Oklahoma State Department of Health
Creating a State of Health

May 18, 2018

CCN: 37G148
Survey Event ID: IC4Z11

Ms. Anne Wesenberg-Acker, Administrator
Gatesway Foundation, Inc V
1313 East College
Broken Arrow, OK 74012

Dear Ms. Wesenberg-Acker:

On **May 14, 2018**, agents from our office concluded a complaint investigation at your facility, to determine if your facility was in compliance with Federal requirements for participation in the Medicaid program. The deficiencies identified during this inspection are listed on the enclosed form CMS-2567. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

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 your plan of correction to:

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

If you fail to submit an acceptable plan of correction by the due date, we may recommend termination of your provider agreement to the Oklahoma Health Care Authority [42CFR488.456(b)(1)(ii)].

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/IID 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

If you disagree with the determination of noncompliance, you or your legal representative may request a hearing before an administrative law judge of the Oklahoma State Health Department. Procedures governing this process are set out in 42 CFR §431.151 - 154. You may appeal the finding of noncompliance that led to termination of your Medicaid certification, but not the termination itself. A written request for hearing must be filed no later than 60 days from the date of receipt of this letter. Such written request should be made directly to:

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) 271-5604

A request for a hearing must identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It must also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense).

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

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/kd

Enclosure

Oklahoma State
Department of Health

INVESTIGATIVE REPORT

Facility: **Gatesway Foundation Inc. V**
Address: **1301 East College**
City, State, Zip: **Broken Arrow, Ok. 74012**
Provider #: **37G040**
Complaint #: **OK00051966**
Investigation Date(s): **05/14/18**

ALLEGATION(S)	TAG NUMBERS CITED	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to provide allowable reasons for resident discharges.	W201	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 **05/14/18** at **11:55 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 surveyor to conduct a more thorough investigation.

A sample of clients, including the 2 named clients, was selected based on issues related to the allegations. Due to cognitive status, the named clients were unable to be interviewed. The following regulatory areas were investigated: client protections, abuse/neglect, governing body, healthcare, safety and policy/procedure.

Allegation #1: The facility failed to provide allowable reasons for resident discharges.

Interviews with the administrator, assistant administrator and qualified intellectual disabilities professional were conducted as well as reviews of the sampled clients' records. Statements and documentation indicated the 2 named clients and their legal guardians had previously been issued 30 day discharge notices. The documented reasons for both clients' discharges did not follow regulatory guidelines or the facility's parameters listed in their policy and procedure of allowable reasons for involuntary discharge of a client.

This allegation was substantiated. See W201 in the statement of deficiencies.

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

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:

Interview:

Number of interviews conducted with residents identified in the allegation(s). (If not interviewed, explain why in the description of findings.) **0**

Total number of resident interviews conducted: **1**

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: **3**

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

Nick Hope, RN, Clinical Health Facility Surveyor

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

Pamela Dean, RN, Clinical Health Facility Surveyor

Date report was completed: 05/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37G148	A BUILDING _____ B WING _____	C 05/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATESWAY FOUNDATION, INC V	1313 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 was conducted on 05/14/18 to investigate complaint #OK00051966.	W 000		
W 201	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(4)(i) If a client is to be either transferred or discharged, the facility must have documentation in the client's record that the client was transferred or discharged for good cause. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to follow their policy and procedures for issuing involuntary discharge notices for 2 (#1 and #2) of 2 sampled clients who were given involuntary discharge notices from the facility. No other client was identified by the facility to have received an involuntary discharge notice within the previous year. Findings: Clients #1 and #2 had diagnoses which included intellectual disability. Both clients had legal guardians On 05/14/18 at 12:00 PM, facility records and policy and procedures were reviewed. Facility policy and procedure for active treatment participation requirements documented: "Goal achievements and progress of the resident must be documented; continued lack of progress or non-cooperation must be addressed by the	W 201		

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 201	Continued From page 1	W 201		

Interdisciplinary Team. If no progress is evident, or if a resident continues to refuse to participate in active treatment after three quarterly reviews, the resident's team will convene to amend the Active Treatment Plan to better suit the resident. If all attempts have failed, the resident will be subject to a 30-day notice and either the family or guardian must obtain alternative placement."

