Oklahoma State Department of Health
Creating a State of Health

June 8, 2018

CCN: 37G035
Survey Event ID: 25LT11

Ms. Anne Wesenberg-Acker, Administrator
Gatesway Foundation, Inc Ii
1217 East College
Broken Arrow, OK 74012

Dear Ms. Wesenberg-Acker:

On **May 30, 2018**, agents from our office concluded a complaint investigation at your facility to determine if your facility was in compliance with the Federal requirements for participation in the Medicaid program. This inspection found apparent violations of federal regulations 42 CFR 483, Subpart I, Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Determination of Immediate Jeopardy

This complaint investigation found the most serious deficiency in your facility to constitute immediate jeopardy. The following deficiency has been determined to constitute immediate jeopardy:

W0122	**483.420**	**CLIENT PROTECTIONS**
W0149	**483.420(d)(1)**	**STAFF TREATMENT OF CLIENTS**
LL244	**1-O.S. 63-1-1918(B)(12)**	**Rights and Responsibilities - Violations**

Conditions of Participation "Not Met"

It is our determination that the fololowing conditions of participation were not met at the time of the survey:

W0102	**483.410**	**GOVERNING BODY AND MANAGEMENT**
W0122	**483.420**	**CLIENT PROTECTIONS**

Plan of Correction (PoC)

You must submit an acceptable plan of correction within ten calendar days of receipt of the CMS-2567. An acceptable PoC is required before a revisit (to verify correction) will be made. To be considered acceptable, your PoC must contain the following:

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

- How the facility will identify other residents having the potential to be affected by the same deficient practice.

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

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes. This is part of your quality assurance plan. At the revisit, the quality assurance plan shall be reviewed to determine the earliest date of compliance. If there is no finding of continuing non-compliance, **evidence of quality assurance being implemented will be required to establish a correction date earlier than the date of the revisit.**

- An acceptable completion date for correction of each deficiency. Your facility is ultimately accountable for its own compliance. The plan of correction will serve as the facility's allegation of compliance. Unless otherwise stated on the PoC, the last completion date will be the date of alleged compliance.

In addition, the PoC must contain only a Plan of Correction OR evidence refuting each deficient practice in a deficiency citation. It must be specific and realistic, stating exactly how the deficiency will be or was corrected.

Please submit your plan of correction under the second column on the enclosed Form CMS-2567. Address each deficiency, and include the month, day, and year of the expected completion date in the third column. Sign, date, and indicate your title in the appropriate blocks on page 1 of the form. Return the CMS-2567 with the PoCs to:

Long Term Care Complaint and Enforcement Division
Protective Health Services
Oklahoma State Department of Health
1000 N.E. 10th
Oklahoma City, OK 73117-1299

Imposition of Remedies

In accordance with federal regulation 42 C.F.R. 442.117(a)(1) and (2), a survey agency must terminate a facility's certification if it determines that the deficiencies pose immediate jeopardy to residents' health and safety. Termination of certification for Gatesway Foundation, Inc li is scheduled to take effect on August 13, 2018.

Additional Penalties Under State Law

In accordance with the Nursing Home Care Act the following remedies may apply.

§63-1-1914.1. Actions for Violations - Considerations

A. For violations of the Nursing Home Care Act, the rules promulgated thereto, or Medicare/Medicaid certification regulations:

1. The State Department of Health shall seek remedial action against a licensee, owner or operator of a facility and may, after notice and opportunity for a hearing, impose the remedy most likely to:

a. gain and ensure continued compliance with the Nursing Home Care Act, the rules promulgated thereto, or federal certification standards or both rules and standards, or

b. provide for the financial operation of the facility that ensures the health, safety and welfare of the residents;

2. In the alternative or in addition to any remedial action, the State Commissioner of Health may direct the Oklahoma Health Care Authority to withhold vendor payments due to a facility under its programs until such time as the corrections are made;

3. The Department may deny, refuse to renew, suspend or revoke a license, ban future admissions to a facility, assess administrative penalties, or issue a conditional license; and

4. a. Pursuant to an investigation or inspection that reveals a willful violation of rules pertaining to minimum direct-care staffing requirements, the Commissioner shall notify the Oklahoma Health Care Authority and the Authority shall withhold as a penalty a minimum of twenty percent (20%) of the vendor payments due the facility under its programs for each day such violation continues.

b. The Commissioner shall impose an equivalent penalty amount under licensure standards for a facility that does not receive vendor payments under its program that is in willful violation of rules pertaining to minimum direct-care staffing requirements.

O.S. 63, Section 1-1916.1 (A) Violations - Penalties - Criteria for determination of amount of penalty - Appeal - Surrender of license.

§63-1-1916.1. Penalties for Violations

A. Any person who has been determined by the State Department of Health to have violated any provision of the Nursing Home Care Act or any rule promulgated or order issued pursuant to the provisions of the Nursing Home Care Act, may be liable for an administrative penalty for each day that said violation or violations continue to exist. Penalties of not less than Fifty Dollars ($50.00) per day or more than Three Thousand Dollars ($3,000.00) per day may be imposed for deficiencies that do not constitute immediate jeopardy to residents. Penalties of not less than Three Thousand Fifty Dollars ($3,050.00) per day or more than Ten Thousand Dollars ($10,000.00) per day may be imposed for deficiencies constituting immediate jeopardy to residents; provided, however, that specialized facilities for the developmentally disabled or nursing facilities licensed pursuant to this act, which do not participate in Medicaid or Medicare, shall be liable for the maximum penalty, not to exceed Ten Thousand Dollars ($10,000.00) for any related series of violations.

Informal Dispute Resolution

In accordance with 42 CFR §488.331 and §7212 of the State Operations Manual (SOM), 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 833). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 271-6868 or at the address below to acquire a copy of the ODH Form 833 and the Oklahoma IDR Process for Medicare/Medicaid Certified Facilities. The IDR request must be submitted during the same ten calendar days you have for submitting an acceptable plan of correction (PoC) for the cited deficiencies. Failure to submit a completed IDR Request Form and supporting documentation within this timeframe waives your right to the IDR.

The Department is offering informal dispute resolutions to ICF/MR facilities *only* if a survey or complaint investigation finds that a Condition of Participation is not met. If you have any questions regarding the IDR process, please contact the IDR Coordinator at (405) 271-6868 or by fax at (405) 271-2206.

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

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

Appeal Rights for Survey Findings

If you wish to contest any of the deficiencies, including the finding of immediate jeopardy, cited during the inspection, you may submit a written request for an appeal to the following office:

Hearing Clerk
Office of Administrative Hearings
Oklahoma State Department of Health
1000 NE 10th Street
Oklahoma City, OK 73117

Office: (405) 271-1269
Fax: (405) 271-1268

A request for a hearing must be submitted within sixty (60) days of receipt of this letter.

Appeal Rights for Termination of the Provider Agreement

An appeal of the termination of the provider agreement is to be directed to the Oklahoma Health Care Authority, the Medicaid agency for the State of Oklahoma.

If you have any questions, please contact me at (405) 271-6868.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

C: Oklahoma Health Care Authority

ENFORCEMENT MEMO

June 8, 2018

To: Enforcement Staff

From: Sue

Re: Gatesway Foundation, Inc.

- I FAXED this to the facility today, but the hard copies still need to be mailed. It includes language that our legal division thought needed to be included. It also includes language concerning a CMP and a Ban on Admissions.
- Please make sure a copy goes to Emily Lindsey at the Health Care Authority
- Please send a copy of the deficiencies to OHCA also.
- Prepare 1539 for termination and send to OHCA ASAP.

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Gatesway Foundation, Inc II**
Address: **1217 East College**
City, State, Zip: **Broken Arrow, OK 74012**
Provider #: **37G035**
Complaint #: **OK00052027**
Investigation Date(s): **05/29/18 through 05/30/18**

ALLEGATION(S)	TAG NUMBERS CITED	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to provide care and services according to client needs.	**W102, W122,W149, W153, W154, W155, W186 L244, M102**	**S**

☒ **Violation (s) unrelated to this complaint were also cited during the survey/investigation.**
A Description of Significant Findings Related To Each Allegation is Provided Below:

An unannounced visit was made to the facility on **05/29/18** at **8:20 AM**. The person in charge of the facility at that time, the administrator, was contacted to announce the survey and the general nature of the complaint. Details of the allegations were not discussed in order for the surveyors to conduct a more thorough investigation.

The named client was included in a sample of clients based on issues relevant to the allegations. The following regulatory areas were investigated: client protection, governing body and management, physical environment and facility staffing.

Allegation #1: The facility failed to provide care and services according to clients' needs.

During the survey, clients were observed in the living area and bedrooms of the facility. Staff and client interviews were conducted and voiced concerns about a situation which could be considered neglect. A camera feed from an incident identified by the staff and clients was viewed by the surveyors. The incident appeared to be consistent with the staff not providing appropriate care to the clients in the facility.

Protective Health Services – Long Term Care
1000 NE 10th Street
Oklahoma City, OK 73117-1299
www.health.ok.gov

Based on observation, interview and record review, it was determined the facility failed to provide care and services to prevent neglect.

This allegation was substantiated.

Refer to W102, W122, W149, W153, W154, W155, W186, L244, M102, CMS-2567 Statement of Deficiencies.

The items indicated below were utilized during the investigation.

Yes ☐ No ☒ Will referrals be made to another agency by this Department?

Record Review: (Records that were reviewed in conjunction with the complaint.)

Yes ☐	N/A ☒	Medication Administration Records
Yes ☒	N/A ☐	Facility Incident Reports
Yes ☒	N/A ☐	ADL (Activities of Daily Living) Flow Sheets
Yes ☐	N/A ☒	Hospital Records
Yes ☐	N/A ☒	Physician Progress Notes
Yes ☒	N/A ☐	Physician Orders
Yes ☒	N/A ☐	Nurses Notes
Yes ☐	N/A ☒	Dietary Notes
Yes ☐	N/A ☒	Laboratory and X-Ray Reports
Yes ☐	N/A ☒	Social Services Reports
Yes ☒	N/A ☐	Activities Reports
Yes ☒	N/A ☐	Treatment Sheets
Yes ☒	N/A ☐	Pharmacy Records
Yes ☐	N/A ☒	Meal Intake Records
Yes ☐	N/A ☒	Weight Records
Yes ☒	N/A ☐	Skin Assessments
Yes ☒	N/A ☐	Assessment & Care Plan Records (Care Plan and MDS)
Yes ☐	N/A ☒	Therapy and/or Ancillary Services Records
Yes ☒	N/A ☐	Resident Council Minutes
Yes ☐	N/A ☒	Health Care Authority Staffing Reports
Yes ☐	N/A ☒	Personnel Records/Background Check, etc.
Yes ☒	N/A ☐	Staff Time Sheets, Schedules, etc.
Yes ☒	N/A ☐	Facility In-Service Records
Yes ☐	N/A ☒	Medical Examiner Reports
Yes ☐	N/A ☒	Ambulance Records
Yes ☐	N/A ☒	Death Certificate
Yes ☒	N/A ☐	Facility Investigation Reports
Yes ☒	N/A ☐	Facility Policy and Procedure Manual
Yes ☐	N/A ☒	Current Credentials of licensed, registered, or certified personnel and/or consultants
Yes ☒	N/A ☐	Facility Admission/ transfer records
Yes ☒	N/A ☐	Other:**video records**

Interview:

Number of interviews conducted with residents identified in the allegation(s). (If not interviewed, explain why in the description of findings.) 1
Total number of resident interviews conducted: 4

Yes ☒	No ☐	N/A ☐	Was the alleged perpetrator interviewed?
Yes ☒	No ☐	N/A ☐	Were interviews conducted with staff? Number: 6
Yes ☐	No ☒	N/A ☐	Were interviews conducted with family?
Yes ☐	No ☒	N/A ☐	Was the physician interviewed?
Yes ☐	No ☐	N/A ☒	Was the complainant interviewed?

