



Delivery via email to: kcrenshaw@leisurecare.com

October 19, 2021

License Number: AL7267

Ms. Kimberly Crenshaw, Administrator
The Linden At Stonehaven Square
10802 East 81st Street
Tulsa, OK 74133

Survey Event ID: J5TO11

Dear Ms. Crenshaw:

On **October 11, 2021**, representatives from the Oklahoma State Department of Health (OSDH) concluded a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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

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

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

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

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



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

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

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

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

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

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

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



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

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

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

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

Sincerely,

Lisa Calvin

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

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: The Linden at Stonehaven Square
Address: 10802 East 81st Street
City, State, Zip: Tulsa, Ok 74133
Provider #: AL7267
Complaint #: OK00056128
Investigation Date(s): October 6th, 7th, 8th, 10, and 11th 2021.

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide a clean comfortable sanitary environment.	US

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

An unannounced on-site investigation was initiated on 10/06/2021 at 12:10 p.m.

A sample of 3 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

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

Resident rooms were observed to be clean. Staff were interviewed on cleaning resident rooms, and products used for sanitization of high touch areas. No lingering odors were noted in the hallways or resident rooms. Administrative staff provided copies of cleaning services used for sanitization of common areas and touch points. Housekeeping was observed cleaning resident rooms. Carpet in hallway was observed to have some stains, administration reports holding off having carpets cleaned due to recent outbreak status. An investigation specific to a clean environment was conducted. No deficient practice was found related to a clean environment.

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.

Mary Cooper By Edna

Mary Cooper RN/CHFS

Date report completed: 10/12/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: The Linden At Stonehaven Square
Address: 10802 East 81st Street
City, State, Zip: Tulsa, Okla. 74133
Provider #: AL7267
Complaint #: OK00057799
Investigation Date(s): October 6th, 7th, 8th, 10, and 11th 2021.

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The center failed to ensure the residents' right to visitors of choice and visitation that is not limited.	US
The center failed to follow proper infection control procedures to prevent the spread of Covid-19	S
3. The center failed to ensure care was ordered by the physician.	US

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

An unannounced on-site investigation was initiated on 10/06/2021 at 12:10 p.m.

A sample of 3 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

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

Family members were observed going to resident rooms and assisting residents outside for visitation. Residents were observed leaving with family members outside of the facility. Policy and procedure was reviewed. Family is allowed to visit in resident rooms and outside. Staff were interviewed and report visitation does occur in resident rooms at this time. Visitors are not required to make appointments. A residents' family member

reported she has no issues with being able to visit with her family member in the memory care. An investigation specific to visitation was completed, no deficient practice was identified.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, 1505 for details.

Allegation #3: Deficient practice was unsubstantiated related to this allegation. Resident records were reviewed for health shake orders. The resident named in the allegation did not have a physicians' order for health shakes since admission and has had no weight loss. Staff were interviewed regarding residents who have orders for health shakes. Health shakes are given between meals. No issues were reported with residents receiving their health shakes. Health shakes are offered to residents who do not eat well. Weight loss records were reviewed. An investigation specific to diet orders was completed, no deficient practice was found related to diet orders.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #1 and #3. 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.

Mary Cooper By Ed Re

Mary Cooper RN/CHFS

Date report completed: 10/12/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: The Linden at Stonehaven Square
Address: 10802 East 81st Street
City, State, Zip: Tulsa, Okla. 74133
Provider #: AL7267
Complaint #: OK00057826
Investigation Date(s): October 6th, 7th, 8th, 10th, and 11th 2021.

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The center failed to follow proper infection control procedures to prevent the spread of infections.	S
2. The center failed to ensure medications were properly administered.	S

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

An unannounced on-site investigation was initiated on 10/06/2021 at 12:10 p.m.

A sample of 3 residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, 1505 for details.

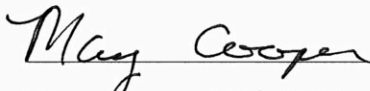
Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, 0921 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

