



Delivery via email to: Glee@CovLiving.org

May 27, 2021

License Number: CC1902AL

Mr. Rickey Lee, Administrator
Covenant Living At Inverness
3800 West 71st Street South
Tulsa, OK 74132

Survey Event ID: Q67K11

Dear Mr. Lee:

On **May 6, 2021**, representatives from the Oklahoma State Department of Health (OSDH) concluded Covid-19 Focused infection control survey along in conjunction with a complaint survey at your center. The deficiencies found during the survey are identified on the enclosed STATE FORM.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Based on no actual harm being identified, we will not recommend to the Office of General Counsel of OSDH that remedies be imposed at this time. Your facility will be given an opportunity to correct deficiencies. If upon revisit your facility has not corrected the deficiencies, imposition of remedies will be recommended to the Office of General Counsel of OSDH.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template. Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action will be completed for each violation; and
- (6) Be signed by the administrator.



Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, 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 833AL). 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) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406



Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Covenant Living at Inverness
Address: 3800 West 71st Street South
City, State, Zip: Tulsa Ok 74132
Provider #: CC1902AL
Complaint #: OK00056953
Investigation Date(s): 05/04/21 through 05/06/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to follow their policy to protect and ensure the residents are free from sexual exploitation.	S

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

An unannounced on-site investigation was initiated on 05/04/2021 at 4:24 p.m.

A sample of five residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1512 and C1914 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink that reads "Billie Seeman". The signature is written in a cursive style with a horizontal line underneath it.

Billie Seeman, RN Clinical Health Facility Surveyor

Date report completed: 05/07/2021

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Covenant Living at Inverness
Address: 3800 West 71st Street South
City, State, Zip: Tulsa Ok 74132
Provider #: CC1902AL
Complaint #: OK00056981
Investigation Date(s): 05/04/21 through 05/06/21

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to administer medications as ordered.	S
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☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 05/04/2021 at 4:24 p.m.

A sample of three residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegation.

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 substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 and C1920 and 1951 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Thank you for bringing these concerns to our attention.

A handwritten signature in black ink, appearing to read "Billie Seeman", written over a horizontal line.

Billie Seeman, RN, Clinical Health Facility Surveyor

Date report completed: 05/10/2021

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CC1902AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/06/2021
NAME OF PROVIDER OR SUPPLIER COVENANT LIVING AT INVERNESS		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 WEST 71ST STREET SOUTH TULSA, OK 74132		
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C 000	INITIAL COMMENTS On 05/04/21 through 05/06/21, the Oklahoma State Department of Health completed a COVID-19 Focused Survey to determine if the facility was in compliance with implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. Complaint #OK00056953 and #OK00056981 were investigated in conjunction with this survey. Total residents: 35	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

Oklahoma State Department of Health

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

TITLE

(X6) DATE

Oklahoma State Department of Health

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C1505	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure medication was administered as ordered by the physician for one (#3) of three sampled residents whose records were reviewed for medication administration. The facility identified 35 residents who resided in the center. Findings: Resident #3 was admitted to the facility with diagnoses which included seasonal allergies and dementia. A physician's order, dated 01/28/21, documented to administer Flonase two sprays in each nostril daily as needed for allergies. An annual assessment, dated 02/19/21, documented the resident was oriented to self only, was forgetful, and had poor judgment. The service plan, dated 02/19/21, documented the resident was not responsible for ordering her	C1505		

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C1505	Continued From page 2 medication and did not self administer her medication. The medication administration records (MAR), dated 01/2021, 02/2021 and 03/2021, revealed Flonase was not on the MAR to be administered as needed and was not administered as needed 01/29/21 through 03/31/21. On 05/06/21 at 11:50 a.m., licensed practical nurse (LPN) #1 was asked if the Flonase was administered to the resident in January, February, or March 2021. She stated no, it had not been administered because it had not been transcribed to the MAR to be administered.	C1505		
C1512 SS=E	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set	C1512		

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C1512	Continued From page 3 forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to: ~ensure a cognitively impaired resident was	C1512		

