

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

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



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 <u>05/14/18</u> at <u>11:55 AM</u>. 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.

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Will referrals be made to another agency by this Department?
ords that were reviewed in conjunction with the complaint.)
Medication Administration Records Facility Incident Reports ADL (Activities of Daily Living) Flow Sheets Hospital Records Physician Progress Notes Physician Orders Nurses Notes Dietary Notes Laboratory and X-Ray Reports Social Services Reports Activities Reports Treatment Sheets Pharmacy Records Meal Intake Records Weight Records Skin Assessments Assessment & Care Plan Records (Care Plan and MDS) Therapy and/or Ancillary Services Records Resident Council Minutes Health Care Authority Staffing Reports Personnel Records/Background Check, etc. Staff Time Sheets, Schedules, etc. Facility In-Service Records Medical Examiner Reports Ambulance Records Death Certificate Facility Investigation Reports Facility Policy and Procedure Manual Current Credentials of licensed, registered, or certified personnel and/or consultants Facility Admission/ transfer records Other:
Other: conducted with residents identified in the allegation(s). (If not interviewed, explain why dings.) other other: Other: Conducted with residents identified in the allegation(s). (If not interviewed, explain why dings.) Other: Other:

Yes	No N/A	W	as the complainant interviewed?				
Yes 🛛	No 🗌	Was the	complaint based on entity reported incident or anonymous complaint?				
In the event following: Yes Yes Yes Yes Yes Yes Yes Yes	of a serious in No N/A No N/A No N/A No N/A	⊠ En ⊠ Po ⊠ Fu	n unexpected death, were interviews conducted with any or all of the mergency Personnel blice Officers uneral Home Personnel ther				
Observation	ns:						
Yes Yes Yes Yes Yes Yes Wound Medica Dietary Persona Dignity Restora	ation Pass V Issues	Wo Wo inv	ere sampled residents selected based on the allegations? For residents identified in the allegation(s) present at the facility during the evestigation? The event of injury, was the area of injury observed? For residents identified in the allegation(s) present at the facility during the evestigation? The event of injury, was the area of injury observed? For sampled residents in the allegations? The event of injury, was the area of injury observed? For sampled residents in the allegations? For sampled residents in the facility during the event in the				
1							
Nick Hope,	RN, Clinical	Health Fa	acility Surveyor				
Name(s) of	any additiona	al surveyo	or(s) who participated in the investigation of this complaint:				
Pamela Dea	an, RN, Clinic	eal Health	Facility Surveyor				
Date report	Date report was completed: 05/16/18						

PRINTED: 05/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED				
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W 201	O5/14/18 to investig ADMISSIONS, TRA CFR(s): 483.440(b)	rvey was conducted on gate complaint #OK00051966. ANSFERS, DISCHARGE b(4)(i) Ither transferred or discharged, we documentation in the	W 2	01			
		the client was transferred or					
	Based on record red determined the faci and procedures for notices for 2 (#1 an	s not met as evidenced by: eview and interview, it was lity failed to follow their policy issuing involuntary discharge d #2) of 2 sampled clients oluntary discharge notices				ļ	
		identified by the facility to voluntary discharge notice year. Findings:					
		ad diagnoses which included /. Both clients had legal					
	On 05/14/18 at 12:0 policy and procedure	00 PM, facility records and res were reviewed.					
		procedure for active treatment ements documented:					
	must be documente	s and progress of the resident ed; continued lack of progress must be addressed by the					
ABODATOD	A DIBECTOR'S OB BBOVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	***************************************		(6) 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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	determined the faci and procedures for	view and interview, it was lity failed to follow their policy issuing involuntary discharge				
Oklahoma S	tate Department of Health					

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
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		nad diagnoses which included y. Both clients had legal				
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		procedure for active treatment ements documented:				
	must be documented or non-cooperation. Interdisciplinary Teator if a resident contain active treatment at the resident's team. Active Treatment Plif all attempts have subject to a 30-day guardian must obtain	s and progress of the resident ed; continued lack of progress must be addressed by the am. If no progress is evident, tinues to refuse to participate after three quarterly reviews, will convene to amend the lan to better suit the resident. failed, the resident will be notice and either the family or ain alternative placement."				
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
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Oklahoma State Department of Health STATE FORM

Oklahoma State Department of Health
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		ht. The staff log sheet had no any day in April and only 3 tion in May.				
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	was identified or an provided of the clie	ation for February or March y other documentation nt's participation towards the s since the annual IHP in			:	

Oklahoma State Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		` ′	E CONSTRUCTION	(X3) DATE COMP	
	NH7258		B WING		05/1) 4/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	, , , , , , ,	
GATESW	VAY FOUNDATION, IN	C V	T COLLEGE ARROW, OK			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
LL705	At 12:45 PM, the adadministrator and the They were asked if to conduct a quarter client #2's participa IHPs. They all states staff had document on the clients' goals stated, "No." They sheets of staff documents of determine a leventh of the clients' active the clients' active the clients active th	dministrator, assistant ne QIDP were interviewed. there had been enough time orly evaluation of client #1's or tion in their current annual ed, "No." They were asked if red completely and accurately and objectives. They all were asked if the provided logumentation would be sufficient I of participation in either of eatment plans. They all again assistant administrator and the the facility's policy and treatment participation. They arding to the facility's policy and treatment and the				
	incomplete docume participation on the have issued the 30-	entation of the clients' ir identified goals, should they -day involuntary notices to the ns of client #1 or client #2				