 By Ed M.
Mary Cooper RN/CHFS

Date report completed: 10/12/2021

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/11/2021
NAME OF PROVIDER OR SUPPLIER THE LINDEN AT STONEHAVEN SQUARE		STREET ADDRESS, CITY, STATE, ZIP CODE 10802 EAST 81ST STREET TULSA, OK 74133		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	INITIAL COMMENTS An abbreviated survey was conducted on October 6th through the 8th, 10th and 11th, 2021 to investigate complaint #OK00055957, #OK00056128, #OK00057799 and #OK00057826. Listed below are abbreviations that will be used throughout this document. ADL-Activitied of Daily Living AL-Assisted Living a.m.-before noon B/P-Blood Pressure bpm-beats per minute CMA-Certified Medication Aide CNA-Certified Nursing Assistant GM-General Manager HWD-Health and Wellness Director IU-International Units lbs-pounds MAR-Medication administration record MC-Memory Care mcg-micrograms MG-Milligrams p.m. after midday Res-Resident RN-Registered Nurse PCR-Polymerase chain reaction Tab-Tablet	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;	C 522		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C 522	Continued From page 1 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 the nurse failed to assess and complete a significant change assessment for one (#4) of three sampled residents reviewed for completed assessments. The HWD identified 94 residents resided in the center. Findings: Medication Policy titled, "Residents", dated January 2003, read in part, "...Medication refusal...The resident may choose not to take the prescribed medication. The community will respect this right, will document the refusal and staff will notify the Health and Wellness Leader. The Health and Wellness leader will report recurring refusals or refusals that pose an imminent danger to the resident's health care practitioner and/or responsible party..." Resident (Res) #4 admitted to the center with diagnoses which included hypertension, copd, Alzheimers disease, and dementia. Res #4's "Care Plan", dated 08/05/20, read in parts, "...Independent with getting in and out of bed...Needs verbal reminders for dressing but is independent...Hospice aides provide shower assistance 2-3 times per week...Needs verbal reminders for grooming...Urinary	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 2 incontinence...Needs verbal reminders for toileting and/or continence care but is independent...Verbal reminders for meal time but goes to dining room independently...Fall Risk Evaluation...Resident is at a moderate risk for falls...Has the resident experienced a fall in the last three months? No..." "Progress Notes" documented as follows; "...On 09/06/2020 at 2:36 PM Late entry for 09/04/2020 9:00 AM: Resident noted, by staff, to be lying on the floor near the end of his bed..." "...On 09/08/2020 at 11:27 AM...Resident had refused all food all day Monday and so far today. Resident condition weaker today than previously..." Family member was notified and Res was sent to the hospital. "...On 09/08/2020 at 5:10 PM Resident returned to the unit at 1445 [2:45 p.m.] today with no new med changed and no new diagnoses..." "...On 09/09/2020 at 5:02 PM Resident's hospice nurse visited today. Resident continues not to be interested in eating food. Resident continues to not speak, but answers questions with head shakes and nods..." "...On 10/02/2020 at 12:18 PM Resident found lying in floor..." "...On 10/07/2020 at 12:38 PM Tiredness/Weakness: mostly sleepy today: refused breakfast and lunch..does not want to eat..." "...On 11/09/2020 at 2:24 PM During safety checks upon entering residents room staff noted resident lying on the floor next to his bed..." "...On 11/15/2020 at 1:31 PM During safety checks resident was noted to be laying on the floor next to his bed. Resident had emesis underneath him. Resident stated he did not feel good and c/o nausea and abdominal pain...Resident was sent out to hospital via	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 3 EMSA..." On 10/08/21 at 10:35 a.m., HWD #2 was asked if Res #4 had a decline in September due to COVID. She replied, yes. Res #4's care plan and progress notes were reviewed with HWD #2. She was asked if a significant change assessment should have been completed due to residents need for increased assistance with ADL's. She stated, "Yes, it should have been completed." HWD #2 was asked if the progress notes documented the resident continued to refuse or medications were not given due to resident "sleeping". She replied, no it only documents him refusing his meals. September, October and November 2020 MAR'S were reviewed with HWD #2. She was asked if the physician was notified that the resident had refused his medications. She stated, "It wasn't done."	C 522		
C 910 SS=D	310:663-9-1 NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged:	C 910		

Oklahoma State Department of Health

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C 910	Continued From page 4 This Rule is not met as evidenced by: The facility failed to provide RN supervision to ensure physician orders were completed, and the physician was notified for; a. resident refusals for daily weights for one (#2) of three sampled residents reviewed for weights. b. resident refusals of medications for one (#4) of three sampled residents reviewed for medication administration. c. abnormal heart rates for one (#5) of three residents reviewed for vital signs. The HWD identified 94 residents resided in the center. Findings: Medication Policy titled, " Residents", dated January 2003, read in part, "...Medication refusal...The resident may choose not to take the prescribed medication. The community will respect this right, will document the refusal and staff will notify the Health and Wellness Leader. The Health and Wellness leader will report recurring refusals or refusals that pose an imminent danger to the resident's health care practitioner and/or responsible party..."	C 910		