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C1512	Continued From page 4 protected from sexual abuse for one (#3) of one sampled residents whose records were reviewed for sexual abuse allegations; ~ensure an allegation of abuse was thoroughly investigated for two (#3 and #6) of five sampled residents whose records were reviewed for an allegation of abuse; and ~provide the resident protection during an investigation of an allegation of abuse for two (#3 and #6) of five sampled residents whose records were reviewed for abuse. This had the potential to affect all 35 residents who resided in the facility. A facility policy titled, "Abuse, Fraud, and Wrongdoing", documented, "...The Assisted Living Director will investigate any reports of abuse, fraud, or other wrongdoing...If a report of abuse, fraud, or other wrongdoing is received...The Assisted Living Director is notified immediately...Any urgent medical or safety issues are addressed immediately...The Assisted Living Director or other designated representative initiates and [sic] investigation..." 1. Resident #3 was admitted to the facility with diagnoses which included dementia. An annual assessment, dated 02/19/21, documented the resident was oriented to self, forgetful and had poor judgment. The assessment documented the resident had fair strength, mobility and gait, and required one person assistance with bathing and dressing. A Short Portable Mental Status Questionnaire (SPMSQ), dated 02/19/21, documented the	C1512		

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C1512	Continued From page 5 resident was severely intellectually impaired. A hand written note, dated 04/06/21, documented a conversation with resident #3 concerning her relationship with resident #4. The note documented resident #4 was just a friend and she did not mind him kissing her. The note documented the resident was asked if she wanted to have a sexual relationship with resident #4. The resident stated she would have to wait and see. A handwritten note, dated 04/06/21, documented a call had been made to the family of resident #3 concerning resident #4. The note documented the power of attorney for resident #3 did not want resident #4 in the apartment with resident #3 alone. A typed note located in the front of the activities of daily living book, dated 04/09/21, documented, "Per family's request, please make sure [resident #3 and resident #4] are not in each other's apartments visiting each other. They can visit with each other out in the open." The note was signed by the assisted living director. The facility did not provide documentation resident #3 had been monitored to ensure resident #4 was not in her room. The service plan for resident #3 did not document she required increased monitoring to ensure she was not alone with a male resident in her room or his room. An Oklahoma State Department of Health (OSDH) incident report, dated 04/19/21, documented Resident #4 was found in resident #3's bed naked with resident #3 naked from the waist down on 04/16/21, after resident #4 had	C1512		

Oklahoma State Department of Health

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C1512	Continued From page 6 been notified multiple times a day, he was not to be in resident #3's apartment. The report also documented the POA felt like the resident could be taken advantage of and felt like the resident did not have the cognition to be a consenting adult. The report documented the center would continuously monitor resident #4's activity. A typed note, signed by the healthcare scheduler, dated 04/20/2021, documented, "To whom it may concern: On Friday April 7, 2021 (The assisted living director stated the correct date of the incident was 04/16/21) at approximately 1:45 p.m. I witnessed [resident #4], a resident of Covenant Living at Inverness/Redbud Court Assisted Living laying on top of the bed of [resident #3]. [Resident #3] is also a resident of Covenant Living. [Resident #4] was completely naked, laying on his side with his back to me, and [resident #3] was laying on her back, naked from the waist down. I was trying to locate [resident #4] for the medication aide who was trying to administer medication to the residents during the afternoon med pass. [Resident #4] was not in his room, nor was he anywhere in the public areas of the campus. I knocked loudly on [resident #3's] door and announced myself before I entered the room. Upon seeing the two naked in bed, I told [resident #4] he needed to get up, get dressed and leave [resident #3's] apartment. The two were laying on top of the bed, and the bed was still made, so they were not under the sheets. I could only see [resident #4's] back side when I entered the room. I could see all of [resident #3], as she was laying on her back. I promptly left the apartment	C1512		

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C1512	Continued From page 7 after I told [resident #4] he had to leave, so I do not know the condition of the bedspread or sheets after they got up. [Resident #4] and [resident #3] both got up and got dressed and came out of her apartment together. It took several minutes for them both to get dressed, and I did go into the room one more time before they were fully dressed to check and make sure they were not still in bed. Before I found them in [resident #3's] room, I was at the front of the facility, away from my desk helping get other residents to the main lobby to board a bus. The aide on duty was at lunch. By the time I got back to my desk and it was discovered that [resident #4] was not in his room, about 20-25 minutes had passed. The above statements are true to the best of my recollection..." A nurse's progress note for resident #3, dated 04/20/21, documented, "...This Nurse assessed Resident this day for physical injuries such as skin tearing, scratches, bruising that may or may not of occurred to her during an encounter of sexual nature in her room with a male Resident on Friday April the 16th 2021 during the early afternoon hours. This Nurse had a witness present during assessment with Resident's permission to do so. No evidence of physical trauma observed. This Nurse reported clinical findings to AL (assisted living director)...Resident does not appear to be in any visible distress and is not able to recall said encounter." A physician visit note for resident #3, dated 04/28/21, documented the resident had severe dementia, had a score of three on the	C1512		

