change.

Rent is due and payable in advance, upon receipt of the billing statement sent on the 25th of the month. A late charge of twenty-five dollars (\$25), plus interest at the maximum legal rate, can be assessed if the monthly rent is not paid by the tenth (10th) day of the month. Your rights to occupy and use Your room and to receive other services under this Agreement are contingent upon Your timely payment of the monthly rent. (Exhibit #2 to this Agreement describes the services included). Charges for services and supplies not included in our monthly rent are also listed in Exhibit #3

- B. Adjustments to Rates.** Living Rose shall have the right, upon thirty (30) days prior written notice, to change Your monthly rate and other fees and charges.
- C. Absences from Living Rose.** You are responsible for paying Your monthly rent even when You are absent from Your room. This includes, but is not limited to times when You are on vacation or when You have been transferred temporarily to a skilled nursing facility, or if You have been transferred to an outside health care facility. You are not entitled to any discount to Your monthly rent during such absences. Any exception might be an absence lasting longer than 30 continuous days and with prior management's consent.
- D. Pets.** Due to our small environment, pets will be handled on a case by case basis, and at the discretion of the administrator. 7

1

Resident or Responsible Party and Administrator's Initials/Date

SL 10/21/18

IN WITNESS WHEREOF, Living Rose Christian Assisted Living Home and You have executed this Agreement in duplicate. By my signature I indicate knowledge of the document in its entirety, and understand that the written contract constitutes the entire agreement between the resident and Living Rose Christian Assisted Living Center, INC.

RESIDENT(S):

Name: #4

Address: 1108 N. Fern Ave Broken Arrow, OK 74012

#4 (Signature) 10/21/18 (Date)

RESPONSIBLE PERSON (if applicable):

Name: _____

Address: _____

(Signature) 10/21/18 (Date)

LIVING ROSE CHRISTIAN ASSISTED LIVING HOME:

By: Tammy Spinazzola

Its: Administrator

[Signature] (Signature) 10-21-18 (Date)

Living Rose Christian Assisted Living Home

Acknowledgement of Resident Admission Agreement

Tammy Spinazzola verbally reviewed the Resident Admission Agreement with me, #4. During the time the Resident Admission Agreement was being verbally reviewed, I was encouraged to ask questions, to ensure I understood what was being read/communicated to me.

#4
Resident Signature

10-21-18
Date

Jay Spina
Supervisor Signature

10/21/18
Date

nursing facility). By signing this agreement, you acknowledge that Living Rose Assisted Living Home has informed you that we do not offer a risk-free environment. You also affirm that you elected to move to our assisted living community with full awareness of the inherent risks that come from our community that promotes freedom, independence, and certain privacy our resident's cherish.

#4

Resident's Signature

10-21-18

Date

Responsible Party on Behalf of Resident

10-21-18

Date



Administrator's Signature (or designee)

10-21-18

Date

Living Rose Christian Assisted Living Home

Resident Record

Full Name: #4 Admission Date: 10-21-18

Date of Birth: 4-16-36 Are you an U.S. Citizen? yes

What do you like to do in your spare time?

Crosswords
Game Shows
Rides
Bird watching
Visiting Guest

How would you describe yourself?

Quiet, Self Entertaining

Name of Physician: Dr. Mitchell Duinack Physician's Phone Number (918) 710-4200

Physician's Address: 7501 Riverside Pkway, Tulsa, OK 74136

Name of Dentist: Dr. Parks / Dental Depot Dentist's Phone Number (918) 518-1526

Dentist's Address: 1950 Kenasha Ave / 71st Broken Arrow, OK 74012

Who should Living Rose contact in case of an emergency?

Name	Address	Phone Number
	<u>111th</u>	<u>(918) 402-4891</u>

Is there any other information about yourself that you would like to share with us?

Living Rose Assisted Living Home
Quality Assurance Committee Meeting Report

Today's Date: 8/21/19	Minutes: 22	Name of Person Preparing Report: Tammy Spinazzola
Names of Attendees and Credentials		
1	Tammy Spinazzola Administrator	
2	Melinda McWhitt, RN	
3	Talena Ralony	
4		
5		
Trends and Incidents: 1) Not up to date Assessment Form for Resident And Not up to date admission Forms for New Resident		
Customer Satisfaction Measures: 1) Monitor for 1 yr All charts monthly & put into place Flags on ^{Form at in} charts of Residents to draw our attention of Timely Up-dates. 2) New Resident Forms Filled out day of Admission + Form that needs Quality Assurance Efforts and Outcomes: ^{notary, charts to be flagged/needs to be returned 1 week} All Forms, Paperwork for Resident charts ^{And all contract forms kept in Resident charts,} Are filled out at appropriate times		
Other: 		

SEP 17 2019
 51.