Oklahoma State Department of Health

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C 910	Continued From page 5 1. Res #2 was admitted to the center with diagnoses which included unspecified dementia, hypertension, and anxiety. A " Physicians Order Sheet", dated 09/08/2021 read in parts"...07/08/21 Weight monitor-Daily-take and record daily weight. Report to nurse if weight gain of 3lb or more in 24 hours If 2-3 lb weight gain in 24 hours administer lasix per order..." 04/23/21 Furosemide 40MG Tab-Daily as needed...Take one tablet by mouth once daily as needed...Administer if resident has edema to extremities and or weight gain of 3 of more lbs daily...PRN Indicated for CHF..." The MAR's for September and October 2021, had no weights documented, and no documentation that Res #2 was assessed for edema. The center provided a document titled " Weight" for Res #2. It documented on 09/01/21 a weight of 133 lbs. No other weights were provided at this time. On 10/07/2021 at 09:13 a.m., HWD #2 was asked if she had been aware Res #2 refused to be weighed every day. She replied, I wasn't aware every day. At 09:45 a.m. HWD #2 said, I called the doctor in August and asked to d/c the lasix since the resident wasn't allowing us to weigh him. I haven't got a response. She was asked where it is documented the resident was assessed for edema as ordered. She replied, I didn't make a note, the staff notifies me. On 10/08/21 at 10:25 a.m., the HWD #2 was asked if the daily weights had not been obtained as ordered. She replied, correct. She was asked	C 910		

Oklahoma State Department of Health

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C 910	Continued From page 6 if the resident refused, what was done about it. She replied, it should have been reported. HWD #2 was asked if the edema assessments were completed. She stated, " the days I was not here, it wasn't done." She was asked if the staff had notified her the resident was consistently refusing weights. She replied, no. 2. Res #4 admitted to the center with diagnoses which included hypertension, copd, Alzheimers disease, and dementia. Res #4's "Care Plan", dated 08/05/20, read in parts,"...Independent with getting in and out of bed...Needs verbal reminders for dressing but is independent...Hospice aides provide shower assistance 2-3 times per week...Needs verbal reminders for grooming...Urinary incontinence...Needs verbal reminders for toileting and/or continence care but is independent...Verbal reminders for meal time but goes to dining room independently...Fall Risk Evaluation...Resident is at a moderate risk for falls...Has the resident experienced a fall in the last three months? No..." September 2021 MAR documented, Res #4 refused one or more medications on 28 out of 30 days. October 2021 MAR documented, Res #4 refused one or more medications on 26 of 31 days. November MAR documented Res #4 refused one or more medications on 9 of 13 days. Res#4 was sent to the ER on 11/13/2020 and did not return to the center. On 10/08/21 at 10:35 a.m., HWD #2 was asked if the progress notes documented the resident continued to refuse his medications. She replied,	C 910		

Oklahoma State Department of Health

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NAME OF PROVIDER OR SUPPLIER THE LINDEN AT STONEHAVEN SQUARE		STREET ADDRESS, CITY, STATE, ZIP CODE 10802 EAST 81ST STREET TULSA, OK 74133		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 910	Continued From page 7 no it only documents him refusing his meals. September, October and November 2020 MAR'S were reviewed with HWD #2. She was asked if the physician was notified that the resident had refused his medications. She stated, "It wasn't done." 3. Res #5 was admitted to the center with diagnoses which included, bradycardia, hypertension, Alzheimers disease and dehydration. "Physicians Order", dated September 08, 2021, read in parts"...03/03/21-Blood Pressure and Heart Rate-Daily-Take and record BP and pulse daily..." There were no parameters to hold the B/P medication. Center "Vital Sign Parameters" undated, read in parts"...Unless otherwise specified by a Resident's Health Care Practitioner, RA's shall notify the Health & Wellness Director, designated nurse, and/or physician as well as non-licensed supervisors...if any vital sign is outside of the parameter listed below...Pulse Above 100 or below 50..." On 10/08/2021 at 10:06 a.m., Res #5's MAR's were reviewed with HWD #2. On 09/04/21 the B/P was 125/59, and heart rate was 85. The medication was held due to parameters. HWD #2 was asked if the medication should have been held, she replied, no. On 09/05/21 the B/P was 130/77, and heart rate was 57. The medication was held due to parameters. HWD #2 was asked if the medication should have been held, she replied, no. On 09/16/21 Heart rate was 111 bpm. On 09/19/21 Heart rate was 103 bpm.	C 910		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/11/2021
NAME OF PROVIDER OR SUPPLIER THE LINDEN AT STONEHAVEN SQUARE		STREET ADDRESS, CITY, STATE, ZIP CODE 10802 EAST 81ST STREET TULSA, OK 74133		
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C 910	Continued From page 8 On 09/20/21 Heart rate was 108 bpm. On 09/24/21 Heart rate was 108 bpm. On 09/25/21 Heart rate was 148 bpm. On 10/01/21 Heart rate was 124 bpm. HWD #2 was asked if she had been notified that Res #5's heart rate was greater then 100 bpm. She stated, " No, I was not."	C 910		
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on observation, interview, and record review the center failed to provide sufficient staffing to administer medications at the time ordered by the physcian for three (#2, #3 and #5) of three sampled residents reviewed for medication administration. The HWD identified 94 residents resided in the center. Findings: Center's "Medication Services Supplement", dated January 2003, read in parts, "...Medication	C 921		