Yes ☒ No ☐ Was the complaint based on entity reported incident or anonymous complaint?

In the event of a serious injury or an unexpected death, were interviews conducted with any or all of the following:

Yes ☐	No ☐	N/A ☒	Emergency Personnel
Yes ☐	No ☐	N/A ☒	Police Officers
Yes ☐	No ☐	N/A ☒	Funeral Home Personnel
Yes ☐	No ☐	N/A ☒	Other

Observations:

Number of sampled residents observed: 4

Yes ☒	N/A ☐		Were sampled residents selected based on the allegations?
Yes ☒	No ☐	N/A ☐	Were residents identified in the allegation(s) present at the facility during the investigation?
Yes ☐	No ☐	N/A ☒	In the event of injury, was the area of injury observed?
Yes ☒	No ☐	N/A ☐	Was equipment being operated in a safe manner?
Yes ☐	No ☒		Was an environmental tour conducted?

☐ Wound Care	☒ Safety Issues
☐ Medication Pass	☐ Medical Intervention
☐ Dietary Issues	☒ Neglect/Abuse
☒ Personal Care	☒ Infection Control
☒ Dignity and Privacy Issues	☒ Cleanliness of Residents
☐ Restorative Care	☐ Assistance With Eating
☒ Nursing Services	☒ Use of Equipment, etc.
☐ Other	

Pamela Dean

Pamela Dean, RN, Clinical Health Facility Surveyor
Date report was completed: 05/31/18

Name(s) of any additional surveyor(s) who participated in the investigation of this complaint:

Nick Hope, RN, Clinical Health Facility Surveyor

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 | TITLE | (X6) DATE

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

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W 104	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the governing body failed to ensure the administrator reported, investigated and protected clients from a incident of neglect for 1 (#2) client with cognitive impairment and was incontinent of bowel and bladder. Eight total clients resided in the facility. Findings: The facility's abuse, neglect and exploitation policy was reviewed. The following documentation was located in the policy: "Definitions:...Neglect: The willful failure to provide individuals served with the goods/services necessary which directly or indirectly results in an individual served suffering or being exposed to substantial risk of imminent injury. Neglect may include, but is not limited to, failure to furnish food, clothing, shelter, medical attention or knowingly failing to implement a required program or maintaining necessary equipment... Procedure: When abuse or neglect of any nature is suspected, reported, or identified, the following procedures will be followed. Failure to report suspected abuse, neglect, or exploitation may result in disciplinary actions, termination, and criminal sanctions..." The abuse, neglect and exploitation policy further documented the steps involved when conducting an investigation of abuse, including assigning the investigator from the facility to complete a preliminary investigation, gathering statements,	W 104		

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W 104	Continued From page 2	W 104		

interviews from the person making the allegation, interviews from the witnesses, interviews from the alleged perpetrator and reviewing all the information to determine a finding.

The facility policy documented, "...It is the responsibility of the supervisor to immediately notify Department Head, who will assure the notification of appropriate agencies and the Chief Executive Officer...The supervisor will take necessary actions to assure the safety, protection, and medical care, if needed, of individual during the investigation of any allegation of abuse, neglect, and/or exploitation..."

Client's #2 had diagnoses which included mild intellectual disability. She had been admitted to the facility on 05/01/18.

On 05/29/18 at 8:20 AM, the surveyor asked the house manager if any of the clients in the facility had issues with incontinence. She identified 3 clients who sometimes were incontinent. She stated 2 of the clients had occasional episodes of incontinence and 1 (#2) client who had frequent episodes of both bowel and bladder incontinence.

A review of client #2's clinical record was conducted. The individual habilitation plan (IHP) was reviewed. The IHP documented the client was incontinent part of the time and staff were to prompt her frequently to use the bathroom. The IHP further documented the client required total assistance with bathing. The IHP documented the client had limited mobility and required a walker while in the facility and a wheelchair for long distances.

Charting notes for the month of May 2017,

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W 104	Continued From page 3 located in the client's clinical record, documented 5 times during the month when she had been incontinent of bowel or bladder. A chart entry dated 05/07/18, by the qualified intellectual disabilities professional (QIDP) documented the client had soiled her clothing 2 times during the 3-11 shift. At 10:30 AM, the surveyor interviewed the director of nurses (DON). She was asked if she was aware of any issues with client #2 having toileting accidents. She stated, client #2 had frequent incontinence of bowel and bladder. She further stated staff were to provide total assistance with client #2 when cleaning herself after toileting. The DON stated client #2 required total assistance with showering, since she had difficulty standing without any assistance. The DON was asked if she was aware of any situations where client #2 had been left soiled and unattended. She stated "Yes." She provided the surveyor with a copy of an e-mail from the assistant administer which had been sent to her and the administrator. The e-mail documented concerns by another client (#1) had been told to by the QIDP to clean up after client #2 had a toileting accident. The DON stated, she had watched a camera feed with the administrator and assistant administrator which showed client #2 had apparently had a toileting accident in the dining area of the facility. The QIDP had been in the facility as the only staff and had not assisted in cleaning up the feces right away or assisting client #2 in showering. The DON stated she had asked the the	W 104		

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W 104	Continued From page 4	W 104		

administrator if the observed incident on the camera feed by the QIDP should be reported and investigated as possible neglect. The DON stated the administrator stated, "No."

At 10:40 AM, the surveyor interviewed the assistant administrator. The assistant administrator told the surveyor of a meeting she had with client #1 on 05/08/18. She stated she had watched a camera feed in the facility from the 3-11 shift on 05/07/18. She stated the camera feed showed feces had remained on the floor of the facility for over 27 minutes. She stated client #1 had told her the QIDP had instructed her to clean up the feces and to watch other clients while she worked in the office.

The assistant administrator told the surveyor she had not observed any staff assisting client #2 with cleaning up after she had the toileting accident. She stated when watching the camera feed with the DON and the administrator she had questioned whether the incident should have been reported and investigated. The assistant administrator stated when asked about reporting and investigating the incident, the administrator stated she was not going to investigate it any further.

At 10:45 AM, the surveyor interviewed the administrator. She was asked if she had watched the camera feed for 05/07/18. She stated, "Yes." She stated she could not really tell what had happened on the camera feed, other than the QIDP looking at something on the floor, leaving the area, remaining out of camera view for over 28 minutes. The camera feed then showed QIDP return to the area and pick up something off the floor.

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W 104	Continued From page 5 The surveyor asked the administrator what she had done after watching the camera feed. She stated she had verbally counseled the QIDP to not leave something on the floor for so long. The administrator was asked if the incident had been reported and investigated. She stated, "No." She was asked if she had interviewed any other staff in the facility regarding the incident. She stated, "No." Between 11:30 AM and 2:00 PM 2 surveyors, the administrator and DON watched a recording of the camera feed from 05/07/18. The following was observed on the camera feed: The camera feed showed 2 views of the facility. In one view, the dining area, partial living area, entry into the kitchen and back door were visible. The other view, is of the front door, entry into an office area and the west hallway to 4 client bedrooms, including client #2's bedroom. --5:44 PM, the camera feed started, several clients are in the dining area, including client #1 and #2. The certified medication aide (CMA) leaves the facility via the front door. The QIDP is the only staff in the facility. --5:51 PM, the QIDP is observed walking down the hallway into an office area. --5:58 PM, client #1 is observed walking out of the kitchen, she looks down at something on the floor under where client #2 is standing. Client #1 was observed to go to the office and say something to the QIDP. --5:59 PM, the QIDP leaves the office area, walks	W 104		

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W 104	Continued From page 6 into the dining area, and looks down at the substance on the floor. She says something to client #2 and assists her in getting her walker. --6:00 PM, client #2 is observed using her walker to start down the hallway toward her bedroom. The QIDP is observed to be talking on the telephone as she walks down the hallway to the office. The substance remains on the floor of the dining area. --6:25 PM the QIDP is observed to leave the office area. At this time she is observed to talk with client #1. --6:29 PM, the QIDP was observed to return down the hall to the office area. No staff have been observed to enter the hallway to client #2's bedroom to assist her. --6:41 PM, certified nurse aide (CNA) #1 who worked at a sister facility, comes in the front door, walks through the facility to the back door. She opens the back door and lets in a group of 7 visitors. She stops by the office area to talk with the QIDP. --6:45 PM, CNA #1 then leaves the facility through the front door. The QIDP remains in the office. No additional staff are in the facility. --7:28 PM, the QIDP leaves the office area, comes out to the dining area and talks with the visitors. --7:30 PM, the QIDP returns to the office, leaving the visitors with the clients. --7:34 PM, the CMA returns to the facility through	W 104		

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W 104	Continued From page 7 the front door. The visitors leave the facility through the back door. At no time during the camera feed, was anyone observed to go down the hallway to client #2's bedroom to assist her with cleaning up from the toileting accident. During the observation of the camera feed, the administrator was asked if the QIDP had provided care to client #2. She stated, "No." The administrator stated she had previously watched the camera feed, but apparently had not watched it carefully. She was asked if the failure of care by the QIDP could be considered neglect. She did not answer. The administrator was asked if she had followed the facility's policy and procedure for reporting, investigating and protecting the client after she had watched the camera feed from the incident on 05/07/18, in which client #2 had been left soiled for over 1 1/2 hours. She stated, "No." She further stated she should have paid closer attention to the camera feed and should have reported, investigated and protected the client during the investigation of the incident The administrator was asked if visitors should have been in the facility with no staff present in the area. She stated she had not watched the entire camera feed previously, so she had not been aware of the visitors in the facility. She stated a staff member should have been present in the facility with the visitors.	W 104		
W 122	CLIENT PROTECTIONS CFR(s): 483.420	W 122		

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W 122	Continued From page 8 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: On 05/29/18 at 3.30 PM, an Immediate Jeopardy (IJ) situation was determined to exist when the facility failed to have a system in place to protect a cognitively impaired client, who required assistance with toileting and showering, from neglect by a staff member. The Oklahoma State Department of Health was notified on 05/29/18, and concurred with the team concerning the existence of an IJ situation. The facility's administrator was informed of the IJ situation on 05/29/18 at 3:35 PM. The Plan of Removal documented the following: "QIDP [qualified intellectual disabilities professional] will be 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 inserviced prior to reporting to the next shift.	W 122		

