STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH7236	A. BUILDING: _____ B. WING _____	C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATESWAY FOUNDATION, INC II	1217 EAST COLLEGE 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
M 000	INITIAL COMMENTS An abbreviated survey to investigate complaint #OK00052027 was conducted on 05/29/18 through 05/30/18.	M 000		
✓ MM150	310:675-11-7 Staffing (a) The ICF/MR-16 shall have available enough qualified staff and support personnel to carry out the residential living, professional and special programs and services for residents as required by their individual needs, and of sufficient size that the facility does not depend on residents or volunteers for services. (b) Each ICF/MR 16 shall maintain at least the minimum direct-care-staff ratios specified in OAC 310:675-13-12(a). (c) In living units for the severely impaired client, the present and on duty direct care staff ratio would be: (1) 1 to 4 from 7:00 a.m. to 3:00 p.m.; (2) 1 to 4 from 3:00 p.m. to 11:00 p.m.; and (3) 1 to 8 from 11:00 p.m. to 7:00 a.m. (d) There should be sufficient dietary, nursing, housekeeping and administrative staff to serve the needs of the facility. This Rule is not met as evidenced by: Based on observation, record review and client and staff interviews, it was determined the facility failed to have a system in place to ensure sufficient direct care staff were available in the facility to provide care.	MM150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37G035	A. BUILDING _____ B. WING _____	C 05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATESWAY FOUNDATION, INC II	1217 EAST COLLEGE 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) COMPLETION DATE
W 000	INITIAL COMMENTS An abbreviated survey to investigate complaint #OK00052027 was conducted on 05/29/18 through 05/30/18.	W 000		
✓ W 102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, it was determined the facility was not in compliance with the Condition of Participation of Governing Body and Management by not meeting the Condition of Participation for Client Protection. Based on observation, record review and client and staff interviews, it was determined the facility failed to implement their policy and procedure to report, investigate and protect a client from neglect by a staff member for 1 (#2) client with cognitive impairment and who was incontinent of bowel and bladder. Eight total clients resided in the facility. Findings: See W149, W153, W154 and W155	W 102		
✓ W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility.	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anne Wesenberg-Jones

TITLE: LNHA

(X6) DATE: 6/11/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Plan of Correction
Gatesway Foundation II
Survey Event ID 25LT11
May 30, 2018
Completion Date: July 9, 2018

MM 150: Staffing
W 186: Direct Care Staff

How will the facility has or intends to correct each deficiency.
QIDP's and House Managers will ensure adequate staffing in the Cottage at all times. If a staff person has to leave that person shall not leave until another staff member has come to relieve other staff of duties.

How the facility will identify other residents having the potential to be affected by the same deficient practice.
All individuals do have the potential to be affected by the deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not occur.
The QIDP's and House Managers will be in-serviced on staffing ratios and the necessity of having proper staffing at all times.

How will the facility monitor its corrective actions to ensure that the deficient practices are being corrected and will not reoccur?
Administration, QIDP's and House Managers will monitor the staffing schedules to insure there are enough staff in the Cottage at all times.

Plan of Correction
Gatesway Foundation II
Survey Event ID 25LT11
May 30, 2018
Completion Date: July 9, 2018

W 102: Governing Body and Management
W 104: Governing Body

How will the facility has or intends to correct each deficiency.
The facility will investigate any and all reports of abuse and neglect in a timely fashion according to State and facility regulations. The facility will also revise the Abuse/Neglect policy to better define "Protect".

How the facility will identify other residents having the potential to be affected by the same deficient practice.
All individuals do have the potential to be affected by the deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not occur.
All staff, QIDP's and House Managers will be in-serviced to signs, definitions and reasons for abuse/neglect and how to report such incidents properly. Staff, QIDP's and House Managers will also be in-serviced to the Abuse Hotline in the homes and how to report.