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C 921	Continued From page 9 errors...A medication error is any situation where the exact orders from the physician were not followed. Some examples include but are not limited to:...Wrong time..." 1. Res #2 was admitted to the center with diagnoses which included unspecified dementia, hypertension, and anxiety. "Med Delivery", dated 10/07/21, documented eight medications were scheduled to be administered at 9 a.m. Medications were administered at 12:27 p.m. and included the following: Amlodipine, Aspirin, Eliquis, Buspirone, Calcium/D 3, Lisinopril, Memantine, and Metoprolol. 2. Res #3 was admitted to the center with diagnoses which included, hypertension, diabetes mellitus, acute kidney failure and hyperlipidemia. "Med Delivery" dated 10/07/21, documented, 16 medications were scheduled to be administered at 9 a.m. Medications were administered at 11:13 p.m. and included the following: Oyster Shell Calcium, Pro-Stat AWC 9advanced wound care) Liquid, PEG 3350 powder (miralax), Aspirin, Loratadine, Metoprol Suc Tab, Levothyroxin Tab, Metformin HCL, Benazepril Tab, Vitamin B-12 Tab, Oxybutynin CHL, Docusate Sodium, Ferrous Sulfate, Vitamin, Tab-a-vite Tab and Furosemide. 3. Res #5 was admitted to the center with diagnoses which included, bradycardia, hypertension, Alzheimer's disease and dehydration. "Med Delivery" dated 10/07/21 documented, six medications were scheduled to be administered at 9 a.m. Medications were administered at 10:17	C 921		

Oklahoma State Department of Health

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C 921	Continued From page 10 p.m. and included the following: Tamsulosin, Memantine, Sertraline HCL, Buspirone HCL, Senna Plus, and Amlodipine. On 10/06/21 at 1:00 p.m., HWD #1 was asked what staffing ratio is for memory care. She replied, seven staff on days, seven staff on evenings and three staff on nights. The center uses agency for emergency staffing plan. She was asked who reviews the MAR's to ensure residents are getting meds as ordered. She replied, I am, daily with a dashboard report. At 2:03 p.m., "Memory Care Nursing Schedule", dated 09/19/21 to 10/02/21, was reviewed with HWD #1. She was asked if CMA #5 was the only staff here to pass medications on 09/25/21. She replied, one staff member went home sick and one staff member didn't show up and we didn't find a replacement CMA until 11:00 or 12:00 p.m. On 10/07/21 at 12:15 p.m., the GM was asked if CMA #5 was the only CMA working in memory care on 09/25/21. She replied, yes. On 10/08/21 At 10:45 a.m., HWD #2 was asked if medications for these three residents were given late on 09/25/21. She acknowledged the medications were given late.	C 921		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5)	C1505		

Oklahoma State Department of Health

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C1505	Continued From page 11 (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the center failed to ensure staff a. were trained to perform COVID-19 testing. b. performed COVID-19 testing according to the manufacturers' recommendations. c. wore appropriate PPE when performing COVID-19 testing.	C1505		

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C1505	Continued From page 12 d. did not allow a COVID positive resident and a COVID negative resident to share a joined bathroom. The HWD identified 94 residents who resided in the facility. Findings: A center document, dated 02/15/2021, "ECP Appendix D Personal Protective Equipment (PPE) Hazard Assessment Certification" read in parts, "...Job/Task...Collecting Samples for SARS-CoV-2 Virus Screening...Protection Type(s) of PPE required...N-95 Respirator Gown Disposable Barrier Gloves Eye Protection..." On 10/06/22 at 1:00 p.m., HWD #1 was asked who performs COVID-19 testing in the center. She replied, herself, HWD #2, CMA #3 and the RN. HWD #1 was asked how often COVID-19 testing was performed for the residents and staff. She replied, testing is being performed twice a week in MC and AL at this time due to outbreak status. HWD #1 was asked what staff are required to wear when in direct contact with a covid positive resident. She stated, "gown, KN95, shield and gloves." The HWD #1 was asked if the center tests following the OSDH grids and recommendations, she stated, "Yes." At 2:45 p.m., HWD #2 was asked if Res #1 and Res #2 share a bathroom. Both residents are identified as ambulatory. How did you ensure the bathroom was cleaned after every use. She replied, when Res#1 was in isolation, the staff performed covid checks every hour, assisted with toileting and cleaning and sanitizing as well.	C1505		

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C1505	Continued From page 13 At 2:37 p.m., CMA #2 was asked who does the COVID-19 testing. She replied, HWD#1, RN, and CMA #3. At 3:20 p.m., the GM was asked what cleaning the facility does if a covid positive and covid negative resident share the same bathroom. She replied, the staff use sani wipes, and disinfect hourly in rooms. At 3:54 p.m., Res #2 was observed lying in his bed, Res #2 shares his bathroom with Res #1. At 3:59 p.m., CMA #1 was asked who does her covid testing. She replied, CMA #3 and the RN. She was asked is she ever had to swab herself. She stated, "Yes I have, last week." She was asked if that was the only time she had tested herself. She replied, one other time. She was asked why she tested herself. She stated, "I just did it." At 4:09 p.m., CNA #1 was asked when she last had a covid test. She replied, last week on Thursday. She was asked if she had ever tested herself. She replied, yes one time. She was asked when. She replied, last Thursday. She was asked if she had ever been trained to perform covid testing and who trained her. She replied, it was CMA #4. On 10/07/2021 at 09:23 a.m., HWD #1 was asked if there was a policy about who could perform COVID-19 testing. She replied, no as long as they were trained by the nurses. She was asked if staff were allowed to test themselves. She stated, " Not really, No." HWD #1 was asked if there was any documentation that staff who were performing COVID-19 testing had been	C1505		