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W 122	Continued From page 9 Policies and procedures will be reviewed and revised an (sic) 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 (sic) you but the entire community. Currently Gatesway is re-structuring the nursing staff and CMA's [certified medication aide] will be counted in the census and an additional LPN [licensed practical nurse] 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." The IJ was removed effective 05/29/18 at 11:59 PM, although the deficient practice remained. All components of the plan had been carried out. Staff from all shifts were interviewed and voiced an understanding of the plan of removal. Based on observation, record review and client and staff interviews, it was determined the facility was not in compliance with the Condition of Participation for Client Protections. The facility failed to implement their policy and procedure to report, investigate and protect a client from neglect by a staff member. See W149	W 122		

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W 131	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(8) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not compelled to perform services for the facility. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 1 (#1) client was not compelled to perform a service for the convenience of staff. This had the potential to affect all 8 clients who resided in the facility. Findings: The facility's policy and procedure for rights and responsibilities documented: "...No individual will be compelled to perform work or service for Gatesway without compensation." Client #1 had diagnoses which included mild intellectual disability. At 10:00 AM, the surveyor interviewed client #1. She was asked how she liked living in the facility. She stated things were going pretty well now. The surveyor asked her if there had been any problems in the past. She stated, "Yes." Client #1 stated earlier in the month, client #2 had an accident and feces was left on the floor in the dining room. Client #1 further stated the qualified intellectual disabilities professional (QIDP) had told her to clean up client #2's feces and to watch other clients while the QIDP worked in the office. She stated she did not feel comfortable with that because it was the staff's job.	W 131		

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W 131	Continued From page 11 At 10:30 AM, the surveyor interviewed the director of nurses (DON). She was asked if she was aware of any issues with client #2 having toileting accidents. She stated, client #2 had frequent incontinence of bowel and bladder. The DON was told of the surveyor's interview with client #1 in which she told the surveyor she had been told by the QIDP to clean up feces and watch other clients. She was asked if she had been made aware of the incident. She stated, "Yes." The DON provided the surveyor with a copy of an e-mail dated 05/08/18, which had been sent to the administrator and herself. The e-mail documented client #1 had spoken with the assistant administrator on 05/08/18. The e-mail described a situation which had occurred on the evening of 05/07/18. The e-mail documented client #1 told the assistant administrator she had been told by the QIDP to clean up client #2's feces from the floor of the facility as well as to watch two other clients in the facility. The DON told the surveyor she and the assistant administrator had met with the administrator and watched the camera feed on the 3-11 shift of 05/07/18. She stated the camera feed appeared to show something on the floor under where client #2 had been standing. The DON stated the QIDP looked at the floor and at client #1 and left the area. She stated the camera feed showed client #2 using her walker to walk down the hallway to her room. She stated in the camera feed the feces remained on the floor of the facility for over 27 minutes. She stated at that time it appears the QIDP said something to client #1. Client #1 then put on gloves and started to pick up the feces from the floor, but then backed away. The DON was asked if client #1 should have	W 131		

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W 131	Continued From page 12 been cleaning up feces from another client. She stated, "No." She further stated that was the staff's job. At 10:40 AM, the surveyor interviewed the assistant administrator. The assistant administrator told the surveyor of the meeting she had with client #1 on 05/08/18. She described the same information that had been provided to the surveyor by the DON of the feces remaining on the floor of the facility and not being cleaned up for over 27 minutes. She stated client #1 had told her the QIDP had instructed her to clean up the feces and to watch other clients while she worked in the office. Between 11:30 AM and 2:00 PM 2 surveyors, the administrator and DON watched a recording of the camera feed from 05/07/18. The following was observed on the camera feed: The camera feed showed 2 views of the facility. In one view, the dining area, partial living area, entry into the kitchen and back door are visible. The other view, is of the front door, entry into an office area and the west hallway to 4 client bedrooms, including client #2's bedroom. --5:44 PM, the camera feed started, several clients are in the dining area, including client #1 and #2. The certified medication aide (CMA) leaves the facility via the front door. The QIDP is the only staff in the facility. --5:51 PM, the QIDP is observed walking down the hallway into an office area. --5:58 PM, client #1 is observed walking out of the kitchen, she looks down at something on the	W 131		

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floor under where client #2 is standing. She is observed to go to the office and say something to the QIDP.

--5:59 PM, the QIDP leaves the office area, walks into the dining area, and looks down at the substance on the floor. She says something to client #2 and assists her in getting her walker.

--6:00 PM, client #2 is observed using her walker to start down the hallway toward her bedroom. The QIDP is observed to be talking on the telephone as she walks down the hallway to the office. The substance remains on the floor of the dining area.

--6:06 PM, client #1 is observed to be redirecting another client away from the substance on the floor of the dining area.

--6:07 PM, client #1 is observed as she takes chairs from the dining table and places them across the floor, creating a barrier so other clients will not walk in the area where the substance is on the floor. The QIDP has not been observed to leave the office area.

--6:25 PM the QIDP is observed to leave the office area. At this time she is observed to talk with client #1.

--6:26 PM, client #1 is observed to walk down the hall to the office area. She is observed to leave the office area and put on disposable gloves.

--6:27 PM, client #1 is observed to drop a piece of paper over the substance on the floor. She started to bend over to pick up the substance, but quickly backed away. The QIDP is observed to

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W 131	Continued From page 14 use a paper towel to pick up the substance. She then takes the towel to the kitchen area. No observation was made of any attempts to clean or sanitize the floor after the substance had been removed. --6:29 PM, the QIDP was observed to return down the hall to the office area. At 12:45 PM, during the observation of the camera feed, the administrator was asked if the QIDP should have cleaned up the area and not have instructed client #1 to do so. She stated, "Yes." She further stated staff were not to have clients assist with providing care to other clients.	W 131		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by. On 05/29/18 at 3:30 PM, an Immediate Jeopardy (IJ) situation was determined to exist when the facility failed to have a system in place to protect a cognitively impaired client, who required assistance with toileting and showering, from neglect by a staff member. The Oklahoma State Department of Health was notified on 05/29/18, and concurred with the team concerning the existence of an IJ situation. The facility's administrator was informed of the IJ situation on 05/29/18 at 3:35 PM.	W 149		

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W 149	Continued From page 15 The Plan of Removal documented the following: "QIDP [qualified intellectual disabilities professional] will be given a formal reprimand and be put on an immediate 90 day probation period. An 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 inserviced prior to reporting to the next shift. Policies and procedures will be reviewed and revised an (sic) 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 (sic) you but the entire community. Currently Gatesway is re-structuring the nursing staff and CMA's [certified medication aide] will be counted in the census and an additional LPN [licensed practical nurse] 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	W 149		

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W 149	Continued From page 16 and they are to be worn whenever they are on the campus Until permanent badges can be obtained volunteers will be given paper badges." The IJ was removed effective 05/29/18 at 11:59 PM, although the deficient practice remained. All components of the plan had been carried out. Staff from all shifts were interviewed and voiced an understanding of the plan of removal. 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 1 (#2)client from neglect by a staff member. Eight total clients resided in the facility. Findings: The facility's abuse, neglect and exploitation policy was reviewed. The following documentation was located in the policy: "Definitions:...Neglect. The willful failure to provide individuals served with the goods/services necessary which directly or indirectly results in an individual served suffering or being exposed to substantial risk of imminent injury. Neglect may include, but is not limited to, failure to furnish food, clothing, shelter, medical attention or knowingly failing to implement a required program or maintaining necessary equipment..." The policy documented the following procedure"... When abuse or neglect of any nature is suspected, reported, or identified, the following procedures will be followed. Failure to report suspected abuse, neglect, or exploitation	W 149		

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may result in disciplinary actions, termination, and criminal sanctions. Reporting: All allegations of abuse, neglect, or exploitation will be reported to the following agencies...OKLA [Oklahoma] STATE DEPARTMENT OF HEALTH."

The abuse, neglect and exploitation policy further documented the steps involved when conducting an investigation of abuse, including assigning the investigator from the facility to complete a preliminary investigation, gathering statements, interviews from the person making the allegation, interviews from the witnesses, interviews from the alleged perpetrator and reviewing all the information to determine a finding.

The facility's policy documented, "...The supervisor will take necessary actions to assure the safety, protection, and medical care, if needed, of individual during the investigation of any allegation of abuse, neglect, and/or exploitation..."

Client #2 had diagnoses which included mild intellectual disability. She had been admitted to the facility on 05/01/18.

On 05/29/18 at 8:20 AM, the surveyor asked the house manager if any of the clients in the facility had issues with incontinence. She identified 3 clients who sometimes were incontinent. She stated 2 of the clients had occasional episodes of incontinence and 1 (#2) client had frequent episodes of both bowel and bladder incontinence.

A review of client #2's clinical record was conducted. The individual habilitation plan (IHP) was reviewed. The IHP documented the client was incontinent part of the time and staff were to

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prompt her frequently to use the bathroom. The IHP further documented the client required total assistance with bathing. The IHP documented the client had limited mobility and required a walker while in the facility and a wheelchair for long distances.

Charting notes for the month of May 2017, located in the client's clinical record, documented 5 times during the month when she had been incontinent of bowel or bladder.

A chart entry dated 05/07/18, by the qualified intellectual disabilities professional (QIDP) documented the client had soiled her clothing 2 times during the 3-11 shift.

At 10.00 AM, the surveyor interviewed client #1. She was asked how she liked living in the facility. She stated things were going pretty well now. The surveyor asked her if there had been any problems in the past. She stated, "Yes." Client #1 stated earlier in the month, client #2 had an accident and feces was left on the floor in the dining room. Client #1 further stated the QIDP had told her to clean up client #2's feces and to watch other clients while the QIDP worked in the office.

At 10:30 AM, the surveyor interviewed the director of nurses (DON). She was asked if she was aware of any issues with client #2 having toileting accidents. She stated, client #2 had frequent incontinence of bowel and bladder. She further stated staff were to provide total assistance with client #2 when cleaning herself after toileting. The DON stated client #2 required total assistance with showering, since she had difficulty standing without any assistance.

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W 149	Continued From page 19 The DON was told of the surveyor's interview with client #1 in which she told the surveyor she had been told by the QIDP to clean up feces and watch other clients She was asked if she had been made aware of the incident. She stated, "Yes." The DON provided the surveyor with a copy of an e-mail dated 05/08/18, which had been sent to the administrator and the DON. The e-mail documented client #1 had spoken with the assistant administrator on 05/08/18. The e-mail described a situation which had occurred on the evening of 05/07/18. The e-mail documented client #1 told the assistant administrator she had been told by the QIDP to clean up client #2's feces from the floor of the facility as well as to watch two other clients in the facility. The DON told the surveyor she and the assistant administrator had met with the administrator and watched the camera feed on the 3-11 shift of 05/07/18. She stated the camera feed appeared to show something on the floor under where client #2 was standing. The DON stated the QIDP looked at the floor and at client #1 and left the area. She stated the camera feed showed client #2 using her walker to walk down the hallway to her room. She stated in the camera feed the feces remained on the floor of the facility for over 27 minutes. She stated at that time it appears the QIDP said something to client #1. Client #1 then put on gloves and started to pick up the feces from the floor, but then backed away. The DON stated she had asked the administrator if the observed incident of the QIDP not immediately cleaning up the feces and the observation of the client attempting to pick up the feces should be reported and investigated as	W 149		

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(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
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possible neglect The DON stated the administrator stated, "No."

