OKLAHOMA
State Department
of Health

Delivery via email to: Tbrown@Montereau.net

June 30, 2021

License Number: CC7204AL

Ms. Tammy Brown
Montereau Inc.
6800 South Granite Avenue
Tulsa, OK 74136

Survey Event ID: Z0JB11

Dear Ms. Brown:

On **June 2, 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.

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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

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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,

Katie Stagner Digitally signed by Katie Stagner
Date: 2021.06.30 13:35:03 -05'00'

Katie Stagner, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Montereau Inc**
Address: **6800 South Granite Avenue**
City, State, Zip: **Tulsa, OK, 74136**
Provider #: **CC7204AL**
Complaint #: **OK00057120**
Investigation Date(s): **06/01/21 and 06/02/21**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to provide adequate medical care and services: failed to contact representatives with changes in condition: and failed to release medical records.	**US**
2. The center failed to administer medications as prescribed.	**US**
3. The center failed to ensure residents' medications were not misappropriated.	**US**
4. The center failed to provide adequate discharge notice.	**S**

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

An unannounced on-site investigation was initiated 06/01/2021 at 1:00 p.m.

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

The investigation was conducted following standards set by the Centers for Medicare and Medicaid Services (CMS) utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

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

An investigation specific to adequate medical care and services: notification of changes in condition to representatives: and release of medical records was conducted.

Upon entrance of the center and throughout the survey, residents were observed to be assisted by staff with activities of daily living in a dignified and respectful interaction. Residents were observed in common areas, at meal times, during medication pass, and therapy sessions. Residents were observed to be well-groomed, monitored, and supervised during activities of daily living. Staff was observed to assist residents with meals and beverages as needed.

Residents were interviewed and had no concerns with care provided by staff. Residents observed during mealtime were assisted and supervised by staff. Staff reported knowledge of resident care plans, physician orders, and policy and procedures of the center to ensure adequate care for residents. Staff reported and documented notification to representatives and physicians for changes in resident's condition in a timely manner.

Sampled clinical records, including closed records, were reviewed for care plans, physician orders, medication administration records, skin reports, and daily charting records were reviewed. Center incident reports and policy and procedures were reviewed. Documentation of requested medical records was provided. The clinical records documented notification to physician and representatives in a timely manner.

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

An investigation specific to administration of medications as prescribed was conducted.

Staff was observed to administer medications to residents and follow physician orders. Staff provided adequate fluids and time for intake of medications as needed.

Clinical records of sampled residents, including a closed record, were reviewed for care plans, physician orders, interdisciplinary notes, weight records, occupational therapy plan of care, nutritional, supplements and fluid intake, medication and treatment administration records. Center incident reports, physician progress notes, and resident assessments were reviewed.

Allegation #3. Deficient practice was unsubstantiated related to this allegation.

An investigation specific to misappropriation of residents' medications was conducted.

Staff was observed to administer medications to residents and follow physician orders.

Staff was interviewed and reported policy and procedures to follow to ensure residents' medications were secure, correctly counted, and documented.

Sampled residents, including a closed record, were reviewed for medication administration and count logs, physician orders, care plan, interdisciplinary notes, and daily charting notes. The centers policy and procedures, incident reports, investigation reports, and disciplinary actions were reviewed. An incident report of misappropriation of medications documented a thorough investigation was conducted and required reporting was provided in a timely manner.

Allegation #4: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, C 0360 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #4. The facility will be required to submit a plan of correction (POC). The survey 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 federal/state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies, Form 2567.

Deficient practice was unsubstantiated for allegation #1, #2, 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 federal/state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Bobbi Bridges RN

Bobbi Bridges, RN, CHFS

Date report completed: 06/03/2021

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CC7204AL	A. BUILDING: _____ B. WING _____	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEREAU INC	6800 SOUTH GRANITE AVENUE TULSA, OK 74136