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C1505	Continued From page 14 trained. She replied, I don't think so. At 11:37 p.m., HWD #1 was observed wearing a KN95, carrying a box of gloves and a box of rapid tests that had been opened and labeled with the residents name. The swab was placed in each pouch to prepare for COVID testing. HWD #1 was observed to test three residents in their rooms using the following testing steps. HWD #1 sanitized her hands and donned her gloves. She removed the card from the pouch, prepared the card with the solution, swabbed the resident, inserted the q-tip into the card, and placed the testing card back into the pouch. The pouch with the specimen was placed back into the box of clean/unused pouches/equipment. The card was not laid flat during the processing time as recommended by the manufacturer. No faceshield or gown was worn during the testing process. At 2:45 p.m., the GM was asked what the facility policy documented what PPE should be worn when performing COVID-19 testing. The GM provided a copy of a document, dated 02/15/21, titled " ECP Appendix D Personal Protective Equipment (PPE) Hazard Assessment Certification". At 3:55 p.m., the HWD#1 was asked what the policy document about what PPE was to be worn during COVID testing. She replied, if it's a possible covid resident a gown, mask, faceshield and gloves. If it's regular testing, a mask and gloves and change gloves in between. At 4:48 p.m., CMA #5 was observed, wearing a KN95, passing hall trays in MC. She entered a covid positive resident room carrying the meal tray. No PPE was donned prior to entering the	C1505			

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C1505	Continued From page 15 room. No PPE supplies were in the hallway. When she exited the room, she was asked if that resident was in isolation. She replied, yes. She was asked if she put PPE on when she was in the room. She replied, yes, gloves and a gown. A residents room was observed to have a three drawer storage and a biohazard box in the room. On 10/08/21 at 08:02 a.m., CMA #3 was asked if she had ever tested another staff member. She replied, yes. She was asked if there was any documentation that she had been trained. She replied, she was not sure if there was any documentation, it was way back in 2020. At 10:48 a.m, HWD #2 was asked to describe the process for testing with the rapid tests (Abbot Binax cards). She replied, I sanitize my hands, put on a gown and gloves, open the binax card, label the card, lay on flat surface, open dropper, hold over hole, put in 6 drops of solution. Open the swab, swab each nostril 15 seconds about 3-5 times. Insert into the bottom hole, turn clockwise 3 times, pull sticker off, close card, and wait 15 minutes. I leave on flat surface. Take your gown and gloves off and wash your hands. She was asked when she tested resident in their rooms, did she put the testing card back in the packet. She replied, no I carry it to my office. HWD #2 was asked if staff should be donning PPE prior to entry into a covid positive room. She replied, we put the PPE in the room because MC residents were grabbing PPE outside in the hallway, and posed a risk for residents. The decision was made to put the PPE inside the door. At 11:45 a.m., the HWD #2 said the set up was the same in MC. All equipment is on inside of the	C1505		

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C1505	Continued From page 16 resident's door, in 3 cart drawers and biohazard bags. The "Oklahoma State Department of Health" guidelines for PPE, read in parts, "...Quarantine/Isolation...Direct Care Staff...Gloves...Eye Protection...Gown...N95...Required for care of quarantined and COVID-19 positive residents prior to entering room and using appropriate hand hygiene..." "ABBOTT BINAXNOW™ COVID ~19 AG CARD TEST HELPFUL TESTING TIPS" "...During the Test...Leave the card sealed in its foil pouch until just before use and do not use the card if the card or foil pouch is open, damaged, expired or if the blue line is not present. The card must remain flat when performing the test. Carefully flex the card as needed to ensure it lays flat on the table. Do not change the position of the card while the test is being processed..." Cited from "https://www.cdc.gov/csels/dls/preparedlabs/documents/Lessons-Learned-Antigen-Test-BinaxNOW-Ag-Card.pdf"	C1505		



Delivery via email to: kcrenshaw@leisurecare.com

November 1, 2021

License Number: AL7267

Ms. Kimberly Crenshaw, Administrator
The Linden At Stonehaven Square
10802 East 81st Street
Tulsa, OK 74133

Survey Event ID: J5TO11

Dear Ms. Crenshaw:

On **October 11, 2021**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **ALL TAGS:** The POC is not accepted. The date the plan was to be corrected does not allow for enough time for the plan to be developed, implemented, for staff to be trained and for plan monitoring to occur as required by Oklahoma Administrative Code (OAC) 310:663-25-4(b)(c).