At 10:40 AM, the surveyor interviewed the assistant administrator. The assistant administrator told the surveyor of a meeting she had with client #1 on 05/08/18. She described the same information that had been provided to the surveyor by the DON of the feces remaining on the floor of the facility and not being cleaned up for over 27 minutes. She stated client #1 had told her the QIDP had instructed her to clean up the feces and to watch other clients while she worked in the office.

The assistant administrator told the surveyor she had not observed any staff assisting client #2 with cleaning up after she had the toileting accident. She stated she and the DON had watched the camera feed with the administrator and questioned whether the incident should have been reported and investigated. The assistant administrator stated when asked whether the incident should have been reported and investigated the administrator stated she wasn't sure what had happened, so she was not going to investigate it any further.

At 10:45 AM, the surveyor interviewed the administrator. She was asked if she had watched the camera feed for 05/07/18. She stated, "Yes." She stated she could not really tell what had happened on the camera feed, other than the QIDP looking at something on the floor, leaving the area and remaining out of camera view for over 28 minutes. She stated the QIDP then was observed to return to the area and put on gloves and pick up something off the floor.

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	37G035	A BUILDING _____ B WING _____	C 05/30/2018

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The surveyor asked the administrator what she had done after watching the camera feed. She stated she had verbally counseled the QIDP to not leave something on the floor for so long. The administrator was asked if the incident had been reported and investigated. She stated, "No." She was asked if she had interviewed any other staff in the facility regarding the incident. She stated, "No."

The surveyor asked the administrator for sign in sheets of staff working in the facility between 05/07/18 and 05/28/18. The QIDP had signed in for 2 additional shifts, of which she was providing direct care, after the administrator had observed the camera feed.

At 11:00 AM, the QIDP was interviewed. She was asked about the incident which had occurred on 05/07/18. She stated she had been working in the facility as direct care on 05/07/18. She stated she had noticed the feces on the floor below client #2. She further stated she had observed feces running down client #2's legs. She stated she instructed client #2 to take a shower. The QIDP further stated she had been assisting client #2 in the shower, because she could not be left alone, during the time the feces remained on the floor without being cleaned up.

The QIDP was asked if anyone had talked with her about what had occurred on the evening of 05/07/18. She stated the administrator had talked with her and she told the administrator she was in the client's room assisting her during the time of the camera feed. She was asked if she had worked as direct care in the facility since 05/07/18. She stated, "Yes." She stated she had worked at least 2 more shifts in the facility since

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W 149	Continued From page 22 05/07/18. Between 11.30 AM and 2:00 PM the 2 surveyors, administrator and DON watched a recording of the camera feed from 05/07/18. The following was observed on the camera feed: The camera feed shows 2 views of the facility. In one view, the dining area, partial living area, entry into the kitchen and back door were visible. The other view, was of the front door, entry into an office area and the west hallway to the 4 client bedrooms, including client #2's bedroom. --5:44 PM, the camera feed started, several clients were in the dining area, including client #1 and #2. The certified medication aide (CMA) left the facility via the front door. The QIDP was the only staff in the facility. --5:51 PM, the QIDP was observed walking down the hallway into an office area. --5:58 PM, client #1 was observed walking out of the kitchen, she looked down at something on the floor under where client #2 was standing. She was observed to go to the office and say something to the QIDP --5:59 PM, the QIDP left the office area, walked into the dining area, and looked down at the substance on the floor. She said something to client #2 and assisted her in getting her walker. --6:00 PM, client #2 was observed using her walker to start down the hallway toward her bedroom. The QIDP was observed to be talking on the telephone as she walked down the hallway to the office. The substance remained on the	W 149		

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W 149	Continued From page 23 floor of the dining area. --6.06 PM, client #1 was observed to be redirecting another client away from the substance on the floor of the dining area. --6:07 PM, client #1 was observed as she took chairs from the dining table and placed them across the floor, creating a barrier so other clients would not walk in the area where the substance was on the floor. The QIDP had not been observed to leave the office area. --6:25 PM the QIDP was observed to leave the office area. At that time, she was observed to talk with client #1. --6:26 PM, client #1 was observed to walk down the hall to the office area. She was observed to leave the office area and put on disposable gloves. --6:27 PM, client #1 was observed to drop a piece of paper over the substance on the floor. She started to bend over to pick up the substance, but quickly backed away. The QIDP was observed to use a paper towel to pick up the substance. She then took the towel to the kitchen area. No observation was made of any attempts to clean or sanitize the floor after the substance had been removed. --6:29 PM, the QIDP was observed to return down the hall to the office area. No staff had been observed to enter the hallway to client #2's bedroom to assist her. --6:41 PM, a staff member from a sister facility, came in the front door, walked through the facility	W 149		

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W 149	Continued From page 24 to the back door. She opened the back door and let in a group of 7 visitors. She stopped by the office area to talk with the QIDP. --6:45 PM, the staff member then left the facility through the front door. The QIDP remained in the office. No additional staff were in the facility. --7:28 PM, the QIDP left the office area, came out to the dining area and talked with the visitors. --7:30 PM, the QIDP returned to the office, leaving the visitors with the clients. --7:34 PM, the CMA was observed to enter the facility through the front door. The visitors are observed leaving the facility through the back door. At no time, during the camera feed, was the QIDP observed to go down the hallway to client #2's bedroom to assist her as the QIDP had stated in her interview with the surveyor. At no time was anyone observed to go down the hallway to client #2's bedroom to assist her with cleaning up from the toileting accident. At 12:45 PM, during the observation of the camera feed, the administrator was asked if the QIDP had provided care to client #2. She stated, "No." The administrator stated she had previously watched the camera feed, but apparently had not watched it carefully. She was asked if the failure of care by the QIDP could be considered neglect. She did not answer. The administrator was asked if visitors should have been in the facility with no staff present in the area. She stated she had not watched the	W 149		

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W 149	Continued From page 25 entire camera feed, so she had not been aware of the visitors in the facility. She stated a staff member should have been present in the facility with the visitors. The surveyor asked the administrator if allowing the QIDP to continue to work, providing direct care to client #2 after the incident on 05/07/18, had the potential to put the client at continued risk for neglect. She stated, she guessed so.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to report an allegation of neglect to the Oklahoma State Department of Health (OSDH). This had the potential to affect all 8 clients who resided in the facility. Findings: No documentation was located or provided by the facility which indicated any allegations of neglect by a staff had been reported to OSDH. The facility's abuse, neglect and exploitation policy was reviewed. The following documentation was located in the policy:	W 153		

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W 153	Continued From page 26 "Definitions:...Neglect: The willful failure to provide individuals served with the goods/services necessary which directly or indirectly results in an individual served suffering or being exposed to substantial risk of imminent injury. Neglect may include, but is not limited to, failure to furnish food, clothing, shelter, medical attention or knowingly failing to implement a required program or maintaining necessary equipment..." The policy documented the following procedure"... When abuse or neglect of any nature is suspected, reported, or identified, the following procedures will be followed. Failure to report suspected abuse, neglect, or exploitation may result in disciplinary actions, termination, and criminal sanctions. Reporting: All allegations of abuse, neglect, or exploitation will be reported to the following agencies...OKLA [Oklahoma] STATE DEPARTMENT OF HEALTH." Client's #2 had diagnoses which included mild intellectual disability. She had been admitted to the facility on 05/01/18. On 05/29/18 at 8:20 AM, the surveyor asked the house manager if any of the clients in the facility had issues with incontinence. She identified 3 clients who sometimes were incontinent. She stated 2 of the clients had occasional episodes of incontinence and 1 (#2) client who had frequent episodes of both bowel and bladder incontinence. A review of client #2's clinical record was conducted. The individual habilitation plan (IHP) was reviewed. The IHP documented the client was incontinent part of the time and staff were to prompt her frequently to use the bathroom. The	W 153		

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IHP further documented the client required total assistance with bathing. The IHP documented the client had limited mobility and required a walker while in the facility and a wheelchair for long distances.

At 10:30 AM, the surveyor interviewed the director of nurses (DON). She was asked if she was aware of any issues with client #2 having toileting accidents. She stated, client #2 had frequent incontinence of bowel and bladder. She further stated staff were to provide total assistance with client #2 when cleaning herself after toileting. The DON stated client #2 required total assistance with showering, since she had difficulty standing without any assistance.

The DON was asked if she was aware of any situations where client #2 had been left soiled. She stated, "Yes." The DON provided the surveyor with a copy of an e-mail dated 05/08/18, which had been sent to the administrator and the DON. The e-mail documented client #1 had spoken with the assistant administrator on 05/08/18. The e-mail described a situation which had occurred on the evening of 05/07/18. The e-mail documented client#1 told the assistant administrator she had told by the QIDP to clean up client #2 feces from the floor of the facility as well as to watch two other clients in the facility.

The DON told the surveyor she and the assistant administrator had met with the administrator and watched the camera feed on the 3-11 shift of 05/07/18. She stated the camera feed appeared to show something on the floor under where client #2 was standing. The DON stated the QIDP looked at the floor and at client #1 and left the area. She stated the camera feed showed client

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#2 using her walker to walk down the hallway to her room. She stated in the camera feed the feces remained on the floor of the facility for over 27 minutes.

The DON stated she had asked the the administrator if the incident of the QIDP not immediately cleaning up the feces and the observation of client #2 not receiving assistance should have been reported. The DON stated the administrator stated, "No."

At 10:40 AM, the surveyor interviewed the assistant administrator. The assistant administrator told the surveyor of the meeting she had with client #1 on 05/08/18. She described the same information that had been provided to the surveyor by the DON of the feces remaining on the floor of the facility and not being cleaned up for over 27 minutes. She stated client #1 had told her the QIDP had instructed her to clean up the feces and to watch other clients while she worked in the office.

The assistant administrator told the surveyor she had not observed any staff assisting client #2 with cleaning up after she had the toileting accident. She stated she and the DON had watched the camera feed with the administrator and questioned whether the incident should have been reported. The assistant administrator stated when asked about reported and investigating the administrator stated she wasn't sure what had happened, so she was not going to investigate it any further.

At 10:45 AM, the surveyor interviewed the administrator. She was asked if she had watched the camera feed for 05/07/18. She stated, "Yes."

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She stated she could not really tell what had happened on the camera feed, other than the QIDP looking at something on the floor, leaving the area, remaining out of camera view for over 28 minutes. The QIDP then put on gloves and picked up something off the floor.

The surveyor asked the administrator what she had done after watching the camera feed. She stated she had verbally counseled the QIDP to not leave something on the floor for so long. The administrator was asked if the incident had been reported. She stated "No." She further stated at the time she did not think if was something that needed to be reported.

At 11:00 AM, the QIDP was interviewed. She was asked about the incident which had occurred on 05/07/18. She stated she had noticed the feces on the floor below client #2. She further stated she had observed feces running down client #2's legs. She stated she instructed client #2 to take a shower.

The QIDP was asked if anyone had talked with her about what had occurred on the evening of 05/07/18. She stated the administrator had talked with her.