A review of clients #1's clinical record revealed the facility and client's guardian had participated in the annual Individual Habilitation Plan (IHP). The IHP listed goals and objectives for active treatment and was dated to have been conducted on 02/22/18.

A review of clients #2's clinical record revealed the facility and client's guardian had participated in the annual IHP. The IHP listed goals and objectives for active treatment and was dated to have been conducted on 02/28/18.

Record review and staff interview identified the facility had issued 30-day involuntary discharge notices to the guardians of both client #1 and #2 on 04/02/18. The reasons for the discharge notices included statements of both clients having met their highest level for potential of active treatment and the facility was unable to provide any further treatment.

At 12:30 PM, the qualified intellectual disabilities professional (QIDP) was asked for any quarterly reviews of client #1's and #2's participation in their active treatment goals and objectives. She stated she did not have a quarterly review for either clients' current IHP because a full quarter had not yet gone by. She was asked for any staff documentation of both clients' participation

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W 201	Continued From page 2	W 201		

towards their goals and objectives. After reviewing the clinical records, she provided the surveyors with log sheets of daily staff documentation on the clients' goals which included the following:

Client #1 had daily goals for:

a. use of adaptive mobility equipment. The staff log sheets had no documentation for 14 days in April and only 3 days of documentation in May.

b. choice of daily clothing. The staff log sheets had no documentation for 20 days in April and only 3 days of documentation in May.

c. bathing objectives. The staff log sheet had no documentation for any days in April and only 3 days of documentation in May.

d. meal times. No documentation for 13 days in April and only 3 days of documentation in May.

e. socialization. The staff log sheet had no documentation for 14 days in April and only 3 days of documentation in May.

No staff documentation for February or March was identified or any other documentation provided of the client's participation towards the goals and objectives since the annual IHP in February 2018.

Client #2 had daily goals for:

a. behaviors at night. The staff log sheet had no documentation for any day in April and only 3 days of documentation in May.

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W 201	Continued From page 3 b. toileting. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. c. socialization. The staff log sheet had no documentation for 24 days in April and only 3 days of documentation in May. d. meal times. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. e. movie watching. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. No staff documentation for February or March was identified or any other documentation provided of the client's participation towards the goals and objectives since the annual IHP in February 2018. At 12:45 PM, the administrator, assistant administrator and the QIDP were interviewed. They were asked if there had been enough time to conduct a quarterly evaluation of client #1's or client #2's participation in their current annual IHPs. They all stated, "No." They were asked if staff had documented completely and accurately on the clients' goals and objectives. They all stated, "No." They were asked if the provided log sheets of staff documentation would be sufficient to determine a level of participation in either of the clients' active treatment plans. They all again stated, "No." The administrator, assistant administrator and the QIDP were shown the facility's policy and procedure for active treatment participation. They	W 201		

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W 201	Continued From page 4 were asked, if according to the facility's policy and procedure for active treatment and the incomplete documentation of the clients' participation on their identified goals, should they have issued the 30-day involuntary notices to the clients and guardians of client #1 or client #2. They all stated, "No."	W 201		

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	NH7258	A BUILDING _____ B WING _____	C 05/14/2018