Oklahoma State Department of Health STATE FORM

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207, or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503

Provider/Supplier Number 37G148	Provider/Supplier Name GATESWAY FOUNDATION, INC V					
Type of Survey (select all that apply)	A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit M Other	E Initial Certification F Inspection of Care G Validation H Life Safety Code	I J K L	Recertification Sanctions/Hearing State License CHOW		
Extent of Survey (select all that apply)	A Routine/Standard Survey (all B Extended Survey (HHA or Lo C Partial Extended Survey (HH D Other Survey	ong Term Care Facility)				

SURVEY TEAM AND WORKLOAD DATA

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

	Surveyo	r 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 Lea	ader ID								
h_{C}	1.	35580	05/14/2018	05/14/2018	0.50	0.00	2.00	0.00	2.00	5.00
η ης	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 2 1 2018 Am

FORM CMS-670 (12-91)

102000

EventID. IC4Z11

Facility ID. NH7258

Page

age



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, DOUNS WADD)

1 DAO

Kay Determan Long Term Care Enforcement Reviewer Oklahoma State Department of Health

KD/jm

Board of Health





FORM APPROVED OMB NO. 0938-0391

PRINTED: 05/18/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE	SURVEY PLETED
			A. BUILD	ING			С
		37G148	B. WING	B. WING		05	/14/2018
	ROVIDER OR SUPPLIER NY FOUNDATION, INC V			1313	EET ADDRESS, CITY, STATE, ZIP CODE EAST COLLEGE DKEN ARROW, OK 74012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	 INITIAL COMMENTS 		W	000			
W 201	_	te complaint #OK00051966. ISFERS, DISCHARGE	w	201			
	the facility must have	er transferred or discharged, documentation in the e client was transferred or cause.					
	Based on record revi determined the facility and procedures for is notices for 2 (#1 and	not met as evidenced by: liew and interview, it was y failed to follow their policy suing involuntary discharge #2) of 2 sampled clients untary discharge notices					
		dentified by the facility to bluntary discharge notice ear. Findings:					
	1	d diagnoses which included Both clients had legal				•	
	On 05/14/18 at 12:00 policy and procedure	PM, facility records and s were reviewed.					
	Facility policy and pro participation requirem	ocedure for active treatment nents documented:					
	must be documented	and progress of the resident ; continued lack of progress nust be addressed by the					
LABORATORY	DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATUR	Ξ		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.

LNHA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILD		(X3) DATE SURVEY COMPLETED		
		37G148	B. WING				C 14/2018
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 05/	14/2010
				1	313 EAST COLLEGE		
GATESWA	GATESWAY FOUNDATION, INC V			E	BROKEN ARROW, OK 74012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE *
W 201	Interdisciplinary Team or if a resident continuin active treatment affithe resident's team what in active Treatment Plan If all attempts have fasubject to a 30-day noguardian must obtain. A review of clients #1 the facility and client's in the annual Individual The IHP listed goals a treatment and was doon 02/22/18. A review of clients #2 the facility and client's in the annual IHP. The objectives for active the have been conducted. Record review and standing to 14/02/18. The reactive to the guardian on 04/02/18. The reactive treatment and the facility had issued 30 notices to the guardian on 04/02/18. The reactive treatment and the facility had issued 30 notices to the guardian on 04/02/18. The reactive treatment and the facility had issued 30 notices included statement and the facility had issued 30 notices to the guardian of 04/02/18. The reactive treatment and the facility had issued 30 notices included statement and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices included statement and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facility had issued 30 notices to the guardian treatment and the facili	n. If no progress is evident, ues to refuse to participate ter three quarterly reviews, ill convene to amend the not better suit the resident. It is to better suit the resident will be otice and either the family or alternative placement." 's clinical record revealed as guardian had participated all Habilitation Plan (IHP), and objectives for active atted to have been conducted. It is clinical record revealed as guardian had participated atted to have been conducted. It is clinical record revealed as guardian had participated as gu	W	201			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/18/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