Between 11:30 AM and 2:00 PM the surveyors, administrator and DON watched a recording of the camera feed from 05/07/18. The following was observed on the camera feed:

The camera feed shows 2 views of the facility. In one view, the dining area, partial living area, entry into the kitchen and back door are visible. The other view, is of the front door, entry into an office area and the west hallway to the 4 client

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W 153	Continued From page 30 bedrooms, including client #2's bedroom. The surveyors watched the camera feed for the 05/07/18 shift between 5:44 PM through 7:34 PM During this time the QIDP is the only staff member present in the facility. At 5:59 PM, the QIDP is observed to look at a substance on the floor in the dining room under where client #2 is standing. The QIDP is observed to provide client #2 her walker and direct her to the hallway toward her bedroom. At this time the QIDP is observed to go down another hallway to an office area. The QIDP was not observed to leave the office area until 6:25 PM at which time she went into the dining area and assisted another client in picking up the substance from the floor. At 6:29 PM, the QIDP is observed to return to the office area and was not observed to leave the office area until 7:38 PM. At no time during the camera feed was the QIDP observed to go down the hallway of client #2's bedroom to assist her in cleaning herself after the toileting accident. At 12:45 PM, during the observation of the camera feed, the administrator was asked if the QIDP had provided care to client #2. She stated, "No." She was asked if she had reported the incident to OSDH as possible neglect. She stated, "No." She stated after viewing the camera feed again, she probably should have reported the incident.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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W 154	Continued From page 31 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to investigate an allegation of neglect for 1 (#2) client with cognitive impairment. This had the potential to affect all 8 clients who resided in the facility. Findings: No documentation was located or provided by the facility which indicated any allegations of neglect by a staff member had been investigated by the facility. The facility's abuse, neglect and exploitation policy was reviewed. The following documentation was located in the policy: "Definitions:...Neglect: The willful failure to provide individuals served with the goods/services necessary which directly or indirectly results in an individual served suffering or being exposed to substantial risk of imminent injury. Neglect may include, but is not limited to, failure to furnish food, clothing, shelter, medical attention or knowingly failing to implement a required program or maintaining necessary equipment..." The policy documented the following procedure"... When abuse or neglect of any nature is suspected, reported, or identified, the following procedures will be followed...." The abuse, neglect and exploitation policy documented the steps involved when conducting and investigation of abuse, including assigning the investigator from the facility to complete a	W 154		

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preliminary investigation, gathering statements, interviews from the person making the allegation, interviews from the witnesses, interviews from the alleged perpetrator and reviewing all the information to determine a finding.

Client's #2 had diagnoses which included mild intellectual disability. She had been admitted to the facility on 05/01/18.

On 05/29/18 at 8:20 AM, the surveyor asked the house manager if any of the clients in the facility had issues with incontinence. She identified 3 clients who sometimes were incontinent. She stated 2 of the clients had occasional episodes of incontinence and 1 (#2) client who had frequent episodes of both bowel and bladder incontinence.

A review of client #2's clinical record was conducted. The individual habilitation plan (IHP) was reviewed. The IHP documented the client was incontinent part of the time and staff were to prompt her frequently to use the bathroom. The IHP further documented the client required total assistance with bathing. The IHP documented the client had limited mobility and required a walker while in the facility and a wheelchair for long distances.

At 10:30 AM, the surveyor interviewed the director of nurses (DON). She was asked if she was aware of any issues with client #2 having toileting accidents. She stated, client #2 had frequent incontinence of bowel and bladder. She further stated staff were to provide total assistance with client #2 when cleaning herself after toileting. The DON stated client #2 required total assistance with showering, since she had difficulty standing without any assistance.

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W 154	Continued From page 33 The DON was asked if she was aware of any situations where client #2 had been left soiled. She stated, "Yes." The DON provided the surveyor with a copy of an e-mail dated 05/08/18, which had been sent to the administrator and the DON. The e-mail documented client #1 had spoken with the assistant administrator on 05/08/18. The e-mail described a situation which had occurred on the evening of 05/07/18. The e-mail documented client#1 told the assistant administrator she had told by the QIDP to clean up client #2 feces from the floor of the facility as well as to watch two other clients in the facility. The DON told the surveyor she and the assistant administrator had met with the administrator and watched the camera feed on the 3-11 shift of 05/07/18. She stated the camera feed appeared to show something on the floor under where client #2 was standing. The DON stated the QIDP looked at the floor and at client #1 and left the area. She stated the camera feed showed client #2 using her walker to walk down the hallway to her room. She stated in the camera feed the feces remained on the floor of the facility for over 27 minutes. The DON stated she had asked the administrator if the incident of the QIDP not immediately cleaning up the feces and the observation of client #2 not receiving assistance to bath should be investigated. The DON stated the administrator replied, "No." At 10:40 AM, the surveyor interviewed the assistant administrator. The assistant administrator told the surveyor of the meeting she had with client #1 on 05/08/18. She described	W 154		

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the same information that had been provided to the surveyor by the DON of the feces remaining on the floor of the facility and not being cleaned up for over 27 minutes. She stated client #1 had told her the QIDP had instructed her to clean up the feces and to watch other clients while she worked in the office.

The assistant administrator told the surveyor she had not observed any staff assisting client #2 with cleaning up after she had the toileting accident. She stated she and the DON had watched the camera feed with the administrator and questioned whether the incident should have been investigated . The assistant administrator stated when asked about investigating the administrator stated she wasn't sure what had happened, so she was not going to investigate it any further.

At 10:45 AM, the surveyor interviewed the administrator. She was asked if she had watched the camera feed for 05/07/18. She stated, "Yes." She stated she could not really tell what had happened on the camera feed, other than the QIDP looking at something on the floor, leaving the area, remaining out of camera view for over 28 minutes.

The surveyor asked the administrator what she had done after watching the camera feed. She stated she had verbally counseled the QIDP to not leave something on the floor for so long. The administrator was asked if the incident had been investigated She stated "No." She further stated at the time she did not think if was something that needed to be investigated.

At 11:00 AM, the QIDP was interviewed. She was

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asked about the incident which had occurred on 05/07/18. She stated she had noticed the feces on the floor below client #2. She further stated she had observed feces running down client #2's legs. She stated she instructed client #2 to take a shower.

The QIDP was asked if anyone had talked with her about what had occurred on the evening of 05/07/18. She stated the administrator had talked with her.

Between 11:30 AM and 2:00 PM the surveyors, administrator and DON watched a recording of the camera feed from 05/07/18. The following was observed on the camera feed:

The camera feed shows 2 views of the facility. In one view, the dining area, partial living area, entry into the kitchen and back door are visible. The other view, is of the front door, entry into an office area and the west hallway to the 4 client bedrooms, including client #2's bedroom.

The surveyors watched the camera feed for 05/07/18 from 5:44 PM through 7:34 PM. During this time the QIDP is the only staff member present in the facility. At 5:59 PM, the QIDP is observed to look at a substance on the floor in the dining room under where client #2 is standing The QIDP is observed to provide client #2 her walker and direct her to the hallway toward her bedroom. At this time the QIDP is observed to go do another hallway to an office area. The QIDP was not observed to leave the office area until 6:25 PM at which time she went into the dining area and assisted another client in picking up the substance from the floor.

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W 154	Continued From page 36 At 6:29 PM, the QIDP is observed to return to the office area and was not observed to leave the office area until 7:38 PM. At no time during the camera feed was the QIDP observed to go down the hallway of client #2 bedroom to assist her in cleaning herself after the toileting accident. At 12:45 PM, during the observation of the camera feed, the administrator was asked if the QIDP had provided care to client #2. She stated, "No." She was asked if she had conducted an investigation of the incident. She stated, "No." She stated after viewing the camera feed again, she should have investigated the incident.	W 154		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to protect clients from further incidents of neglect while investigating an allegation of neglect. This had the potential to affect all 8 clients who resided in the facility. Findings: The facility's abuse, neglect and exploitation policy was reviewed. The following documentation was located in the policy: "Definitions:...Neglect: The willful failure to provide individuals served with the goods/services necessary which directly or indirectly results in an individual served suffering	W 155		

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or being exposed to substantial risk of imminent injury. Neglect may include, but is not limited to, failure to furnish food, clothing, shelter, medical attention or knowingly failing to implement a required program or maintaining necessary equipment..."

The policy documented the following procedure"... When abuse or neglect of any nature is suspected, reported, or identified, the following procedures will be followed...."

The abuse, neglect and exploitation policy documented the steps involved when conducting and investigation of abuse, including assigning the investigator from the facility to complete a preliminary investigation, gathering statements, interviews from the person making the allegation, interviews from the witnesses, interviews from the alleged perpetrator and reviewing all the information to determine a finding.

The facility's policy documented, "...The supervisor will take necessary actions to assure the safety, protection, and medical care, if needed, of individual during the investigation of any allegation of abuse, neglect, and/or exploitation..."

Client's #2 had diagnoses which included mild intellectual disability. She had been admitted to the facility on 05/01/18.

On 05/29/18 at 8:20 AM, the surveyor asked the house manager if any of the clients in the facility had issues with incontinence. She identified 3 clients who sometimes were incontinent. She stated 2 of the clients had occasional episodes of incontinence and 1 (#2) client who had frequent

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W 155	Continued From page 38 episodes of both bowel and bladder incontinence. A review of client #2's clinical record was conducted. The individual habilitation plan (IHP) was reviewed. The IHP documented the client was incontinent part of the time and staff were to prompt her frequently to use the bathroom. The IHP further documented the client required total assistance with bathing. The IHP documented the client had limited mobility and required a walker while in the facility and a wheelchair for long distances. At 10:30 AM, the surveyor interviewed the director of nurses (DON). She was asked if she was aware of any issues with client #2 having toileting accidents. She stated, client #2 had frequent incontinence of bowel and bladder. She further stated staff were to provide total assistance with client #2 when cleaning herself after toileting. The DON stated client #2 required total assistance with showering, since she had difficulty standing without any assistance. The DON was asked if she was aware of any situations where client #2 had been left soiled. She stated, "Yes." The DON provided the surveyor with a copy of an e-mail dated 05/08/18, which had been sent to the administrator and the DON. The e-mail documented client #1 had spoken with the assistant administrator on 05/08/18. The e-mail described a situation which had occurred on the evening of 05/07/18. The e-mail documented client#1 told the assistant administrator she had told by the QIDP to clean up client #2 feces from the floor of the facility as well as to watch two other clients in the facility. The DON told the surveyor she and the assistant	W 155		

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administrator had met with the administrator and watched the camera feed on the 3-11 shift of 05/07/18. She stated the camera feed appeared to show something on the floor under where client #2 was standing. The DON stated the QIDP looked at the floor and at client #1 and left the area. She stated the camera feed showed client #2 using her walker to walk down the hallway to her room. She stated in the camera feed the feces remained on the floor of the facility for over 27 minutes. .

At 10:40 AM, the surveyor interviewed the assistant administrator. The assistant administrator told the surveyor of the meeting she had with client #1 on 05/08/18. She described the same information that had been provided to the surveyor by the DON of the feces remaining on the floor of the facility and not being cleaned up for over 27 minutes.

At 10:45 AM, the surveyor interviewed the administrator. She was asked if she had watched the camera feed for 05/07/18. She stated, "Yes." She stated she could not really tell what had happened on the camera feed, other than the QIDP looking at something on the floor, leaving the area, remaining out of camera view for over 28 minutes, putting on gloves and picking up something off the floor.