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C1512	Continued From page 8 mini-mental state examination (MMSE) (A score of 0-17 indicated severe cognitive impairment.) and was not able to consent to a physical relationship. 2. Resident #4 was admitted to the facility with diagnoses which included Alzheimer's disease and dementia. A preadmission assessment, dated 07/02/2020, documented the resident was alert, forgetful, and had fair judgment. The assessment documented the resident had fair mobility, gait, and strength and ambulated with a cane. An interdisciplinary communication sheet to the physician, dated 04/20/21, documented the resident had been very aggressive with sexual tendencies towards female residents and requested orders to decrease the behaviors. A nurse progress note, dated 04/21/21, documented the resident's physician had seen the resident and made a referral to a psychiatrist due to increased sexual libido. A nurse progress note, dated 04/26/21, documented the psychiatrist had seen the resident and the psychiatrist had contacted the resident's physician with recommendations for treatment. The facility did not provide documentation which indicated resident #4 had been monitored to ensure he was not in resident #3's apartment from 04/07/21 to 05/04/21. The service plan for resident #4 was not updated to include sexual behaviors or interventions. The service plan did not reveal the resident required increased monitoring to ensure he was not alone behind	C1512		

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C1512	Continued From page 9 closed doors with resident #3. On 05/05/21 at 11:23 a.m., the assisted living director was asked what the relationship was between resident #3 and resident #4. She stated resident #4 used to walk resident #3 to her room after meals. She stated the door to resident #3's room was closed and staff entered and found resident #4 kissing resident #3 on 04/06/21. She stated she called the family of resident #3 and they did not want her to have men in her room due to her decline in cognition. She was asked if she had documented the incident. She provided a hand written note which documented the phone call to resident #3's family and a note which documented an interview was conducted with resident #3 on 04/06/21. The facility did not provide any other documentation of an investigation of the incident. She then stated after that encounter resident #4 was found in resident #3's apartment naked lying on resident #4's bed with resident #3 naked from the waist down. She was asked what interventions were put in place to protect the residents. She stated a sign was posted on resident #4's apartment door to remind him not to enter female resident rooms. She stated the staff had monitored him closely when he was out of his room and he had been put on medication to decrease sexual libido. At 12:16 p.m., certified medication aide (CMA) #2 was asked how often resident #4 was monitored. She stated we do a visual check every thirty minutes. She was asked for documentation of the monitoring. She provided one form dated 05/05/21. She stated she was told by licensed practical nurse (LPN) #2 to start documenting on	C1512		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CC1902AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/06/2021
NAME OF PROVIDER OR SUPPLIER COVENANT LIVING AT INVERNESS		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 WEST 71ST STREET SOUTH TULSA, OK 74132		
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C1512	Continued From page 10 the form today 05/05/21. At 12:22 p.m., the assisted living director observed resident #4's apartment. The note was not hanging on the door and the note was not found in his apartment. The frequent monitoring documentation for 04/07/21 through 05/04/21 was not located in the activities of daily living book or in resident #4's clinical record. At 2:01 p.m., certified nurse aide (CNA) #3 was asked about resident #3's cognition. She stated resident #3 was confused and had dementia. She was asked if resident #4 was monitored. She stated she re-directed him many times out of resident #3's apartment. She stated, "I tried to keep an eye on him." At 2:57 p.m., CMA #7 was asked how often resident #4 was provided visual checks. She stated she was doing every hour visual checks because the resident was found naked in a female residents apartment. She stated she was informed today to do every thirty minute visual checks and document the checks on a visual check monitoring form. On 05/06/21 at 4:12 p.m., the family member of resident #3 was asked if there was a relationship between resident #3 and a male resident. She stated she had been told by the administrator resident #4 was pursuing resident #3. The family member stated resident #4 was not able to consent to a sexual relationship and she informed the facility she did not want the two residents in either apartment alone. She stated she had witnessed resident #4 persuade resident #3 to go to the dining room when she was not feeling well. The family member stated resident #4 was bossy and controlling and she felt like resident #4 would	C1512		