Oklahoma State Department of Health
Creating a State of Health

January 9, 2020

License Number: AL7260

Ms. Tammy Spinazzola, Administrator
Living Rose Christian Assisted Living Home
1108 North Fern Avenue
Broken Arrow, OK 74012

RE: Survey Event ID: FF4312

Dear Ms. Spinazzola:

Enclosed is the summary of deficiencies following the revisit of a State Licensure survey conducted at your Assisted Living Center on **December 27, 2019**. These deficiencies remain uncorrected from our original inspection conducted **August 20, 2019**.

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 (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 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;

Board of Health

Gary Cox, JD
Commissioner of Health

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

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

R Murali Krishna, MD
Ronald D Osterhout
Charles Skillings

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(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) 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

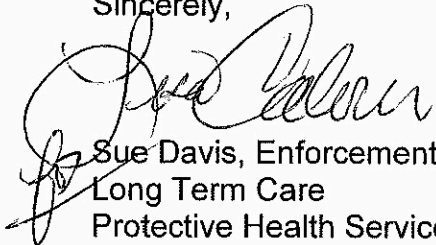
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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,

A handwritten signature in black ink, appearing to read "Sue Davis", is written over the typed name and title.

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/lc

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/27/2019
NAME OF PROVIDER OR SUPPLIER LIVING ROSE CHRISTIAN ASSISTED LIVING H		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 NORTH FERN AVENUE BROKEN ARROW, OK 74012		
(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 follow-up survey was conducted on 12/27/19. The census was 4. The following deficient practice was cited.	{C 000}		
C 961 SS=F	310:663-9-6(a) MINIMUM STAFF FOR SERVICES (a) The right number of trained staff shall be on duty, awake, and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents and to carry out all the processes listed in the continuum of care facility's, or assisted living center's, written emergency and disaster preparedness plan for fires and other natural disasters. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure trained staff were on duty to meet the needs for 4 (#1, 2, 3, and #4) of 4 sampled residents. This failed practice had the widespread potential for more than minimal harm for all 4 residents residing at the center. Findings: Upon entry to the center on 12/27/19 at 12:50 p.m., residents were observed in the dining area and ambulating to the dining area. The administrator's friend was observed following a	C 961		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/27/2019
NAME OF PROVIDER OR SUPPLIER LIVING ROSE CHRISTIAN ASSISTED LIVING H		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 NORTH FERN AVENUE BROKEN ARROW, OK 74012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER LIVING ROSE CHRISTIAN ASSISTED LIVING H			STREET ADDRESS, CITY, STATE, ZIP CODE 1108 NORTH FERN AVENUE BROKEN ARROW, OK 74012		
(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 961	Continued From page 1 resident to the dining area. She stated her name, but did not give a title. She stated the administrator would return in a moment and then started to check on the resident's lunch. At 12:55 p.m., the administrator entered the center. The administrator's friend exited the center at that time. The administrator was asked if the person who left was an employee. She stated it was a friend she was training for possible employment, if she would work out as an employee. She stated her friend was in class to become a long term care aide, but was not yet a LTCA. The administrator stated she had been down the street at the store picking up some glue to glue a chair and had only been gone about 5 minutes. The administrator was asked if she was aware she could not leave residents without trained staff. She stated she knew and never left residents without trained staff. There were no complaints by the residents at the time of the survey.	C 961			



Oklahoma State Department of Health
Creating a State of Health

January 27, 2020

License Number: AL7260

Ms. Tammy Spinazzola, Administrator
Living Rose Christian Assisted Living Home
1108 North Fern Avenue
Broken Arrow, OK 74012

RE: Survey Event FF4312

Dear Ms. Spinazzola:

On December 27, 2019, a Licensure inspection 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 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 **January 21, 2020**.

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

Sincerely,

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

SD/jt

Board of Health

Gary Cox, JD
Commissioner of Health

Timothy E Starkey, MBA (*President*)
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Ronald D Osterhout
Charles Skillings

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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: 1/21/2020	
	Facility Name: Livingrose Christian Assisted Living Home	
	License Number: AL7260	
	Survey Event ID: FF4312	
Date Survey Completed: 12/27/2019		
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C961	Based on: observation, interview, and record review, it was determined the center failed to ensure trained staff were on duty to meet the needs for 4(#1,#2,#3, and #4) of 4 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?	As the Administrator I will ensure that all staff will from here forward have proper certification and training that meet the needs of all residents and the homes written emergency and disaster preparedness plan for fires and other natural disasters.	
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 will 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?	That as the Administrator I will ensure from here forward only certified trained staff will be left to care for residents at Livingrose.	
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.	I the Administrator will ensure only trained staff will be left to care for residents. As the Administrator I will make sure trained staff only is left to care for residents. At our QA meetings every 3 months the attendees present will go over the importance of having trained staff only be left with residents without Administrator present, for the next 2 meetings. The next 2 QA meetings will question the Administrator to look into any new employee file, questioning, has all training been done before New Staff is left on their own to care for residents.	
OSDH Response: Element accepted: Yes ☐ No ☐		
5. On what date will corrective action be completed?	1/21/20	
OSDH Response: Element accepted: Yes ☐ No ☐		
Administrator's Signature: Tammy Spinazzola OAC 310/663-25-4(F)	Date 1/21/20	
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.		