How will the facility monitor its corrective actions to ensure that the deficient practices are being corrected and will not reoccur?
The Administrator and/or Designee will follow up on any reports of suspected abuse/neglect in a timely manner with a proper investigation and reporting as needed. Proper documentation will be kept of the investigation and available upon request.

Plan of Correction
Gatesway Foundation II
Survey Event ID 25LT11
May 30, 2018
Completion Date: July 9, 2018

LL 811: Infection Control
W 454: Infection Control

How will the facility has or intends to correct each deficiency.
The QIDP responsible for this infraction has been counseled and has been put on a 90 day probation.

How the facility will identify other residents having the potential to be affected by the same deficient practice.
All individuals do have the potential to be affected by the deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not occur.
All staff will be in-serviced on Infection Control and proper cleaning procedures specifically on the disposal of environmental and resident waste.

How will the facility monitor its corrective actions to ensure that the deficient practices are being corrected and will not reoccur?
Administration, QIDP's and/or House Managers will monitor staff by observation and/or watching the camera's to insure this deficient practice does not happen again.

Plan of Correction
Gatesway Foundation II
Survey Event ID 25LT11
May 30, 2018
Completion Date: July 9, 2018

LL244: Rights and Responsibilities - Violations
W 122: Client Protections
W 131: Protection of Client Rights
W 149: Staff Treatment of Clients
W 153: Staff Treatment of Clients
W 154: Staff Treatment of Clients
W 155: Staff Treatment of Clients

How will the facility has or intends to correct each deficiency.

A Plan of Removal and Implemented (attached).

-The QIDP has been formally reprimanded and placed on a 90 day probation.
- Staff and management have been in-serviced over abuse, neglect and infection control.
- Abuse, neglect and ethics policies and procedures have been updated.
- A second LPN has been hired effective June 11, 2018.
- The Program Director has been put in charge of Volunteers and has been updated on handing out name badges indicating a person is a volunteer. The Program Director will make sure all Volunteers have at least one staff overseeing the event.

How the facility will identify other residents having the potential to be affected by the same deficient practice.
All individuals do have the potential to be affected by the deficient practice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not occur.

The Plan of Removal and Implementation will be completed.

All staff will be in-serviced regarding the rights of all clients not to perform staff duties such as cleaning up feces, urine, etc. and how that may be deemed abuse.

All staff will be in-serviced on assisting clients with all activities of daily living to include but not all inclusive, showering, toileting, dressing, etc. and how that may be deemed neglect.

All management will be in-serviced on reporting abuse and neglect. The Administrator has sent in a late report on the May 7 incident and reported the QIDP to the Board of Nursing.

How will the facility monitor its corrective actions to ensure that the deficient practices are being corrected and will not reoccur?

Administration and Management will monitor all reports of suspected abuse/neglect and send an initial and/or combined initial and final report to OSDH within 24 hours of the initial report.

Plan of Removal and Implementation

- QIDP will given a formal reprimand and be put on an immediate 90 day probation period. Any further infractions will result in immediate termination. QIDP will not work in any cottage as direct care staff.
- Staff will not leave a cottage until a replacement is in the cottage and census is in compliance with State Regulations.
- Staff and the management team will be in-serviced over abuse and neglect and infection control along with ethics by 12 midnight on 5/29/18. Any staff not in-serviced by 12 midnight will be in-serviced prior to reporting to the next shift.
- Policies and procedures will be reviewed and revised an indicated to more specifically address staffing, abuse, neglect and ethics such as the types and definition of abuse, what constitutes neglect and how unethical behavior can negatively affect not on you but the entire community.
- Currently Gatesway is re-structuring the nursing staff and CMA's will be counted in the census and an additional LPN will be hired and the LPN's will pass the bulk of the medications.
- Any time a volunteer is on the property a staff person will be present to oversee them.
- Volunteers will be given badges identifying them as volunteers and the organization they represent and they are to be worn whenever they are on the campus. Until permanent badges can be obtained volunteers will be given paper badges.