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C1512	Continued From page 11 take advantage of resident #3. The incident report and investigation notes from the incident on 04/16/21 revealed resident #4 was not removed from the facility, was not placed on 1:1 supervision and was not seen for his aggressive sexual tendencies until 04/21/21 (five days after the incident on 04/16/21 and 16 days after he was found kissing resident #3 in her apartment.). The facility did not provide documentation resident #4 had been monitored from 04/07/21 to 05/04/21. The facility did not provide documentation other residents and/or staff members were interviewed after the kissing incident on 04/05/21 or after the incident on 04/16/21. 3. Resident #6 had diagnosis which included dementia. An annual assessment, dated 02/27/21, documented the resident was oriented to self, confused, had fair judgment, was anxious with aggressive behaviors at times. The assessment documented the resident had fair mobility, gait, strength and required one person assist with bathing, eating and colostomy care. A combined initial and final OSDH incident report, dated 04/23/21, documented a sitter heard screaming and yelling and saw resident #6 and CMA #5 come out of a room. The sitter witness the resident's wrists were red and reported the incident to the assisted living director. The report documented the CMA was immediately removed from the memory care and an investigation was initiated and statements were taken from the staff on duty. The nurse examined the resident and did not find redness	C1512		

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C1512	Continued From page 12 on the resident's wrists, arms or any other part of her body except a fading bruise on her right wrist. The report documented resident #6 was "Out of sorts", combative and required two other staff members to assist in cleaning the resident and changing the colostomy bag. A hand written statement, dated 04/23/21, documented the sitter heard yelling and resident #6 and CMA #5 came out of a room. The statement documented the sitter noticed the resident's wrists were "really red" and the sitter asked the CMA why the resident's wrists were red. The statement documented the CMA stated, "Well she scratched me." and the CMA held out her arm to show the sitter. The CMA stated the resident would not let her change the colostomy bag. The statement also documented two other incidents involving CMA #5. The statement documented CMA #5 raised her voice and made a rude comment to the sitter in front of resident #2. The statement documented the sitter witnessed resident #6 with her shirt wet. The sitter asked the resident what happened and the resident stated, She (CMA #5) slapped her. The notification to the nurse aide registry, dated 04/23/21, documented the employee was not suspended or fired. On 05/05/21 at 10:40 a.m., the assisted living director was asked how she conducted the investigation of the allegation of abuse involving CMA #5. She stated she switched CMA #5 to do CNA duties on the assisted living hall and moved another staff member to the memory care. The	C1512		

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C1512	Continued From page 13 assisted living director was asked if she had done interviews or observations of other residents to see if they had been abused by CMA #5. She stated no, she stated the residents on the memory care did not seem afraid of the CMA. She was asked if CMA #5 worked on the assisted living side of the building prior to the abuse allegation. She stated yes. She was asked if she interviewed the residents on the assisted living halls concerning CMA #5. She stated no. The facility did not provide documentation other residents were observed for injuries or interviewed during the investigation of the allegation of abuse involving CMA #5. The CMA was not suspended or removed from access to the residents during the investigation of the allegation of abuse.	C1512		
C1914 SS=D	310:663-19-1(d) REPORTS TO THE DEPARTMENT (d) Each assisted living center shall report to the Department those incidents specified in 310:663-19-1(b). An assisted living center may use the Department's Long Term Care Incident Report Form. This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to submit an incident report to the Oklahoma State Department of Health (OSDH) for two (#3 and #4) of two sampled residents whose records were reviewed	C1914		

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C1914	Continued From page 14 for abuse allegations. This had the potential to affect all 35 residents who resided in the facility. Findings: Resident #3 An annual assessment, dated 02/19/21, documented the resident had a diagnosis of dementia, was oriented to self, forgetful and had poor judgment. The assessment documented the resident had fair strength, mobility and gait and required one person assistance with bathing and dressing. A Short Portable Mental Status Questionnaire (SPMSQ), dated 02/19/21, documented, the resident was severely intellectually impaired. A type written note located in the front of the activities of daily living book, dated 04/09/21, documented, "Per family's request, please make sure [resident #3 and resident #4] are not in each other's apartments visiting each other. They can visit with each other out in the open." The note was signed by the assisted living director. A physician's health care visit note, dated 04/28/21, documented the resident was not able to consent to a physical relationship. Resident #4 A preadmission assessment, dated 07/02/2020, documented the resident had diagnosis which included dementia, was alert, forgetful and had fair judgment. The assessment documented the resident had fair mobility, gait and strength, ambulated with a cane.	C1914		

