Oklahoma State Department of Health
Creating a State of Health

July 15, 2019

License Number: AL7238

Ms. Danna Wise, Administrator
Autumn Leaves Of Tulsa
7807 S Mingo Rd
Tulsa, OK 74133

Survey Event ID: CL2H11

Dear Ms. Wise:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **June 17, 2019**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Autumn Leaves of Tulsa**
Address: **7807 S. Mingo RD**
City, State, Zip: **Tulsa, OK, 74133**
Provider #: **AL7238**
Complaint #: **OK53467**
Investigation Date(s): **06/14/19 and 06/17/19**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to ensure food was prepared and served in a sanitary manner.	US

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

An unannounced on-site investigation was initiated on Friday, June 14, 2019 at 2:00 p.m.

The center is a memory care facility. No residents were named in the complaint.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

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

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

On entry of the center a tour was conducted with the assistance of the administrator (ADM). A tour of the kitchen was done at that time. The floor was observed to be clean as was the counters and refrigerators. The food was stored with labels and dates on each item. The dates on the items labeled was current and within the time frame per regulation. No pureed food was found saved in the refrigerator at the time of this survey/observation.

Staff was interviewed including the dietary manager and asked about any pureed foods being reused. She said they puree fresh food for each meal served. The cook was interviewed and asked if they reused pureed food from lunch for dinner. She said they only pureed enough servings for the residents that required puree diet for each meal. They do not use the pureed meal from lunch for a resident's dinner. Each meal was pureed using the menu from the meal being served. She said they will keep potatoes, noodles, rice and bread to use in the puree foods to supplement instead of water or supplement mix for texture.

Multiple interviews with staff were conducted. No staff had complaints related to food or cleanliness of the kitchen. No family member was available at the center at the time of the survey. The ADM said she had not received any complaints from staff, residents, or family members related to the kitchen cleanliness or food.

Determination Summary and Follow-Up Action:
Deficient practice was unsubstantiated for allegation 1. No further action is required.

A determination that an allegation was unsubstantiated (**US**) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Justina Leach RN/CHFS

Date report completed: 06/20/2019

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
	AL7238	A. BUILDING: _____ B. WING _____	06/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LEAVES OF TULSA	7807 S MINGO RD TULSA, OK 74133

(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
C 000	INITIAL COMMENTS An abbreviated survey was conducted to investigate complaint #OK53467. The census was24. No deficient practice was cited.	C 000		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL7238	AUTUMN LEAVES OF TULSA

Type of Survey (select all that apply)

3								

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				

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. 32488	06/14/2019	06/17/2019	0.50	0.00	1.25	0.00	4.00	4.00
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3.								
4.								
5.								
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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**

JUL 16 2019