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LL000	Initial Comments An abbreviated survey was conducted on 05/14/18 to investigate complaint #OK00051966.	LL000		
LL705	310:675-7-4(a) RESIDENT TRANSFER OR DISCHARGE (a) Reasons for transfer or discharge. Involuntary transfer or discharge of a resident may be initiated by a facility only for one or more of the following: (1) Medical reasons, including needs that the facility is unable to meet, as documented by the attending physician, in consultation with the medical director if the medical director and attending physician are not the same person. (2) The resident's safety, or for the safety of other residents, as documented by the clinical record. The facility shall show through medical records that: (A) the resident has had a comprehensive assessment by an interdisciplinary team and alternative measures have been attempted unsuccessfully; or (B) the resident is a danger to himself, herself or other resident as documented by the medical record and the facility is not capable of managing that resident. (3) The non-payment of charges for the resident's care as documented by the facility's business records for services for more than 30 days. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to follow their policy and procedures for issuing involuntary discharge	LL705		

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LL705	Continued From page 1	LL705		

notices for 2 (#1 and #2) of 2 sampled clients who were given involuntary discharge notices from the facility.

No other client was identified by the facility to have received an involuntary discharge notice within the previous year. Findings:

Clients #1 and #2 had diagnoses which included intellectual disability. Both clients had legal guardians.

On 05/14/18 at 12:00 PM, facility records and policy and procedures were reviewed.

Facility policy and procedure for active treatment participation requirements documented:

"Goal achievements and progress of the resident must be documented; continued lack of progress or non-cooperation must be addressed by the Interdisciplinary Team. If no progress is evident, or if a resident continues to refuse to participate in active treatment after three quarterly reviews, the resident's team will convene to amend the Active Treatment Plan to better suit the resident. If all attempts have failed, the resident will be subject to a 30-day notice and either the family or guardian must obtain alternative placement."

A review of clients #1's clinical record revealed the facility and client's guardian had participated in the annual Individual Habilitation Plan (IHP). The IHP listed goals and objectives for active treatment and was dated to have been conducted on 02/22/18.

A review of clients #2's clinical record revealed the facility and client's guardian had participated in the annual IHP. The IHP listed goals and

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LL705	Continued From page 2 objectives for active treatment and was dated to have been conducted on 02/28/18. Record review and staff interview identified the facility had issued 30-day involuntary discharge notices to the guardians of both client #1 and #2 on 04/02/18. The reasons for the discharge notices included statements of both clients having met their highest level for potential of active treatment and the facility was unable to provide any further treatment. At 12:30 PM, the qualified intellectual disabilities professional (QIDP) was asked for any quarterly reviews of client #1's and #2's participation in their active treatment goals and objectives. She stated she did not have a quarterly review for either clients' current IHP because a full quarter had not yet gone by. She was asked for any staff documentation of both clients' participation towards their goals and objectives. After reviewing the clinical records, she provided the surveyors with log sheets of daily staff documentation on the clients' goals which included the following: Client #1 had daily goals for: a. use of adaptive mobility equipment. The staff log sheets had no documentation for 14 days in April and only 3 days of documentation in May. b. choice of daily clothing. The staff log sheets had no documentation for 20 days in April and only 3 days of documentation in May. c. bathing objectives. The staff log sheet had no documentation for any days in April and only 3 days of documentation in May.	LL705		

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LL705	Continued From page 3 d. meal times. No documentation for 13 days in April and only 3 days of documentation in May. e. socialization The staff log sheet had no documentation for 14 days in April and only 3 days of documentation in May. No staff documentation for February or March was identified or any other documentation provided of the client's participation towards the goals and objectives since the annual IHP in February 2018. Client #2 had daily goals for: a. behaviors at night. The staff log sheet had no documentation for any day in April and only 3 days of documentation in May. b. toileting. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. c. socialization. The staff log sheet had no documentation for 24 days in April and only 3 days of documentation in May. d. meal times. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. e. movie watching. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. No staff documentation for February or March was identified or any other documentation provided of the client's participation towards the goals and objectives since the annual IHP in February 2018.	LL705		