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C1914	Continued From page 15 An interdisciplinary communication sheet to the physician, dated 04/20/21, documented the resident had been very aggressive with sexual tendencies towards female residents. On 05/05/21 at 11:23 a.m., the assisted living director was asked if there was a relationship between resident #3 and resident #4's. She stated resident #4 used to walk resident #3 to her room after meals. She stated the door to resident #3's room was closed and staff entered and found resident #4 kissing resident #3 on approximately 04/06/21. She stated she called the family of resident #3 and they did not want her to have men in her room due to her decline in cognition. On 05/05/21 at 12:26 p.m., the assisted living director was asked if a report was sent to the OSDH. She stated she did not fill out or submit an incident report to the OSDH when resident #4 and resident #3 kissed. On 05/06/21 at 4:12 p.m., the family of resident #3 was asked about the relationship between resident #3 and #4. She stated she was told by the assisted living director on 04/06/21 the male resident was pursuing resident #3. She stated she did not have a good feeling and requested the male resident not be alone with resident #3.	C1914		
C1920 SS=E	310:663-19-2(a) MEDICATION ADMINISTRATION (a) Each assisted living center shall adopt written procedures to ensure safe administration of medications.	C1920		

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C1920	Continued From page 16 This Rule is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement their policy for medication destruction for two (#3 and #7) of three sampled residents who had discontinued medications. This had the potential to affect all 35 residents who resided in the facility. Findings: The facility's policy, titled, "Medications are Permanently Discontinued", not dated, documented, "...The Designated staff person discusses the discontinuance with the resident and/or responsible party... To properly dispose of permanently discontinued medications the Designated staff person and another adult witness who is not a resident...Returns the medication to the dispensing pharmacy for disposal; or Disposes of the medication in a medical waste receptacle...The designated staff person and witness will document destruction on the Centrally Stored Medication Record." 1. Resident #3 The medication ordered/received log documented the resident received Flonase, antidiarrheal capsules 96, triamcinalone ointment, benadryl 96 tablets on 07/24/20. A physician order, dated 09/29/20, documented to discontinue the following medications due to non use: tears eye drops, Flonase, imodium, benadryl, zyrtec, triamcinalone ointment. The medication destruction log documented the tears eye drops, antidiarrheal capsules, benadryl	C1920		

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C1920	Continued From page 17 capsules, triamcinalone ointment 15 grams, was logged into the book on 01/19/21. The destruction log did not document the disposition of the medication or initials of a staff person or witness to indicate the medications were destroyed. The Flonase was not documented on the medication destruction log. On 05/06/21 at 4:12 p.m., the resident's family member was asked if she was notified when the medications were discontinued. She stated no, she did not know the medications had been discontinued or destroyed until recently. 2. Resident #7 A medication destruction log for resident #7 documented Fioricet/But/APAP/CAF (schedule three controlled substance.) was discontinued on 05/11/20. The log documented the medication was expired and was destroyed on 06/30/20. The log revealed the medication was not witnessed by a staff member when it was destroyed. On 05/06/21 at 10:42 a.m., licensed practical nurse (LPN) #1 was asked to describe the facility's policy/procedure for medication destruction of controlled medications. She stated the controlled medication was supposed to be witnessed by a second person prior to being destroyed. The LPN was asked if the medications were supposed to be written in the destruction log book when they were removed from the medication cart. She stated yes, the medications were supposed to be counted and logged into the medication destruction log book and then placed in the locked cabinet in the medication room. She stated when the medication was destroyed or donated it was re-counted, dated and initialed on the destruction	C1920		

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C1920	Continued From page 18 log the disposition of the medication.	C1920		
C1951 SS=E	310:663-19-3(a) MAINTENANCE OF RECORDS (a) There shall be an organized, accurate, clinical record, typewritten, electronic, or legibly written with pen and ink, for each resident admitted. The resident's record shall document all services provided under the direction of a licensed health care professional consistent with professional standards of practice. This Rule is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure: ~ a physician's order for medication administration was in the clinical record for one (#3) of three sampled residents whose records were reviewed for medication administration and; ~ a record of discontinued medications was maintained for three (#6, 7 and #8) of three sampled residents whose records were reviewed for discontinued medications. This had the potential to affect all 35 residents who resided in the facility. Findings: The facility's policy, titled, "Medication Records", documented, "...Records of medications are maintained...A record of all medication brought into the community is maintained for three years...A record of medications that are disposed of in the community is maintained for at least 3 years...Written physician orders for all medications are maintained in the resident's chart	C1951		