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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

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C 000	INITIAL COMMENTS An abbreviated survey was conducted on October 6th through the 8th, 10th and 11th, 2021 to investigate complaint #OK00055957, #OK00056128, #OK00057799 and #OK00057826. Listed below are abbreviations that will be used throughout this document. ADL-Activitied of Daily Living AL-Assisted Living a.m.-before noon B/P-Blood Pressure bpm-beats per minute CMA-Certified Medication Aide CNA-Certified Nursing Assistant GM-General Manager HWD-Health and Wellness Director IU-International Units lbs-pounds MAR-Medication administration record MC-Memory Care mcg-micrograms MG-Milligrams p.m. after midday Res-Resident RN-Reglstered Nurse PCR-Polymerase chain reaction Tab-Tablet	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;	C 522		

Oklahoma State Department of Health

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



TITLE *General Manager*

(X6) DATE

10/29/2021

Oklahoma State Department of Health

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C 522	Continued From page 1 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 the nurse failed to assess and complete a significant change assessment for one (#4) of three sampled residents reviewed for completed assessments. The HWD identified 94 residents resided in the center. Findings: Medication Policy titled, "Residents", dated January 2003, read in part, "...Medication refusal...The resident may choose not to take the prescribed medication. The community will respect this right, will document the refusal and staff will notify the Health and Wellness Leader. The Health and Wellness leader will report recurring refusals or refusals that pose an imminent danger to the resident's health care practitioner and/or responsible party..." Resident (Res) #4 admitted to the center with diagnoses which included hypertension, copd, Alzheimers disease, and dementia. Res #4's "Care Plan", dated 08/05/20, read in parts, "...Independent with getting in and out of bed...Needs verbal reminders for dressing but is independent...Hospice aides provide shower assistance 2-3 times per week...Needs verbal reminders for grooming...Urinary	C 522		

Oklahoma State Department of Health

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C 522	Continued From page 2 incontinence...Needs verbal reminders for toileting and/or continence care but is independent...Verbal reminders for meal time but goes to dining room independently...Fall Risk Evaluation...Resident is at a moderate risk for falls...Has the resident experienced a fall in the last three months? No..." "Progress Notes" documented as follows; "...On 09/06/2020 at 2:36 PM Late entry for 09/04/2020 9:00 AM: Resident noted, by staff, to be lying on the floor near the end of his bed..." "...On 09/08/2020 at 11:27 AM...Resident had refused all food all day Monday and so far today. Resident condition weaker today than previously..." Family member was notified and Res was sent to the hospital. "...On 09/08/2020 at 5:10 PM Resident returned to the unit at 1445 [2:45 p.m.] today with no new med changed and no new diagnoses..." "...On 09/09/2020 at 5:02 PM Resident's hospice nurse visited today. Resident continues not to be interested in eating food. Resident continues to not speak, but answers questions with head shakes and nods..." "...On 10/02/2020 at 12:18 PM Resident found lying in floor..." "...On 10/07/2020 at 12:38 PM Tiredness/Weakness: mostly sleepy today; refused breakfast and lunch..does not want to eat..." "...On 11/09/2020 at 2:24 PM During safety checks upon entering residents room staff noted resident lying on the floor next to his bed..." "...On 11/15/2020 at 1:31 PM During safety checks resident was noted to be laying on the floor next to his bed. Resident had emesis underneath him. Resident stated he did not feel good and c/o nausea and abdominal pain...Resident was sent out to hospital via	C 522		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL7267	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/11/2021
NAME OF PROVIDER OR SUPPLIER THE LINDEN AT STONEHAVEN SQUARE			STREET ADDRESS, CITY, STATE, ZIP CODE 10802 EAST 81ST STREET TULSA, OK 74133		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 522	Continued From page 3 EMSA..." On 10/08/21 at 10:35 a.m., HWD #2 was asked if Res #4 had a decline in September due to COVID. She replied, yes. Res #4's care plan and progress notes were reviewed with HWD #2. She was asked if a significant change assessment should have been completed due to residents need for increased assistance with ADL's. She stated, "Yes, it should have been completed." HWD #2 was asked if the progress notes documented the resident continued to refuse or medications were not given due to resident "sleeping". She replied, no it only documents him refusing his meals. September, October and November 2020 MAR'S were reviewed with HWD #2. She was asked if the physician was notified that the resident had refused his medications. She stated, "It wasn't done."	C 522			
C 910 SS=D	310:663-9-1 NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged:	C 910			

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**SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
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(X5)
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C 910 Continued From page 4

C 910

This Rule is not met as evidenced by:
The facility failed to provide RN supervision to ensure physician orders were completed, and the physician was notified for;

- a. resident refusals for daily weights for one (#2) of three sampled residents reviewed for weights.
- b. resident refusals of medications for one (#4) of three sampled residents reviewed for medication administration.
- c. abnormal heart rates for one (#5) of three residents reviewed for vital signs.