(X3) DATE SURVEY COMPLETED

С 37G148 B. WNG 05/14/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1313 EAST COLLEGE GATESWAY FOUNDATION, INC V **BROKEN ARROW, OK 74012** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 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:

days of documentation in May.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		37G148	B. WING			C 5/14/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 1313 EAST COLLEGE BROKEN ARROW, OK 74012	IP CODE	3/14/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
W 201	days of documentation c. socialization. The documentation for 24 days of documentation d. meal times. The sedocumentation for 23 days of documentation for 23 days of documentation for 23 days of documentation. No staff documentation was identified or any provided of the client' goals and objectives: February 2018. At 12:45 PM, the adm administrator and the They were asked if the to conduct a quarterly client #2's participation in the clients' goals a stated, "No." They we sheets of staff document of the clients' active treat stated, "No." The administrator, as	flog sheet had no days in April and only 3 in in May. staff log sheet had no days in April and only 3 in in May. staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May. The staff log sheet had no days in April and only 3 in in May.	W	201			
	QIDP were shown the procedure for active t	e facility's policy and reatment participation. They					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	_	(X3) DATE SURVEY COMPLETED	
		37G148	B. WING	B. WNG		C 05/14/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 1313 EAST COLLEGE BROKEN ARROW, OK			<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORR	E'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) MPLETION DATE
W 201	procedure for active to incomplete document participation on their have issued the 30-d	ling to the facility's policy and treatment and the tation of the clients' identified goals, should they ay involuntary notices to the of client #1 or client #2.	w	201			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	NH7258		B. WING		05/4) 4/2018
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 03/1	4/2010
GATESWA	AY FOUNDATION, INC V	1313 EAST BROKEN A	COLLEGE RROW, OK 7	4012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S, PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
LL000	Initial Comments		LL000			
	An abbreviated surve 05/14/18 to investigat	y was conducted on e complaint #OK00051966.				
LL705	310:675-7-4(a) RESII DISCHARGE	DENT TRANSFER OR	LL705			
	may be initiated by a of the following: (1) Medical reasons, if facility is unable to me attending physician, if medical director if the attending physician a (2) The resident's safteresidents, as docume The facility shall show that: (A) the resident has he assessment by an internative measures	r discharge of a resident facility only for one or more including needs that the eet, as documented by the n consultation with the medical director and re not the same person. eety, or for the safety of other inted by the clinical record. In the through medical records and a comprehensive erdisciplinary team and				
	other resident as doc record and the facility that resident. (3) The non-payment	ranger to himself, herself or umented by the medical is not capable of managing of charges for the resident's by the facility's business or 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					

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE LN4A

5/23/18

STATE FORM

6899

IC4Z11

continuation sheet 1 of 5

FORM APPROVED Oklahoma State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING. C NH7258 B. WING 05/14/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1313 EAST COLLEGE GATESWAY FOUNDATION, INC V **BROKEN ARROW, OK 74012** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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.

Oklahoma State Department of Health

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

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	ETED
			_			
		NH7258	B. WNG		054	
		N117230			05/1	4/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CATESINA	Y FOUNDATION, INC V	1313 EAST	COLLEGE			
GHIESWA	A FOUNDATION, INC V	BROKEN A	RROW, OK 7	4012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE.	(X5) COMPLETE DATE
LL705	Continued From page	2	LL705			
LLIOU	_		LLYGG			
	objectives for active to have been conducted	reatment and was dated to I on 02/28/18.				
		aff interview identified the				
		day involuntary discharge and #2				
	_	isons for the discharge				
		ements of both clients having				
		for potential of active				
		ility was unable to provide				
	any further treatment.					
	At 12:30 PM, the qual	lified intellectual disabilities				
		vas asked for any quarterly				
		and #2's participation in				
		goals and objectives. She				
		ve a quarterly review for IHP because a full quarter				
		She was asked for any staff				
	documentation of both					
	towards their goals ar					
		records, she provided the				
	surveyors with log she					
	documentation on the	_				
	included the following	·				
	Client #1 had daily go	pals for:				
	a. use of adaptive mo	obility equipment. The staff				
		cumentation for 14 days in				
	April and only 3 days	of documentation in May.	:			
	h abaian ef delle elet	thing. The staff less treats				
		thing. The staff log sheets n for 20 days in April and				
	only 3 days of docum					
		. The staff log sheet had no				
		y days in April and only 3				
	days of documentatio	on in May.				
	1		1			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	EIED
				- · · ·		
	NH7258		B. WING		05/1	14/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GATESWA	Y FOUNDATION, INC V	1313 EAST				
	·		RROW, OK 7			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
LL705	Continued From page	3	LL705			
	April and only 3 days	ocumentation for 13 days in of documentation in May.				
		days in April and only 3				
	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 go	pals for:				:
		. The staff log sheet had no y day in April and only 3 on in May.				
	b. toileting. The staf documentation for 23 days of documentation	days in April and only 3				
		staff log sheet had no days in April and only 3 on 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.					
		The staff log sheet had no days in April and only 3 on in May.				
	was identified or any provided of the client	on for February or March other documentation 's participation towards the since the annual IHP in				

STATE FORM

PRINTED: 05/18/2018 **FORM APPROVED** Oklahoma State Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING NH7258 05/14/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1313 EAST COLLEGE **GATESWAY FOUNDATION, INC V BROKEN ARROW, OK 74012** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL) PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY LL705 Continued From page 4 LL705 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."

Oklahoma State Department of Health

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 2 4 2018 m