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C1951	Continued From page 19 in the "Physician Orders" section..." Physician's Orders Resident #3 had diagnoses which included seasonal allergies and dementia. The medication received/ordered log documented the resident received 3 bottles of Flonase on 01/29/21. The physician's order for the Flonase, received on 01/29/21 was not in the resident's clinical record. On 05/06/21 at 9:03 a.m., the pharmacy was contacted. The pharmacy technician was asked why the pharmacy delivered the Flonase on 01/29/21. He stated the resident had an order from her primary care physician for the Flonase dated 01/28/21. At 11:05 a.m., licensed practical nurse (LPN) #1 was asked for the physician's order for the Flonase written on 01/28/21. She stated it was not in the resident's clinical record. Discontinued Medications On 05/06/21 at 9:17 a.m., the medication destruction cabinets were reviewed with LPN #1. A sign was posted on the top and bottom cabinet which documented "STOP DO NOT put anything in this cabinet until it is logged into the destruction log book." The LPN stated the bottom cabinet was for medication that was discontinued and the top cabinet was for controlled medications that were discontinued. Resident #6 had 8 syringes of Lorazepam topical	C1951		

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C1951	Continued From page 20 cream in the cabinet. Resident #7 had four discontinued medications in the cabinet. Resident #8 had 15 different discontinued medications in the cabinet. The medications were not logged into the medication destruction log book. At 9:17 a.m., LPN #1 was asked about the process for medications that were discontinued or expired. She stated they were pulled off the medication cart, counted and signed into the medication destruction log book and then placed into the cabinet. She stated when they were destroyed they were counted and destroyed. She stated they donated some medications and if the medications were donated they would be placed in the donation box. At 9:28 a.m., certified medication aide (CMA) #2 was asked about the process for discontinued medications. She stated the medications were removed from the cart by CMA #4. The CMA stated she was responsible for getting the medications ready to be donated. She stated she marked out the resident's name and prescription number and wrote the name of the medication on a paper inside the donation box. The CMA stated she did not know who the medications had belonged to because she did not log the medication before she placed it in the donation box. At 9:35 a.m., CMA #4 was asked if she counted and logged the medications removed from the medication cart to be destroyed or donated in the log book. She stated no. She was asked how	C1951		

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C1951	Continued From page 21 would the center know what happened to the medication. She stated they would not know. She stated the nurse was responsible for the controlled medications.	C1951		



OKLAHOMA
State Department
of Health

Delivery via email to: Glee@CovLiving.org

June 15, 2021

License Number: CC1902AL

Mr. Rickey Lee, Administrator
Covenant Living At Inverness
3800 West 71st Street South
Tulsa, OK 74132

Survey Event ID: Q67K11

Dear Mr. Lee:

On **May 6, 2021**, a complaint investigation and COVID focus survey were conducted at your Assisted Living Center. 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, 2021**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Sincerely,

Tempal Killman

Digitally signed by Tempal
Killman

Date: 2021.06.15 09:00:48 -05'00'

Tempal Killman, Administrative Assistant
Long Term Care Enforcement Division
Oklahoma State Department of Health

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Oklahoma State Department of Health

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C 000	INITIAL COMMENTS On 05/04/21 through 05/06/21, the Oklahoma State Department of Health completed a COVID-19 Focused Survey to determine if the facility was in compliance with implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. Complaint #OK00056953 and #OK00056981 were investigated in conjunction with this survey. Total residents: 35	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505	This plan of correction is being submitted using the optional state plan of correction template.	

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

TITLE

(X6) DATE

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: CC1902AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/06/2021
NAME OF PROVIDER OR SUPPLIER COVENANT LIVING AT INVERNESS		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 WEST 71ST STREET SOUTH TULSA, OK 74132		
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C1505	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure medication was administered as ordered by the physician for one (#3) of three sampled residents whose records were reviewed for medication administration. The facility identified 35 residents who resided in the center. Findings: Resident #3 was admitted to the facility with diagnoses which included seasonal allergies and dementia. A physician's order, dated 01/28/21, documented to administer Flonase two sprays in each nostril daily as needed for allergies. An annual assessment, dated 02/19/21, documented the resident was oriented to self only, was forgetful, and had poor judgment. The service plan, dated 02/19/21, documented the resident was not responsible for ordering her	C1505		