The HWD identified 94 residents resided in the center.

Findings:

Medication Policy titled, " Residents", dated January 2003, read in part, "...Medication refusal...The resident may choose not to take the prescribed medication. The community will respect this right, will document the refusal and staff will notify the Health and Wellness Leader. The Health and Wellness leader will report recurring refusals or refusals that pose an imminent danger to the resident's health care practitioner and/or responsible party..."

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C 910	Continued From page 5 1. Res #2 was admitted to the center with diagnoses which included unspecified dementia, hypertension, and anxiety. A " Physicians Order Sheet", dated 09/08/2021 read in parts"...07/08/21 Weight monitor-Daily-take and record daily weight. Report to nurse if weight gain of 3lb or more in 24 hours If 2-3 lb weight gain in 24 hours administer lasix per order..." 04/23/21 Furosemide 40MG Tab-Daily as needed...Take one tablet by mouth once daily as needed...Administer if resident has edema to extremities and or weight gain of 3 of more lbs daily...PRN Indicated for CHF..." The MAR's for September and October 2021, had no weights documented, and no documentation that Res #2 was assessed for edema. The center provided a document titled " Weight" for Res #2. It documented on 09/01/21 a weight of 133 lbs. No other weights were provided at this time. On 10/07/2021 at 09:13 a.m., HWD #2 was asked if she had been aware Res #2 refused to be weighed every day .She replied, I wasn't aware every day. At 09:45 a.m. HWD #2 said, I called the doctor in August and asked to d/c the lasix since the resident wasn't allowing us to weigh him. I haven't got a response. She was asked where it is documented the resident was assessed for edema as ordered. She replied, I didn't make a note, the staff notifies me. On 10/08/21 at 10:25 a.m., the HWD #2 was asked if the daily weights had not been obtained as ordered. She replied, correct. She was asked	C 910		

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C 910	Continued From page 6 if the resident refused, what was done about it. She replied, it should have been reported. HWD #2 was asked if the edema assessments were completed. She stated, " the days I was not here, it wasn't done." She was asked if the staff had notified her the resident was consistently refusing weights. She replied, no. 2. Res #4 admitted to the center with diagnoses which included hypertension, copd, Alzheimers disease, and dementia. Res #4's "Care Plan", dated 08/05/20, read in parts,"...Independent with getting in and out of bed...Needs verbal reminders for dressing but is independent...Hospice aides provide shower assistance 2-3 times per week...Needs verbal reminders for grooming...Urinary incontinence...Needs verbal reminders for toileting and/or continence care but is independent...Verbal reminders for meal time but goes to dining room independently...Fall Risk Evaluation...Resident is at a moderate risk for falls...Has the resident experienced a fall in the last three months? No..." September 2021 MAR documented, Res #4 refused one or more medications on 28 out of 30 days. October 2021 MAR documented, Res #4 refused one or more medications on 26 of 31 days. November MAR documented Res #4 refused one or more medications on 9 of 13 days. Res#4 was sent to the ER on 11/13/2020 and did not return to the center. On 10/08/21 at 10:35 a.m., HWD #2 was asked if the progress notes documented the resident continued to refuse his medications. She replied,	C 910		

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C 910	Continued From page 7 no it only documents him refusing his meals. September, October and November 2020 MAR'S were reviewed with HWD #2. She was asked if the physician was notified that the resident had refused his medications. She stated, "It wasn't done." 3. Res #5 was admitted to the center with diagnoses which included, bradycardia, hypertension, Alzheimers disease and dehydration. "Physicians Order", dated September 08, 2021, read in parts"...03/03/21-Blood Pressure and Heart Rate-Daily-Take and record BP and pulse daily..." There were no parameters to hold the B/P medication. Center "Vital Sign Parameters" undated, read in parts"...Unless otherwise specified by a Resident's Health Care Practitioner, RA's shall notify the Health & Wellness Director, designated nurse, and/or physician as well as non-licensed supervisors...if any vital sign is outside of the parameter listed below...Pulse Above 100 or below 50..." On 10/08/2021 at 10:06 a.m., Res #5's MAR's were reviewed with HWD #2. On 09/04/21 the B/P was 125/59, and heart rate was 85. The medication was held due to parameters. HWD #2 was asked if the medication should have been held, she replied, no. On 09/05/21 the B/P was 130/77, and heart rate was 57. The medication was held due to parameters. HWD #2 was asked if the medication should have been held, she replied, no. On 09/16/21 Heart rate was 111 bpm. On 09/19/21 Heart rate was 103 bpm.	C 910		