The surveyor asked the administrator what she had done after watching the camera feed. She stated she had verbally counseled the QIDP to not leave something on the floor for so long

The surveyor asked the administrator for sign in sheets of staff working in the facility between 05/07/18 and 05/28/18. The QIDP had signed in

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for 2 additional shifts of which she had been providing direct care in the facility after the administrator had observed the camera feed.

At 11:00 AM, the QIDP was interviewed. She was asked about the incident which had occurred on 05/07/18. She stated she had noticed the feces on the floor below client #2. She further stated she had observed feces running down client #2's legs. She stated she instructed client #2 to take a shower.

The QIDP was asked if anyone had talked with her about what had occurred on the evening of 05/07/18. She stated the administrator had talked with her. She was asked if she had continued to work in the facility as direct care since 05/07/18. She stated, "Yes, at least 2 more times."

Between 11:30 AM and 2:00 PM the surveyors, administrator and DON watched a recording of the camera feed from 05/07/18. The following was observed on the camera feed:

The camera feed showed 2 views of the facility. In one view, the dining area, partial living area, entry into the kitchen and back door are visible. The other view, is of the front door, entry into an office area and the west hallway to the 4 client bedrooms, including client #2's bedroom.

The surveyors watched the camera feed from 5:44 PM through 7:34 PM. During this time the QIDP is the only staff member present in the facility. At 5:59 PM, the QIDP is observed to look at a substance on the floor in the dining room under where client #2 is standing. The QIDP is observed to provide client #2 her walker and

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W 155	Continued From page 41 direct her to the hallway toward her bedroom. At this time the QIDP is observed to go do another hallway to an office area. The QIDP was not observed to leave the office area until 6:25 PM at which time she went into the dining area and assisted another client in picking up the substance from the floor. At 6:29 PM, the QIDP is observed to return to the office area and was not observed to leave the office area until 7:38 PM. At no time during the camera feed was the QIDP observed to go down the hallway of client #2's bedroom to assist her in cleaning herself after the toileting accident. At 12:45 PM, during the observation of the camera feed, the administrator was asked if the QIDP had provided care to client #2. She stated, "No." She was asked if the clients in the facility had been protected from the potential of further neglect The administrator stated after viewing the camera feed again, the QIDP should not have been working as direct care until an investigation had been conducted. The administrator was asked if the QIDP had continued to work as direct care since 05/07/18. She stated, "Yes." She was asked if the client had been protected from further neglect by the QIDP. She stated, "No. I guess not."	W 155		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present	W 186		

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W 186	Continued From page 42 on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD 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. Eight clients resided in the facility. Findings: Client #2 had diagnoses which included mild intellectual disability. The individual habilitation plan (IHP) documented the client was incontinent part of the time and staff were to prompt her frequently to use the bathroom. The IHP further documented the client required total assistance with bathing. The IHP documented the client had limited mobility and required a walker while in the facility and a wheelchair for long distances. On 05/29/18, at 10:30 AM, the surveyor interviewed the director of nurses (DON). She was asked if she was aware of any issues with having adequate staff in the facility to provide care to the clients. The DON provided the surveyor a copy of an e-mail dated 05/08/18, which had been sent to the administrator and the DON. The e-mail documented a client had spoken with the assistant administrator on 05/08/18. The e-mail described a situation which had occurred on the evening of 05/07/18. The e-mail documented client #1 told the assistant administrator she had	W 186		

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been told by the QIDP to clean up client #2's feces from the floor of the facility as well as to watch two other clients in the facility.

The DON told the surveyor she and the assistant administrator had met with the administrator and watched the camera feed on the 3-11 shift of 05/07/18. She stated the camera feed appeared to show something on the floor under where client #2 was standing. The DON stated the QIDP looked at the floor and at client #2 and left the area. She stated the camera feed showed client #2 using her walker to walk down the hallway to her room. She stated in the camera feed the feces remained on the floor of the facility for over 27 minutes.

At 10:40 AM, the surveyor interviewed the assistant administrator. The assistant administrator told the surveyor of the meeting she had with client #1 on 05/08/18. She described the same information that had been provided to the surveyor by the DON of the feces remaining on the floor of the facility and not being cleaned up for over 27 minutes.

The assistant administrator told the surveyor she had not observed any staff assisting client #2 with cleaning up after she had the toileting accident.

At 10:45 AM, the surveyor interviewed the administrator. She was asked if she had watched the camera feed for 05/07/18. She stated, "Yes." The surveyor asked the administrator what she had done after watching the camera feed. She stated she had verbally counseled the QIDP to not leave something on the floor for so long.

At 11:00 AM, the QIDP was interviewed. She was

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asked about the incident which had occurred on 05/07/18. She stated she had been working in the facility as direct care on 05/07/18. The QIDP stated the certified medication aide (CMA) had left the facility to pass medications at a sister facility on the campus. She stated she was the only staff in the facility during the time the CMA was gone. She stated she had noticed the feces on the floor below client #2. She further stated she had observed feces running down client #2's legs. She stated she instructed client #2 to take a shower.

The surveyors watched the camera feed from 05/07/18 for the time frame of 5:44 PM through 7:34 PM. During this time the QIDP is the only staff member present in the facility. At 5:59 PM, the QIDP is observed to look at a substance on the floor in the dining room under where client #2 is standing. The QIDP is observed to provide client #2 her walker and direct her to the hallway toward her bedroom. At this time, the QIDP is observed to go down another hallway to an office area. The QIDP was not observed to leave the office area until 6:25 PM at which time she went into the dining area and assisted another client in picking up the substance from the floor.

At 6:29 PM, the QIDP is observed to return to the office area and was not observed to leave the office area until 7:38 PM. At no time during the camera feed was the QIDP observed to go down the hallway of client #2's bedroom to assist her in cleaning herself after the toileting accident.

At 12:45 PM, during the observation of the camera feed, the administrator was asked if the QIDP had provided care to client #2. She stated, "No." She was asked if sufficient staff had been

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W 186	Continued From page 45 present in the facility to provide care to the client after the toileting accident. She stated, "No." She further stated the facility required 2 direct care staff to be present at all times.	W 186		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure a sanitary environment in the dining room was provided. This had the potential to affect all 8 clients who resided in the facility. Findings: On 05/29/18 at 10.00 AM, the surveyor interviewed client #1. She was asked how she liked living in the facility. She stated things were going pretty well now. The surveyor asked her if there had been any problems in the past. She stated, "Yes." Client #1 stated earlier in the month, client #2 had an accident and feces was left on the floor in the dining room. Client #1 further stated the QIDP had told her to clean up the client #1's feces and to watch other clients while the QIDP worked in the office. At 10:30 AM, the DON was told of the surveyor's interview with client #1 in which she told the surveyor she had been told by the QIDP to clean up feces and watch other clients. She was asked if she had been made aware of the incident. She stated, "Yes." The DON provided the surveyor with a copy of an e-mail dated 05/08/18, which	W 454		

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had been sent to the administrator and the DON. The e-mail documented client #1 had spoken with the assistant administrator on 05/08/18. The e-mail described a situation which had occurred on the evening of 05/07/18. The e-mail documented client#1 told the assistant administrator she had told by the QIDP to clean up client #2's feces from the floor of the facility as well as to watch two other clients in the facility.

The DON told the surveyor she and the assistant administrator had met with the administrator and watched the camera feed on the 3-11 shift of 05/07/18. She stated the camera feed appeared to show something on the floor under where client #2 was standing. The DON stated the QIDP looked at the floor and at client #2 and left the area. She stated the camera feed showed client #2 using her walker to walk down the hallway to her room. She stated in the camera feed the feces remained on the floor of the facility for over 27 minutes. She stated at that time it appears the QIDP said something to client #1. Client #1 then put on gloves and started to pick up the feces from the floor, but then backed away. The DON stated the QIDP appeared to pick up the substance with a paper towel, but did not clean or disinfect the floor in the area.

At 10.40 AM, the surveyor interviewed the assistant administrator. The assistant administrator told the surveyor of the meeting she had with client #1 on 05/08/18. She described the same information that had been provided to the surveyor by the DON of the feces remaining on the floor of the facility and not being cleaned up for over 27 minutes. She stated client #1 had told her the QIDP had instructed her to clean up the feces and to watch other clients while she

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	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

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worked in the office.

At 10.45 AM, the surveyor interviewed the administrator. She was asked if she had watched the camera feed for 05/07/18. She stated, "Yes." She stated she could not really tell what had happened on the camera feed, other than the QIDP looking at something on the floor, leaving the area, remaining out of camera view for over 28 minutes.

At 11:00 AM, the QIDP was interviewed She was asked about the incident which had occurred on 05/07/18. She stated she had been working in the facility as direct care on 05/07/18. She stated she had noticed the feces on the floor below client #2. She further stated she had observed feces running down client #2 legs. She stated she instructed client #2 to take a shower. She stated she had been assisting client #2 so she had not had time to clean up the feces from the floor right away. She was asked if she had cleaned and disinfected the area of the feces after she had picked it up. She stated she was not sure.

Between 11:30 AM and 2:00 PM the surveyors, administrator and DON watched a recording of the camera feed from 05/07/18. The following was observed on the camera feed:

The camera feed showed 2 views of the facility. In one view, the dining area, partial living area, entry into the kitchen and back door are visible. The other view, is of the front door, entry into an office area and the west hallway to the 4 client bedrooms, including client #2's bedroom.

--5:44 PM, the camera feed started, several

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W 454	Continued From page 48 clients are in the dining area, including client #1 and #2. The certified medication aide (CMA) leaves the facility via the front door. The QIDP is the only staff in the facility. --5:51 PM, the QIDP is observed walking down the hallway into an office area. --5:58 PM, client #1 is observed walking out of the kitchen, she looks down at something on the floor under where client #2 is standing. She is observed to go to the office and say something to the QIDP. --5:59 PM, the QIDP leaves the office area, walks into the dining area, and looks down at the substance on the floor. She says something to client #2 and assists her in getting her walker. --6:00 PM, client #2 is observed using her walker to start down the hallway toward her bedroom. The QIDP is observed to be talking on the telephone as she walks down the hallway to the office. The substance remains on the floor of the dining area. --6:25 PM the QIDP is observed to leave the office area. At this time she is observed to talk with client #1. --6:27 PM, the QIDP is observed to use a paper towel to pick up the substance. She then takes the towel to the kitchen area. No observation was made of any attempts to clean or sanitize the floor after the substance had been removed. --6:29 PM, the QIDP was observed to return down the hall to the office area.	W 454		

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W 454	Continued From page 49 --6:41 PM, a CNA #1 comes in the front door, walks through the facility to the back door. She opens the back door and lets in a group of 7 visitors. She stops by the office area to talk with the QIDP. --6:45 PM, the staff member then leaves the facility through the front door. The QIDP remains in the office. No additional staff are in the facility. --7:30 PM, the QIDP returns to the office, leaving the visitors with the clients. --7:34 PM, the CMA returns to the facility by the front door. The visitors are observed leaving the facility by the back door. During the time the visitors were in the facility, they and the clients were observed to be walking around in the dining room in the area where the substance had been. At no time during the camera feed, was anyone observed to clean or disinfect the area where the substance had been. At 12:45 PM, during the observation of the camera feed, the administrator was asked if area where the substance had been on the floor had been clean and disinfected. She stated it did not look like it had been cleaned or disinfected. She was asked if not cleaning or disinfecting the area could be considered an issue with infection control. She stated, "Yes."	W 454		