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C1505	Continued From page 2 medication and did not self administer her medication. The medication administration records (MAR), dated 01/2021, 02/2021 and 03/2021, revealed Flonase was not on the MAR to be administered as needed and was not administered as needed 01/29/21 through 03/31/21. On 05/06/21 at 11:50 a.m., licensed practical nurse (LPN) #1 was asked if the Flonase was administered to the resident in January, February, or March 2021. She stated no, it had not been administered because it had not been transcribed to the MAR to be administered.	C1505		
C1512 SS=E	310:663-15-1 & 63 OS 1-1918(B)(12) RESIDENT RIGHTS - Abuse/Neglect Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(12) (12) Every resident shall be free from mental and physical abuse and neglect, as such terms are defined in Section 10-103 of Title 43A of the Oklahoma Statutes, corporal punishment, involuntary seclusion, and from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms, except those restraints authorized in writing by a physician for a specified period of time or as are necessitated by an emergency where the restraint may only be applied by a physician, qualified licensed nurse or other personnel under the supervision of the physician who shall set	C1512	This plan of correction is being submitted using the optional state plan of correction template.	

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C1512	Continued From page 3 forth in writing the circumstances requiring the use of restraint. Use of a chemical or physical restraint shall require the consultation of a physician within twenty-four (24) hours of such emergency; Title 43A O.S. 10-103. Definitions 8. "Abuse" means causing or permitting: a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, or mental anguish, or b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult; 10. "Neglect" means: a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest, b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services; This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to: ~ensure a cognitively impaired resident was	C1512		

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C1512	Continued From page 4 protected from sexual abuse for one (#3) of one sampled residents whose records were reviewed for sexual abuse allegations; ~ensure an allegation of abuse was thoroughly investigated for two (#3 and #6) of five sampled residents whose records were reviewed for an allegation of abuse; and ~provide the resident protection during an investigation of an allegation of abuse for two (#3 and #6) of five sampled residents whose records were reviewed for abuse. This had the potential to affect all 35 residents who resided in the facility. A facility policy titled, "Abuse, Fraud, and Wrongdoing", documented, "...The Assisted Living Director will investigate any reports of abuse, fraud, or other wrongdoing...If a report of abuse, fraud, or other wrongdoing is received...The Assisted Living Director is notified immediately...Any urgent medical or safety issues are addressed immediately...The Assisted Living Director or other designated representative initiates and [sic] investigation..." 1. Resident #3 was admitted to the facility with diagnoses which included dementia. An annual assessment, dated 02/19/21, documented the resident was oriented to self, forgetful and had poor judgment. The assessment documented the resident had fair strength, mobility and gait, and required one person assistance with bathing and dressing. A Short Portable Mental Status Questionnaire (SPMSQ), dated 02/19/21, documented the	C1512		

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C1512	Continued From page 5 resident was severely intellectually impaired. A hand written note, dated 04/06/21, documented a conversation with resident #3 concerning her relationship with resident #4. The note documented resident #4 was just a friend and she did not mind him kissing her. The note documented the resident was asked if she wanted to have a sexual relationship with resident #4. The resident stated she would have to wait and see. A handwritten note, dated 04/06/21, documented a call had been made to the family of resident #3 concerning resident #4. The note documented the power of attorney for resident #3 did not want resident #4 in the apartment with resident #3 alone. A typed note located in the front of the activities of daily living book, dated 04/09/21, documented, "Per family's request, please make sure [resident #3 and resident #4] are not in each other's apartments visiting each other. They can visit with each other out in the open." The note was signed by the assisted living director. The facility did not provide documentation resident #3 had been monitored to ensure resident #4 was not in her room. The service plan for resident #3 did not document she required increased monitoring to ensure she was not alone with a male resident in her room or his room. An Oklahoma State Department of Health (OSDH) incident report, dated 04/19/21, documented Resident #4 was found in resident #3's bed naked with resident #3 naked from the waist down on 04/16/21, after resident #4 had	C1512			