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C 910	Continued From page 8 On 09/20/21 Heart rate was 108 bpm. On 09/24/21 Heart rate was 108 bpm. On 09/25/21 Heart rate was 148 bpm. On 10/01/21 Heart rate was 124 bpm. HWD #2 was asked if she had been notified that Res #5's heart rate was greater then 100 bpm. She stated, " No, I was not."	C 910		
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on observation, interview, and record review the center failed to provide sufficient staffing to administer medications at the time ordered by the physician for three (#2, #3 and #5) of three sampled residents reviewed for medication administration. The HWD identified 94 residents resided in the center. Findings: Center's "Medication Services Supplement", dated January 2003, read in parts, "...Medication	C 921		

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C 921	Continued From page 9 errors...A medication error is any situation where the exact orders from the physician were not followed. Some examples include but are not limited to:...Wrong time..." 1. Res #2 was admitted to the center with diagnoses which included unspecified dementia, hypertension, and anxiety. "Med Delivery", dated 10/07/21, documented eight medications were scheduled to be administered at 9 a.m. Medications were administered at 12:27 p.m. and included the following: Amlodipine, Aspirin, Eliquis, Buspirone, Calcium/D 3, Lisinopril, Memantine, and Metoprolol. 2. Res #3 was admitted to the center with diagnoses which included, hypertension, diabetes mellitus, acute kidney failure and hyperlipidemia. "Med Delivery" dated 10/07/21, documented, 16 medications were scheduled to be administered at 9 a.m. Medications were administered at 11:13 p.m. and included the following: Oyster Shell Calcium, Pro-Stat AWC 9advanced wound care) liquid, PEG 3350 powder (miralax), Aspirin, Loratadine, Metoprol Suc Tab, Levothyroxin Tab, Metformin HCL, Benazepril Tab, Vitamin B-12 Tab, Oxybutynin CHL, Docusate Sodium, Ferrous Sulfate, Vitamin, Tab-a-vite Tab and Furosemide. 3. Res #5 was admitted to the center with diagnoses which included, bradycardia, hypertension, Alzheimer's disease and dehydration. "Med Delivery" dated 10/07/21 documented, six medications were scheduled to be administered at 9 a.m. Medications were administered at 10:17	C 921		

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C 921	Continued From page 10 p.m. and included the following: Tamsulosin, Memantine, Sertraline HCL, Buspirone HCL, Senna Plus, and Amlodipine. On 10/06/21 at 1:00 p.m., HWD #1 was asked what staffing ratio is for memory care. She replied, seven staff on days, seven staff on evenings and three staff on nights. The center uses agency for emergency staffing plan. She was asked who reviews the MAR's to ensure residents are getting meds as ordered. She replied, I am, daily with a dashboard report. At 2:03 p.m., "Memory Care Nursing Schedule", dated 09/19/21 to 10/02/21, was reviewed with HWD #1. She was asked if CMA #5 was the only staff here to pass medications on 09/25/21. She replied, one staff member went home sick and one staff member didn't show up and we didn't find a replacement CMA until 11:00 or 12:00 p.m. On 10/07/21 at 12:15 p.m., the GM was asked if CMA #5 was the only CMA working in memory care on 09/25/21. She replied, yes. On 10/08/21 At 10:45 a.m., HWD #2 was asked if medications for these three residents were given late on 09/25/21. She acknowledged the medications were given late.	C 921			
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5)	C1505			

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C1505	Continued From page 11 (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the center failed to ensure staff a. were trained to perform COVID-19 testing. b. performed COVID-19 testing according to the manufacturers' recommendations. c. wore appropriate PPE when performing COVID-19 testing.	C1505			

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C1505	Continued From page 12 d. did not allow a COVID positive resident and a COVID negative resident to share a joined bathroom. The HWD identified 94 residents who resided in the facility. Findings: A center document, dated 02/15/2021, "ECP Appendix D Personal Protective Equipment (PPE) Hazard Assessment Certification" read in parts, "...Job/Task...Collecting Samples for SARS-CoV-2 Virus Screening...Protection Type(s) of PPE required...N-95 Respirator Gown Disposable Barrier Gloves Eye Protection..." On 10/06/22 at 1:00 p.m., HWD #1 was asked who performs COVID-19 testing in the center. She replied, herself, HWD #2, CMA #3 and the RN. HWD #1 was asked how often COVID-19 testing was performed for the residents and staff. She replied, testing is being performed twice a week in MC and AL at this time due to outbreak status. HWD #1 was asked what staff are required to wear when in direct contact with a covid positive resident. She stated, "gown, KN95, shield and gloves." The HWD #1 was asked if the center tests following the OSDH grids and recommendations, she stated, "Yes." At 2:45 p.m., HWD #2 was asked if Res #1 and Res #2 share a bathroom. Both residents are identified as ambulatory. How did you ensure the bathroom was cleaned after every use. She replied, when Res#1 was in isolation, the staff performed covid checks every hour, assisted with toileting and cleaning and sanitizing as well.	C1505			