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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		

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MM150	Continued From page 1 Eight clients resided in the facility. Findings: Client #2 had diagnoses which included mild intellectual disability. The individual habilitation plan (IHP) documented the client was incontinent part of the time and staff were to prompt her frequently to use the bathroom. The IHP further documented the client required total assistance with bathing. The IHP documented the client had limited mobility and required a walker while in the facility and a wheelchair for long distances. On 05/29/18, at 10:30 AM, the surveyor interviewed the director of nurses (DON). She was asked if she was aware of any issues with having adequate staff in the facility to provide care to the clients. The DON provided the surveyor a copy of an e-mail dated 05/08/18, which had been sent to the administrator and the DON. The e-mail documented a client had spoken with the assistant administrator on 05/08/18. The e-mail described a situation which had occurred on the evening of 05/07/18. The e-mail documented client #1 told the assistant administrator she had been told by the QIDP to clean up client #2's feces from the floor of the facility as well as to watch two other clients in the facility. The DON told the surveyor she and the assistant administrator had met with the administrator and watched the camera feed on the 3-11 shift of 05/07/18. She stated the camera feed appeared to show something on the floor under where client #2 was standing. The DON stated the QIDP looked at the floor and at client #2 and left the area. She stated the camera feed showed client	MM150		

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MM150	Continued From page 2 #2 using her walker to walk down the hallway to her room. She stated in the camera feed the feces remained on the floor of the facility for over 27 minutes. At 10:40 AM, the surveyor interviewed the assistant administrator. The assistant administrator told the surveyor of the meeting she had with client #1 on 05/08/18. She described the same information that had been provided to the surveyor by the DON of the feces remaining on the floor of the facility and not being cleaned up for over 27 minutes. The assistant administrator told the surveyor she had not observed any staff assisting client #2 with cleaning up after she had the toileting accident. At 10:45 AM, the surveyor interviewed the administrator. She was asked if she had watched the camera feed for 05/07/18. She stated, "Yes." The surveyor asked the administrator what she had done after watching the camera feed. She stated she had verbally counseled the QIDP to not leave something on the floor for so long. At 11:00 AM, the QIDP was interviewed. She was asked about the incident which had occurred on 05/07/18 She stated she had been working in the facility as direct care on 05/07/18. The QIDP stated the certified medication aide (CMA) had left the facility to pass medications at a sister facility on the campus. She stated she was the only staff in the facility during the time the CMA was gone. She stated she had noticed the feces on the floor below client #2. She further stated she had observed feces running down client #2's legs. She stated she instructed client #2 to take a shower.	MM150		

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MM150	Continued From page 3 The surveyors watched the camera feed from 05/07/18 for the time frame of 5:44 PM through 7:34 PM. During this time the QIDP is the only staff member present in the facility. At 5:59 PM, the QIDP is observed to look at a substance on the floor in the dining room under where client #2 is standing. The QIDP is observed to provide client #2 her walker and direct her to the hallway toward her bedroom. At this time, the QIDP is observed to go down another hallway to an office area. The QIDP was not observed to leave the office area until 6:25 PM at which time she went into the dining area and assisted another client in picking up the substance from the floor. At 6:29 PM, the QIDP is observed to return to the office area and was not observed to leave the office area until 7:38 PM. At no time during the camera feed was the QIDP observed to go down the hallway of client #2's bedroom to assist her in cleaning herself after the toileting accident. At 12:45 PM, during the observation of the camera feed, the administrator was asked if the QIDP had provided care to client #2. She stated, "No." She was asked if sufficient staff had been present in the facility to provide care to the client after the toileting accident. She stated, "No." She further stated the facility required 2 direct care staff to be present at all times.	MM150		

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LL000	Initial Comments An abbreviated survey to investigate complaint #OK00052027 was conducted on 05/29/18 through 05/30/18.	LL000		
LL244	1-O.S. 63-1-1918(B)(12) Rights and Responsibilities - Violations Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency;	LL244		

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

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This REQUIREMENT is not met as evidenced by.
On 05/29/18 at 3:30 PM, an Immediate Jeopardy (IJ) situation was determined to exist when the facility failed to have a system in place to protect a cognitively impaired client, who required assistance with toileting and showering, from neglect by a staff member.

The Oklahoma State Department of Health was notified on 05/29/18, and concurred with the team concerning the existence of an IJ situation.

The facility's administrator was informed of the IJ situation on 05/29/18 at 3:35 PM.

The Plan of Removal documented the following:

"QIDP [qualified intellectual disabilities professional] will be given a formal reprimand and be put on an immediate 90 day probation period. An 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 inserviced prior to reporting to the next shift.

Policies and procedures will be reviewed and

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revised an (sic) 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 (sic) you but the entire community.

Currently Gatesway is re-structuring the nursing staff and CMA's [certified medication aide] will be counted in the census and an additional LPN [licensed practical nurse] 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."

The IJ was removed effective 05/29/18 at 11:59 PM, although the deficient practice remained. All components of the plan had been carried out. Staff from all shifts were interviewed and voiced an understanding of the plan of removal.

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 1 (#2)client from neglect by a staff member.

Eight total clients resided in the facility. Findings:

The facility's abuse, neglect and exploitation policy was reviewed. The following documentation was located in the policy:

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LL244	Continued From page 3 "Definitions:...Neglect. The willful failure to provide individuals served with the goods/services necessary which directly or indirectly results in an individual served suffering or being exposed to substantial risk of imminent injury. Neglect may include, but is not limited to, failure to furnish food, clothing, shelter, medical attention or knowingly failing to implement a required program or maintaining necessary equipment..." The policy documented the following procedure"... When abuse or neglect of any nature is suspected, reported, or identified, the following procedures will be followed. Failure to report suspected abuse, neglect, or exploitation may result in disciplinary actions, termination, and criminal sanctions. Reporting: All allegations of abuse, neglect, or exploitation will be reported to the following agencies...OKLA [Oklahoma] STATE DEPARTMENT OF HEALTH." The abuse, neglect and exploitation policy further documented the steps involved when conducting an investigation of abuse, including assigning the investigator from the facility to complete a preliminary investigation, gathering statements, interviews from the person making the allegation, interviews from the witnesses, interviews from the alleged perpetrator and reviewing all the information to determine a finding. The facility's policy documented, "...The supervisor will take necessary actions to assure the safety, protection, and medical care, if needed, of individual during the investigation of any allegation of abuse, neglect, and/or exploitation..."	LL244		

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Client #2 had diagnoses which included mild intellectual disability. She had been admitted to the facility on 05/01/18.

On 05/29/18 at 8:20 AM, the surveyor asked the house manager if any of the clients in the facility had issues with incontinence. She identified 3 clients who sometimes were incontinent. She stated 2 of the clients had occasional episodes of incontinence and 1 (#2) client had frequent episodes of both bowel and bladder incontinence.

A review of client #2's clinical record was conducted. The individual habilitation plan (IHP) was reviewed. The IHP documented the client was incontinent part of the time and staff were to prompt her frequently to use the bathroom. The IHP further documented the client required total assistance with bathing. The IHP documented the client had limited mobility and required a walker while in the facility and a wheelchair for long distances.

Charting notes for the month of May 2017, located in the client's clinical record, documented 5 times during the month when she had been incontinent of bowel or bladder.

A chart entry dated 05/07/18, by the qualified intellectual disabilities professional (QIDP) documented the client had soiled her clothing 2 times during the 3-11 shift.

At 10:00 AM, the surveyor interviewed client #1. She was asked how she liked living in the facility. She stated things were going pretty well now. The surveyor asked her if there had been any problems in the past She stated, "Yes." Client #1 stated earlier in the month, client #2 had an accident and feces was left on the floor in the

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dining room. Client #1 further stated the QIDP had told her to clean up client #2's feces and to watch other clients while the QIDP worked in the office.

At 10:30 AM, the surveyor interviewed the director of nurses (DON). She was asked if she was aware of any issues with client #2 having toileting accidents. She stated, client #2 had frequent incontinence of bowel and bladder. She further stated staff were to provide total assistance with client #2 when cleaning herself after toileting. The DON stated client #2 required total assistance with showering, since she had difficulty standing without any assistance.

The DON was told of the surveyor's interview with client #1 in which she told the surveyor she had been told by the QIDP to clean up feces and watch other clients. She was asked if she had been made aware of the incident. She stated, "Yes." The DON provided the surveyor with a copy of an e-mail dated 05/08/18, which had been sent to the administrator and the DON. The e-mail documented client #1 had spoken with the assistant administrator on 05/08/18. The e-mail described a situation which had occurred on the evening of 05/07/18. The e-mail documented client #1 told the assistant administrator she had been told by the QIDP to clean up client #2's feces from the floor of the facility as well as to watch two other clients in the facility.

The DON told the surveyor she and the assistant administrator had met with the administrator and watched the camera feed on the 3-11 shift of 05/07/18. She stated the camera feed appeared to show something on the floor under where client #2 was standing. The DON stated the QIDP looked at the floor and at client #1 and left the

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(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
LL244	Continued From page 6	LL244		

area. She stated the camera feed showed client #2 using her walker to walk down the hallway to her room. She stated in the camera feed the feces remained on the floor of the facility for over 27 minutes. She stated at that time it appears the QIDP said something to client #1. Client #1 then put on gloves and started to pick up the feces from the floor, but then backed away.

The DON stated she had asked the administrator if the observed incident of the QIDP not immediately cleaning up the feces and the observation of the client attempting to pick up the feces should be reported and investigated as possible neglect. The DON stated the administrator stated, "No."

At 10:40 AM, the surveyor interviewed the assistant administrator. The assistant administrator told the surveyor of a meeting she had with client #1 on 05/08/18. She described the same information that had been provided to the surveyor by the DON of the feces remaining on the floor of the facility and not being cleaned up for over 27 minutes. She stated client #1 had told her the QIDP had instructed her to clean up the feces and to watch other clients while she worked in the office.