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LL705	Continued From page 4 At 12:45 PM, the administrator, assistant administrator and the QIDP were interviewed. They were asked if there had been enough time to conduct a quarterly evaluation of client #1's or client #2's participation in their current annual IHPs. They all stated, "No." They were asked if staff had documented completely and accurately on the clients' goals and objectives. They all stated, "No." They were asked if the provided log sheets of staff documentation would be sufficient to determine a level of participation in either of the clients' active treatment plans. They all again stated, "No." The administrator, assistant administrator and the QIDP were shown the facility's policy and procedure for active treatment participation. They were asked, if according to the facility's policy and procedure for active treatment and the incomplete documentation of the clients' participation on their identified goals, should they have issued the 30-day involuntary notices to the clients and guardians of client #1 or client #2 They all stated, "No."	LL705		

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
37G148	GATESWAY FOUNDATION, INC V

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. 35580	05/14/2018	05/14/2018	0.50	0.00	2.00	0.00	2.00	5.00
2. 32615	05/14/2018	05/14/2018	1.00	0.00	2.00	0.00	4.00	0.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.00

Total RO Supervisory Review Hours.... 0.00

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

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

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

MAY 21 2018

Oklahoma State Department of Health
Creating a State of Health

May 24, 2018

CCN: 37G148
Survey Event ID: IC4Z11

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

Dear Ms. Wesenberg-Acker:

On May 14, 2018, a complaint investigation was completed at your ICF/IID facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **June 25, 2018**. 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.**

We will conduct a revisit at your facility to verify that substantial compliance has been achieved and maintained. If we find that your facility is in substantial compliance with all requirements, we will certify your facility for further participation in the Medicaid program. However, if your facility has failed to achieve substantial compliance, the remedy(ies) will continue until such time as you achieve substantial compliance.

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

Sincerely,
Douglas Wood
For
Kay Determan
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

KD/jm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37G148	A. BUILDING _____ B. WING _____	C 05/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATESWAY FOUNDATION, INC V	1313 EAST COLLEGE BROKEN ARROW, OK 74012

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W 000	INITIAL COMMENTS An abbreviated survey was conducted on 05/14/18 to investigate complaint #OK00051966.	W 000		
W 201	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(4)(i) If a client is to be either transferred or discharged, the facility must have documentation in the client's record that the client was transferred or discharged for good cause. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to follow their policy and procedures for issuing involuntary discharge notices for 2 (#1 and #2) of 2 sampled clients who were given involuntary discharge notices from the facility. No other client was identified by the facility to have received an involuntary discharge notice within the previous year. Findings: Clients #1 and #2 had diagnoses which included intellectual disability. Both clients had legal guardians. On 05/14/18 at 12:00 PM, facility records and policy and procedures were reviewed. Facility policy and procedure for active treatment participation requirements documented: "Goal achievements and progress of the resident must be documented; continued lack of progress or non-cooperation must be addressed by the	W 201		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anne Wesenberg-Glen
TITLE: LNHA
(X6) DATE: 5/23/18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 201	Continued From page 1	W 201		

Interdisciplinary Team. If no progress is evident, or if a resident continues to refuse to participate in active treatment after three quarterly reviews, the resident's team will convene to amend the Active Treatment Plan to better suit the resident. If all attempts have failed, the resident will be subject to a 30-day notice and either the family or guardian must obtain alternative placement."

A review of clients #1's clinical record revealed the facility and client's guardian had participated in the annual Individual Habilitation Plan (IHP). The IHP listed goals and objectives for active treatment and was dated to have been conducted on 02/22/18.

A review of clients #2's clinical record revealed the facility and client's guardian had participated in the annual IHP. The IHP listed goals and objectives for active treatment and was dated to have been conducted on 02/28/18.

Record review and staff interview identified the facility had issued 30-day involuntary discharge notices to the guardians of both client #1 and #2 on 04/02/18. The reasons for the discharge notices included statements of both clients having met their highest level for potential of active treatment and the facility was unable to provide any further treatment.