 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE Current Date: 1/21/2020 Facility Name: Livingrose Christian Assisted Living Home License Number: AL7260 Survey Event ID: FF4312 Date Survey Completed: 12/27/2019	
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C961	Based on: observation, interview, and record review, it was determined the center failed to ensure trained staff were on duty to meet the needs for 4(#1,#2,#3, and #4) of 4 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?	As the Administrator I will ensure that all staff will from here forward have proper certification and training that meet the needs of all residents and the homes written emergency and disaster preparedness plan for fires and other natural disasters.	
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 will 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?	That as the Administrator I will ensure from here forward only certified trained staff will be left to care for residents at Livingrose.	
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.	I the Administrator will ensure only trained staff will be left to care for residents. As the Administrator I will make sure trained staff only is left to care for residents. At our QA meetings every 3 months the attendees present will go over the importance of having trained staff only be left with residents without Administrator present, for the next 2 meetings. The next 2 QA meetings will question the Administrator to look into any new employee file, questioning, has all training been done before New Staff is left on their own to care for residents.	
OSDH Response: Element accepted: Yes ☐ No ☐		
5. On what date will corrective action be completed?	1/21/20	
OSDH Response: Element accepted: Yes ☐ No ☐		
Administrator's Signature: Tammy Spinazzola OAC 310:663-25-4(f)	Date 1/21/20	
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.		

PRINTED: 01/09/2020
FORM APPROVED

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/27/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING ROSE CHRISTIAN ASSISTED LIVING HOME

1108 NORTH FERN AVENUE

BROKEN ARROW, OK 74012

(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 follow-up survey was conducted on 12/27/19. The census was 4. The following deficient practice was cited.	(C 000)		
C 961 SS=F	310:663-9-6(a) MINIMUM STAFF FOR SERVICES (a) The right number of trained staff shall be on duty, awake, and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents and to carry out all the processes listed in the continuum of care facility's, or assisted living center's, written emergency and disaster preparedness plan for fires and other natural disasters. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to ensure trained staff were on duty to meet the needs for 4 (#1, 2, 3, and #4) of 4 sampled residents. This failed practice had the widespread potential for more than minimal harm for all 4 residents residing at the center. Findings: Upon entry to the center on 12/27/19 at 12:50 p.m., residents were observed in the dining area and ambulating to the dining area. The administrator's friend was observed following a resident to the dining area. She stated her name, but did not give a title. She stated the	C 961		

Oklahoma State Department of Health

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

TITLE

(X6) 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: 1/21/2020 Facility Name: Livingrose Christian Assisted Living Home License Number: AL7260 Survey Event ID: FF4312 Date Survey Completed: 12/27/2019	
SUMMARY OF DEFICIENCY CITED BY OSDH		
ID Prefix Tag: C961	Based on: observation, interview, and record review, it was determined the center failed to ensure trained staff were on duty to meet the needs for 4(#1,#2,#3, and #4) of 4 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?	As the Administrator I will ensure that all staff will from here forward have proper certification and training that meet the needs of all residents and the homes written emergency and disaster preparedness plan for fires and other natural disasters.	
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 will 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?	That as the Administrator I will ensure from here forward only certified trained staff will be left to care for residents at Livingrose.	
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.	I the Administrator will ensure only trained staff will be left to care for residents. As the Administrator I will make sure trained staff only is left to care for residents. At our QA meetings every 3 months the attendees present will go over the importance of having trained staff only be left with residents without Administrator present, for the next 2 meetings. The next 2 QA meetings will question the Administrator to look into any new employee file, questioning, has all training been done before New Staff is left on their own to care for residents.	
OSDH Response: Element accepted: Yes ☐ No ☐		
5. On what date will corrective action be completed?	1/21/20	
OSDH Response: Element accepted: Yes ☐ No ☐		
Administrator's Signature: Tammy Spinazzola OAC 310:663-25-4(f)	Date 1/21/20	
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.		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/27/2020
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LIVING ROSE CHRISTIAN ASSISTED LIVING H

**1108 NORTH FERN AVENUE
BROKEN ARROW, OK 74012**

(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 follow-up survey was conducted on 02/27/20. The census was 4. All deficient practice was cleared.	{C 000}		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

STATE WORKLOAD REPORT

Provider/Supplier Number
AL7260

Provider/Supplier Name
LIVING ROSE CHRISTIAN ASSISTED LIVING HOME

Type of Survey (select all that apply)

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

Extent of Survey (select all that apply)

A				
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- 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. 32388	02/27/2020	02/27/2020	0.50	0.00	0.75	0.00	1.50	0.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....

0.00

Total RO Supervisory Review Hours.....

0.00

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