The assistant administrator told the surveyor she had not observed any staff assisting client #2 with cleaning up after she had the toileting accident. She stated she and the DON had watched the camera feed with the administrator and questioned whether the incident should have been reported and investigated. The assistant administrator stated when asked whether the incident should have been reported and investigated the administrator stated she wasn't sure what had happened, so she was not going to

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 _____	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
LL244	Continued From page 7 investigate it any further. At 10:45 AM, the surveyor interviewed the administrator. She was asked if she had watched the camera feed for 05/07/18. She stated, "Yes." She stated she could not really tell what had happened on the camera feed, other than the QIDP looking at something on the floor, leaving the area and remaining out of camera view for over 28 minutes. She stated the QIDP then was observed to return to the area and put on gloves and pick up something off the floor. The surveyor asked the administrator what she had done after watching the camera feed. She stated she had verbally counseled the QIDP to not leave something on the floor for so long. The administrator was asked if the incident had been reported and investigated. She stated, "No." She was asked if she had interviewed any other staff in the facility regarding the incident. She stated, "No." The surveyor asked the administrator for sign in sheets of staff working in the facility between 05/07/18 and 05/28/18. The QIDP had signed in for 2 additional shifts, of which she was providing direct care, after the administrator had observed the camera feed. At 11:00 AM, the QIDP was interviewed. She was asked about the incident which had occurred on 05/07/18. She stated she had been working in the facility as direct care on 05/07/18. She stated she had noticed the feces on the floor below client #2. She further stated she had observed feces running down client #2's legs. She stated she instructed client #2 to take a shower. The QIDP further stated she had been assisting client #2 in the shower, because she could not be left	LL244		

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LL244	Continued From page 8 alone, during the time the feces remained on the floor without being cleaned up. The QIDP was asked if anyone had talked with her about what had occurred on the evening of 05/07/18. She stated the administrator had talked with her and she told the administrator she was in the client's room assisting her during the time of the camera feed. She was asked if she had worked as direct care in the facility since 05/07/18. She stated, "Yes." She stated she had worked at least 2 more shifts in the facility since 05/07/18. Between 11:30 AM and 2:00 PM the 2 surveyors, administrator and DON watched a recording of the camera feed from 05/07/18. The following was observed on the camera feed: The camera feed shows 2 views of the facility. In one view, the dining area, partial living area, entry into the kitchen and back door were visible. The other view, was of the front door, entry into an office area and the west hallway to the 4 client bedrooms, including client #2's bedroom. --5:44 PM, the camera feed started, several clients were in the dining area, including client #1 and #2. The certified medication aide (CMA) left the facility via the front door. The QIDP was the only staff in the facility. --5:51 PM, the QIDP was observed walking down the hallway into an office area. --5:58 PM, client #1 was observed walking out of the kitchen, she looked down at something on the floor under where client #2 was standing. She was observed to go to the office and say something to the QIDP.	LL244		

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LL244	Continued From page 9 --5:59 PM, the QIDP left the office area, walked into the dining area, and looked down at the substance on the floor. She said something to client #2 and assisted her in getting her walker. --6.00 PM, client #2 was observed using her walker to start down the hallway toward her bedroom. The QIDP was observed to be talking on the telephone as she walked down the hallway to the office. The substance remained on the floor of the dining area. --6:06 PM, client #1 was observed to be redirecting another client away from the substance on the floor of the dining area. --6:07 PM, client #1 was observed as she took chairs from the dining table and placed them across the floor, creating a barrier so other clients would not walk in the area where the substance was on the floor. The QIDP had not been observed to leave the office area. --6:25 PM the QIDP was observed to leave the office area. At that time, she was observed to talk with client #1. --6:26 PM, client #1 was observed to walk down the hall to the office area. She was observed to leave the office area and put on disposable gloves. --6:27 PM, client #1 was observed to drop a piece of paper over the substance on the floor. She started to bend over to pick up the substance, but quickly backed away. The QIDP was observed to use a paper towel to pick up the substance. She then took the towel to the kitchen area. No observation was made of any attempts to clean or	LL244		

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LL244	Continued From page 10	LL244		

sanitize the floor after the substance had been removed.

--6:29 PM, the QIDP was observed to return down the hall to the office area. No staff had been observed to enter the hallway to client #2's bedroom to assist her.

--6:41 PM, a staff member from a sister facility, came in the front door, walked through the facility to the back door. She opened the back door and let in a group of 7 visitors. She stopped by the office area to talk with the QIDP.

--6:45 PM, the staff member then left the facility through the front door. The QIDP remained in the office. No additional staff were in the facility.

--7:28 PM, the QIDP left the office area, came out to the dining area and talked with the visitors.

--7:30 PM, the QIDP returned to the office, leaving the visitors with the clients.

--7:34 PM, the CMA was observed to enter the facility through the front door. The visitors are observed leaving the facility through the back door.

At no time, during the camera feed, was the QIDP observed to go down the hallway to client #2's bedroom to assist her as the QIDP had stated in her interview with the surveyor. At no time was anyone observed to go down the hallway to client #2's bedroom to assist her with cleaning up from the toileting accident.

At 12:45 PM, during the observation of the camera feed, the administrator was asked if the QIDP had provided care to client #2. She stated,

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LL244	Continued From page 11 "No." The administrator stated she had previously watched the camera feed, but apparently had not watched it carefully. She was asked if the failure of care by the QIDP could be considered neglect. She did not answer. The administrator was asked if visitors should have been in the facility with no staff present in the area. She stated she had not watched the entire camera feed, so she had not been aware of the visitors in the facility. She stated a staff member should have been present in the facility with the visitors. The surveyor asked the administrator if allowing the QIDP to continue to work, providing direct care to client #2 after the incident on 05/07/18, had the potential to put the client at continued risk for neglect. She stated, she guessed so.	LL244		
LL811	310:675-7-17.1.(b) INFECTION CONTROL The facility shall maintain a sanitary environment and prevent the development and transmission of infection in the following areas. (1) Food handling practices. (2) Laundry practices including linen handling. (3) Disposal of environmental and resident wastes. (4) Pest control measures. (5) Traffic control for high-risk areas. (6) Visiting rules for high-risk residents. (7) Sources of air-borne infections. (8) Health status of all employees and residents. (9) Isolation area for residents with communicable diseases.	LL811		

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LL811	Continued From page 12	LL811		

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure a sanitary environment in the dining room was provided.

This had the potential to affect all 8 clients who resided in the facility. Findings:

On 05/29/18 at 10:00 AM, the surveyor interviewed client #1. She was asked how she liked living in the facility. She stated things were going pretty well now. The surveyor asked her if there had been any problems in the past. She stated, "Yes." Client #1 stated earlier in the month, client #2 had an accident and feces was left on the floor in the dining room. Client #1 further stated the QIDP had told her to clean up the client #1's feces and to watch other clients while the QIDP worked in the office.

At 10:30 AM, the DON was told of the surveyor's interview with client #1 in which she told the surveyor she had been told by the QIDP to clean up feces and watch other clients. She was asked if she had been made aware of the incident. She stated, "Yes." The DON provided the surveyor with a copy of an e-mail dated 05/08/18, which had been sent to the administrator and the DON. The e-mail documented client #1 had spoken with the assistant administrator on 05/08/18. The e-mail described a situation which had occurred on the evening of 05/07/18. The e-mail

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LL811	Continued From page 13	LL811		

documented client#1 told the assistant administrator she had told by the QIDP to clean up client #2's feces from the floor of the facility as well as to watch two other clients in the facility.

The DON told the surveyor she and the assistant administrator had met with the administrator and watched the camera feed on the 3-11 shift of 05/07/18. She stated the camera feed appeared to show something on the floor under where client #2 was standing. The DON stated the QIDP looked at the floor and at client #2 and left the area. She stated the camera feed showed client #2 using her walker to walk down the hallway to her room. She stated in the camera feed the feces remained on the floor of the facility for over 27 minutes. She stated at that time it appears the QIDP said something to client #1. Client #1 then put on gloves and started to pick up the feces from the floor, but then backed away. The DON stated the QIDP appeared to pick up the substance with a paper towel, but did not clean or disinfect the floor in the area.

At 10:40 AM, the surveyor interviewed the assistant administrator. The assistant administrator told the surveyor of the meeting she had with client #1 on 05/08/18. She described the same information that had been provided to the surveyor by the DON of the feces remaining on the floor of the facility and not being cleaned up for over 27 minutes. She stated client #1 had told her the QIDP had instructed her to clean up the feces and to watch other clients while she worked in the office.

At 10:45 AM, the surveyor interviewed the administrator. She was asked if she had watched the camera feed for 05/07/18. She stated, "Yes." She stated she could not really tell what had

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LL811	Continued From page 14 happened on the camera feed, other than the QIDP looking at something on the floor, leaving the area, remaining out of camera view for over 28 minutes. At 11:00 AM, the QIDP was interviewed. She was asked about the incident which had occurred on 05/07/18. She stated she had been working in the facility as direct care on 05/07/18. She stated she had noticed the feces on the floor below client #2. She further stated she had observed feces running down client #2 legs She stated she instructed client #2 to take a shower. She stated she had been assisting client #2 so she had not had time to clean up the feces from the floor right away. She was asked if she had cleaned and disinfected the area of the feces after she had picked it up. She stated she was not sure. Between 11:30 AM and 2:00 PM the surveyors, administrator and DON watched a recording of the camera feed from 05/07/18. The following was observed on the camera feed: The camera feed showed 2 views of the facility. In one view, the dining area, partial living area, entry into the kitchen and back door are visible. The other view, is of the front door, entry into an office area and the west hallway to the 4 client bedrooms, including client #2's bedroom. --5:44 PM, the camera feed started, several clients are in the dining area, including client #1 and #2. The certified medication aide (CMA) leaves the facility via the front door. The QIDP is the only staff in the facility. --5:51 PM, the QIDP is observed walking down the hallway into an office area.	LL811		

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LL811	Continued From page 15 --5:58 PM, client #1 is observed walking out of the kitchen, she looks down at something on the floor under where client #2 is standing. She is observed to go to the office and say something to the QIDP. --5:59 PM, the QIDP leaves the office area, walks into the dining area, and looks down at the substance on the floor. She says something to client #2 and assists her in getting her walker. --6:00 PM, client #2 is observed using her walker to start down the hallway toward her bedroom. The QIDP is observed to be talking on the telephone as she walks down the hallway to the office. The substance remains on the floor of the dining area. --6:25 PM the QIDP is observed to leave the office area. At this time she is observed to talk with client #1. --6:27 PM, the QIDP is observed to use a paper towel to pick up the substance. She then takes the towel to the kitchen area. No observation was made of any attempts to clean or sanitize the floor after the substance had been removed. --6:29 PM, the QIDP was observed to return down the hall to the office area. --6:41 PM, a CNA #1 comes in the front door, walks through the facility to the back door. She opens the back door and lets in a group of 7 visitors. She stops by the office area to talk with the QIDP. --6:45 PM, the staff member then leaves the facility through the front door. The QIDP remains	LL811		

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LL811	Continued From page 16 in the office. No additional staff are in the facility. --7:30 PM, the QIDP returns to the office, leaving the visitors with the clients. --7:34 PM, the CMA returns to the facility by the front door. The visitors are observed leaving the facility by the back door. During the time the visitors were in the facility, they and the clients were observed to be walking around in the dining room in the area where the substance had been. At no time during the camera feed, was anyone observed to clean or disinfect the area where the substance had been. At 12:45 PM, during the observation of the camera feed, the administrator was asked if area where the substance had been on the floor had been clean and disinfected She stated it did not look like it had been cleaned or disinfected. She was asked if not cleaning or disinfecting the area could be considered an issue with infection control. She stated, "Yes."	LL811		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
37G035	GATESWAY FOUNDATION, INC II

Type of Survey (select all that apply) [A]

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

Extent of Survey (select all that apply) [ ]

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. PP 32615	05/29/2018	05/30/2018	0.00	2.00	9.00	0.00	8.00	16.00
2. PP 35580	05/29/2018	05/30/2018	1.00	0.00	7.00	0.00	3.50	4.00
3.								
4.								
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12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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

JUN 0 8 2018