At 12:30 PM, the qualified intellectual disabilities professional (QIDP) was asked for any quarterly reviews of client #1's and #2's participation in their active treatment goals and objectives. She stated she did not have a quarterly review for either clients' current IHP because a full quarter had not yet gone by. She was asked for any staff documentation of both clients' participation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 201	Continued From page 2 towards their goals and objectives. After reviewing the clinical records, she provided the surveyors with log sheets of daily staff documentation on the clients' goals which included the following: Client #1 had daily goals for: a. use of adaptive mobility equipment. The staff log sheets had no documentation for 14 days in April and only 3 days of documentation in May. b. choice of daily clothing. The staff log sheets had no documentation for 20 days in April and only 3 days of documentation in May. c. bathing objectives. The staff log sheet had no documentation for any days in April and only 3 days of documentation in May. d. meal times. No documentation for 13 days in April and only 3 days of documentation in May. e. socialization. The staff log sheet had no documentation for 14 days in April and only 3 days of documentation in May. No staff documentation for February or March was identified or any other documentation provided of the client's participation towards the goals and objectives since the annual IHP in February 2018. Client #2 had daily goals for: a. behaviors at night. The staff log sheet had no documentation for any day in April and only 3 days of documentation in May.	W 201		

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W 201	Continued From page 3 b. toileting. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. c. socialization. The staff log sheet had no documentation for 24 days in April and only 3 days of documentation in May. d. meal times. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. e. movie watching. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. No staff documentation for February or March was identified or any other documentation provided of the client's participation towards the goals and objectives since the annual IHP in February 2018. At 12:45 PM, the administrator, assistant administrator and the QIDP were interviewed. They were asked if there had been enough time to conduct a quarterly evaluation of client #1's or client #2's participation in their current annual IHPs. They all stated, "No." They were asked if staff had documented completely and accurately on the clients' goals and objectives. They all stated, "No." They were asked if the provided log sheets of staff documentation would be sufficient to determine a level of participation in either of the clients' active treatment plans. They all again stated, "No." The administrator, assistant administrator and the QIDP were shown the facility's policy and procedure for active treatment participation. They	W 201		

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W 201	Continued From page 4 were asked, if according to the facility's policy and procedure for active treatment and the incomplete documentation of the clients' participation on their identified goals, should they have issued the 30-day involuntary notices to the clients and guardians of client #1 or client #2. They all stated, "No."	W 201		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH7258	A. BUILDING _____ B. WING _____	C 05/14/2018

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GATESWAY FOUNDATION, INC V	1313 EAST COLLEGE BROKEN ARROW, OK 74012

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LL000	Initial Comments An abbreviated survey was conducted on 05/14/18 to investigate complaint #OK00051966.	LL000		
LL705	310:675-7-4(a) RESIDENT TRANSFER OR DISCHARGE (a) Reasons for transfer or discharge. Involuntary transfer or discharge of a resident may be initiated by a facility only for one or more of the following: (1) Medical reasons, including needs that the facility is unable to meet, as documented by the attending physician, in consultation with the medical director if the medical director and attending physician are not the same person. (2) The resident's safety, or for the safety of other residents, as documented by the clinical record. The facility shall show through medical records that: (A) the resident has had a comprehensive assessment by an interdisciplinary team and alternative measures have been attempted unsuccessfully; or (B) the resident is a danger to himself, herself or other resident as documented by the medical record and the facility is not capable of managing that resident. (3) The non-payment of charges for the resident's care as documented by the facility's business records for services for more than 30 days. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to follow their policy and procedures for issuing involuntary discharge	LL705		