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C 000	INITIAL COMMENTS On 06/01/21 through 06/02/21 an abbreviated survey was conducted to investigate complaint #OK00057120. The census was 73.	C 000		
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C 360	Continued From page 1 Department of Health, 1000 NE Tenth Street, Oklahoma City, OK 73117, telephone (405) 271-1269. (3) An assisted living center shall not involuntarily terminate a residency agreement for reasons other than inappropriate placement without following the procedures in this section. This Rule is not met as evidenced by: Based on record review and interview, it was determined the center failed to ensure an involuntary discharge notice contained information regarding a request for a hearing with the Department and the date the notice was given to the resident's representative for one (#3) of one sampled resident that received notice for an involuntary discharge. This deficient practice resulted in the isolated potential for more than minimal harm. Findings: A letter dated May 12, 2021 to resident #3's representative from the center did not contain the date the notice was given to the representative and no information regarding a request for a hearing with the Department. On 06/02/21 at 9:45 a.m., the registered nurse (RN) was asked about the involuntary termination of resident #3's contract. She stated the resident appealed the termination and won the appeal. She stated the center failed to put all the information in the letter. She stated they should have provided information specifically, "As of this date, we are notifying you" and was supposed to put how to appeal. She stated if the center wanted to pursue, they would have to go back to	C 360		

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C 360	Continued From page 2 the Administrative Law Judge and they did not.	C 360		

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of Health

Delivery via email to: Tbrown@Montereau.net

July 29, 2021

License Number: CC7204AL

Ms. Tammy Brown, Administrator
Montereau, Inc
6800 South Granite Avenue
Tulsa, OK 74136

Survey Event ID: Z0JB11

Dear Ms. Brown:

On **June 2, 2021,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **July 14, 2021**.

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

Sincerely,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2021.07.29 10:52:08 -05'00'

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

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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 7/6/2021** **Facility Name:** Montereau **License Number:** CC7204AL **Survey Event ID:** Z0JB11 **Date Survey Completed:** 6/2/2021

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 306	Based on: record review and interview, it was determined the center failed to ensure an involuntary discharge notice contained information regarding a request for a hearing with the Department and the date the notice was given to the resident's representative for one (#3) of one sampled resident that received notice for an involuntary discharge. This deficient practice resulted in the isolated potential for more than minimal harm.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: No opening comments regarding Tag C360

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?	1 out of the 27 residents residing in the Abbey (assisted living memory support) were found to be affected by the alleged 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?	26 out of 27 residents residening in the Abbey (assisted living memory support) were found to potentially be affected by the same alleged deficient practice.
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?	1.On 05/21/21 the resident residing in the Abbey (assisted living memory support) that was found to be affected by the alleged deficient practice was moved out of the Abbey by the resident's daughter. 2. Update Involuntary Discharge Notice policy and procedure to include elements in #3 below to reflect systemic changes made. 3. Administrator or designated administrative staff member will ensure that all regulatory requirements below are included in each Involuntary Discharge Notice prior to delivering to resident and/or resident's representative. a. Explanation of reasons for termination of residency; b. Date of notice; c. Date notice was given to resident and/or resident's representative; d. Date by which resident must leave Assisted Living venue; e. Information that resident, resident's representative or person responsible for payment of resident's care may request a hearing with the Oklahoma State

	Department of Health (OSDH); - request for hearing must be filed within ten (10) business days of receipt of Assisted Living notice; and - written or verbal request should be directed to the Hearing Clerk, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, OK 73117 (405) 271-1269 4. Inservice all administrative staff on: a. regulatory requirements for Involuntary Discharge Notice from Assisted Living. b. on updated Involuntary Dischare Notice policy and procedure.
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.	Assisted Living will monitor its performanceand that corrections are sustained by completing the following: 1. Create Involuntary Discharge Notice template letter that includes all regulatory requirements: a.Explanation of reasons for termination of residency; b. Date of notice; c. Date notice was given to resident and/or resident's representative; d. Date by which resident must leave Assisted Living venue: e. Information that resident, resident's representative or person responsible for payment of resident's care may request a hearing with the Oklahoma State Department of Health (OSDH); - request for hearing must be filed within ten (10) business days of receipt of Assisted Living notice; and - written or verbal request should be directed to the Hearing Clerk, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, OK 73117 (405) 271-1269 2. Create signature sheet to be signed by Administrator or designated administrative staff verifying that all regulatory requirements are included in each Involuntary Discharge Notice prior to delivering to resident and/or resident's representative. 3. Involuntary Discharge Notice and signature sheet will be filed in resident's electronic medical record.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	7/14/2021
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.			**Date 7/8/2021**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health

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

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