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C1512	Continued From page 6 been notified multiple times a day, he was not to be in resident #3's apartment. The report also documented the POA felt like the resident could be taken advantage of and felt like the resident did not have the cognition to be a consenting adult. The report documented the center would continuously monitor resident #4's activity. A typed note, signed by the healthcare scheduler, dated 04/20/2021, documented, "To whom it may concern: On Friday April 7, 2021 (The assisted living director stated the correct date of the incident was 04/16/21) at approximately 1:45 p.m. I witnessed [resident #4], a resident of Covenant Living at Inverness/Redbud Court Assisted Living laying on top of the bed of [resident #3]. [Resident #3] is also a resident of Covenant Living. [Resident #4] was completely naked, laying on his side with his back to me, and [resident #3] was laying on her back, naked from the waist down. I was trying to locate [resident #4] for the medication aide who was trying to administer medication to the residents during the afternoon med pass. [Resident #4] was not in his room, nor was he anywhere in the public areas of the campus. I knocked loudly on [resident #3's] door and announced myself before I entered the room. Upon seeing the two naked in bed, I told [resident #4] he needed to get up, get dressed and leave [resident #3's] apartment. The two were laying on top of the bed, and the bed was still made, so they were not under the sheets. I could only see [resident #4's] back side when I entered the room. I could see all of [resident #3], as she was laying on her back I promptly left the apartment	C1512		

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C1512	Continued From page 7 after I told [resident #4] he had to leave, so I do not know the condition of the bedspread or sheets after they got up. [Resident #4] and [resident #3] both got up and got dressed and came out of her apartment together. It took several minutes for them both to get dressed, and I did go into the room one more time before they were fully dressed to check and make sure they were not still in bed. Before I found them in [resident #3's] room, I was at the front of the facility, away from my desk helping get other residents to the main lobby to board a bus. The aide on duty was at lunch. By the time I got back to my desk and it was discovered that [resident #4] was not in his room, about 20-25 minutes had passed. The above statements are true to the best of my recollection..." A nurse's progress note for resident #3, dated 04/20/21, documented, "...This Nurse assessed Resident this day for physical injuries such as skin tearing, scratches, bruising that may or may not of occurred to her during an encounter of sexual nature in her room with a male Resident on Friday April the 16th 2021 during the early afternoon hours. This Nurse had a witness present during assessment with Resident's permission to do so. No evidence of physical trauma observed. This Nurse reported clinical findings to AL (assisted living director)...Resident does not appear to be in any visible distress and is not able to recall said encounter." A physician visit note for resident #3, dated 04/28/21, documented the resident had severe dementia, had a score of three on the	C1512			

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C1512	Continued From page 8 mini-mental state examination (MMSE) (A score of 0-17 indicated severe cognitive impairment.) and was not able to consent to a physical relationship. 2. Resident #4 was admitted to the facility with diagnoses which included Alzheimer's disease and dementia. A preadmission assessment, dated 07/02/2020, documented the resident was alert, forgetful, and had fair judgment. The assessment documented the resident had fair mobility, gait, and strength and ambulated with a cane. An interdisciplinary communication sheet to the physician, dated 04/20/21, documented the resident had been very aggressive with sexual tendencies towards female residents and requested orders to decrease the behaviors. A nurse progress note, dated 04/21/21, documented the resident's physician had seen the resident and made a referral to a psychiatrist due to increased sexual libido. A nurse progress note, dated 04/26/21, documented the psychiatrist had seen the resident and the psychiatrist had contacted the resident's physician with recommendations for treatment. The facility did not provide documentation which indicated resident #4 had been monitored to ensure he was not in resident #3's apartment from 04/07/21 to 05/04/21. The service plan for resident #4 was not updated to include sexual behaviors or interventions. The service plan did not reveal the resident required increased monitoring to ensure he was not alone behind	C1512		

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C1512	Continued From page 9 closed doors with resident #3. On 05/05/21 at 11:23 a.m., the assisted living director was asked what the relationship was between resident #3 and resident #4. She stated resident #4 used to walk resident #3 to her room after meals. She stated the door to resident #3's room was closed and staff entered and found resident #4 kissing resident #3 on 04/06/21. She stated she called the family of resident #3 and they did not want her to have men in her room due to her decline in cognition. She was asked if she had documented the incident. She provided a hand written note which documented the phone call to resident #3's family and a note which documented an interview was conducted with resident #3 on 04/06/21. The facility did not provide any other documentation of an investigation of the incident. She then stated after that encounter resident #4 was found in resident #3's apartment naked lying on resident #4's bed with resident #3 naked from the waist down. She was asked what interventions were put in place to protect the residents. She stated a sign was posted on resident #4's apartment door to remind him not to enter female resident rooms. She stated the staff had monitored him closely when he was out of his room and he had been put on medication to decrease sexual libido. At 12:16 p.m., certified medication aide (CMA) #2 was asked how often resident #4 was monitored. She stated we do a visual check every thirty minutes. She was asked for documentation of the monitoring. She provided one form dated 05/05/21. She stated she was told by licensed practical nurse (LPN) #2 to start documenting on	C1512		