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LL705	Continued From page 1 notices for 2 (#1 and #2) of 2 sampled clients who were given involuntary discharge notices from the facility. No other client was identified by the facility to have received an involuntary discharge notice within the previous year. Findings: Clients #1 and #2 had diagnoses which included intellectual disability. Both clients had legal guardians. On 05/14/18 at 12:00 PM, facility records and policy and procedures were reviewed. Facility policy and procedure for active treatment participation requirements documented: "Goal achievements and progress of the resident must be documented; continued lack of progress or non-cooperation must be addressed by the Interdisciplinary Team. If no progress is evident, or if a resident continues to refuse to participate in active treatment after three quarterly reviews, the resident's team will convene to amend the Active Treatment Plan to better suit the resident. If all attempts have failed, the resident will be subject to a 30-day notice and either the family or guardian must obtain alternative placement." A review of clients #1's clinical record revealed the facility and client's guardian had participated in the annual Individual Habilitation Plan (IHP). The IHP listed goals and objectives for active treatment and was dated to have been conducted on 02/22/18. A review of clients #2's clinical record revealed the facility and client's guardian had participated in the annual IHP. The IHP listed goals and	LL705		

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LL705	Continued From page 2 objectives for active treatment and was dated to have been conducted on 02/28/18. Record review and staff interview identified the facility had issued 30-day involuntary discharge notices to the guardians of both client #1 and #2 on 04/02/18. The reasons for the discharge notices included statements of both clients having met their highest level for potential of active treatment and the facility was unable to provide any further treatment. At 12:30 PM, the qualified intellectual disabilities professional (QIDP) was asked for any quarterly reviews of client #1's and #2's participation in their active treatment goals and objectives. She stated she did not have a quarterly review for either clients' current IHP because a full quarter had not yet gone by. She was asked for any staff documentation of both clients' participation towards their goals and objectives. After reviewing the clinical records, she provided the surveyors with log sheets of daily staff documentation on the clients' goals which included the following: Client #1 had daily goals for: a. use of adaptive mobility equipment. The staff log sheets had no documentation for 14 days in April and only 3 days of documentation in May. b. choice of daily clothing. The staff log sheets had no documentation for 20 days in April and only 3 days of documentation in May. c. bathing objectives. The staff log sheet had no documentation for any days in April and only 3 days of documentation in May.	LL705		

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LL705	Continued From page 3 d. meal times. No documentation for 13 days in April and only 3 days of documentation in May. e. socialization. The staff log sheet had no documentation for 14 days in April and only 3 days of documentation in May. No staff documentation for February or March was identified or any other documentation provided of the client's participation towards the goals and objectives since the annual IHP in February 2018. Client #2 had daily goals for: a. behaviors at night. The staff log sheet had no documentation for any day in April and only 3 days of documentation in May. b. toileting. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. c. socialization. The staff log sheet had no documentation for 24 days in April and only 3 days of documentation in May. d. meal times. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. e. movie watching. The staff log sheet had no documentation for 23 days in April and only 3 days of documentation in May. No staff documentation for February or March was identified or any other documentation provided of the client's participation towards the goals and objectives since the annual IHP in February 2018.	LL705		

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Plan of Correction
Gatesway Foundation Inc V
Survey Event ID IC4Z11
May 14, 2018
Completion Date: June 25, 2018

LL705: Resident Transfer or Discharge
W 201: Admissions, Transfers, Discharge

How will the facility has or intends to correct each deficiency.
No involuntary discharge notices for failure to participate in active treatment will be given to a client/family/ guardian without the proper documentation showing that the client is unable to continue to participate in our program as outlined in our active treatment policy.

How the facility will identify other residents having the potential to be affected by the same deficient practice.
Goals will be reviewed at each quarterly review and if they have not been met after a maximum of nine (9) months the IDT will meet to amend the Active Treatment Plan to better suit the Client. If all attempts fail, the Client will be subject to a 30 day notice.

What measures will be put into place or what systemic changes will be made to ensure the deficient practice will not occur.
All staff will be in serviced on the importance of maintaining complete and accurate clinical records, goal sheets and client specific documentation. QIDP's will be in-serviced on proper initial IHP and BMP completion and quarterly and annual reviews.

How will the facility monitor its corrective actions to ensure that the deficient practices are being corrected and will not reoccur?
Administration and the QIDP's will monitor the client's records to ensure they are complete and accurate and goal specific to each client.

MAY 24 2018