



Oklahoma State Department of Health
Creating a State of Health

August 26, 2019

License Number: AL6102

Mr. Robert Samples, Administrator
Belfair Of McAlester
802 Windsong Way
McAlester, OK 74501

RE: Survey Event ID: K9VH11

Dear Mr. Samples:

On **August 8, 2019**, agents from our office concluded an *initial* State Licensure survey and complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

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 (attached). 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;

Board of Health

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- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (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) 271-6868 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
1000 N.E. 10th
Oklahoma City, OK 73117-1299

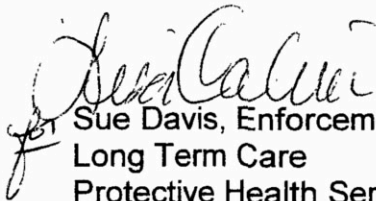
Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- 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) 271-6868 or fax at (405) 271-2206.

If you have questions or need assistance, please feel free to send an email to LTC@health.ok.gov or call (405) 271-6868. 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,



Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Belfair of McAlester
Address: 802 Windsong Way
City, State, Zip: McAlester, OK, 74501
Provider #: AL6102
Complaint #: OK00053855
Investigation Date(s): 08/05/19 through 08/08/19

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED
1. The center failed to have adequate staff to ensure residents received their medications as ordered.	S

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

An unannounced on-site investigation was initiated on Tuesday, August 6, 2019 at 5:00 a.m.

A sample of six residents including any identified residents, were selected for the investigation based on the concerns relevant to the allegations.

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 C0961 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.

Denise Owen, RN

Denise Owen, RN

Date report completed: 08/13/2019

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/08/2019
NAME OF PROVIDER OR SUPPLIER BELFAIR OF MCALESTER		STREET ADDRESS, CITY, STATE, ZIP CODE 802 WINDSONG WAY MCALESTER, OK 74501		
(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
N 000	Initial Comments An initial survey was conducted on 08/06/19 through 08/08/19. Complaint #OK00053855 was investigated in conjunction with the survey. Current census was 15. Deficient practice was cited as follows.	N 000		
N1442 SS=F	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to validate initial skills for 4 (#9 through #11 and #16) of 4 certified medication aides (CMA). This failed practice had the widespread potential for more than minimal harm for all 15 residents who were administered medication. Findings: On 08/06/19 at 11:05 a.m., a review of employee records revealed the following CMA medication administration skills had not been validated prior to administering medications to the residents: CMA/employee #9 - hired 05/11/19; CMA/employee #10 - hired 05/02/19; CMA/employee #11 - hired 05/02/19; and CMA/employee #16 - hired 05/06/19.	N1442		

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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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELFAIR OF MCALESTER

**802 WINDSONG WAY
MCALESTER, OK 74501**

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N1442	Continued From page 1 At 1:36 p.m., the registered nurse stated none of the current CMA medication administration skills had been validated prior to medication administration. POLICY An undated CMA policy documented, "...Policy: This policy addresses methods to ensure that procedures are implemented for training, skill validation, and task assignment for the position of a Certified Medication Aide (CMA)..."	N1442		
C 000	INITIAL COMMENTS An initial survey was conducted on 08/06/19 through 08/08/19. Complaint #OK00053855 was investigated in conjunction with the survey. Current census was 15. Deficient practice was cited as follows.	C 000		
C 341 SS=D	310:663-3-4(b)(1) APPROPRIATE PLACEMENT (b) The resident shall not be eligible for placement in the assisted living center under one (1) or more of the following circumstances: (1) The resident needs care or services that exceed the care or services available in the assisted living center; This Rule is not met as evidenced by:	C 341		

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C 341	Continued From page 2 Based on observation, interview, and record review, it was determined the center failed to deny admission to 1 (#1) of 1 resident who did not meet the center's admission criteria as outlined in the resident care and service agreement. This deficient practice had the isolated potential for more than minimal harm. Findings: Resident #1 was admitted to the center on 06/24/19 with diagnoses that included stage III pressure ulcer (full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough and/or eschar may be visible but does not obscure the depth of the tissue loss), arteriosclerotic heart disease, altered mental status, and chronic pain. The resident's care and service agreement, signed by the resident's responsible party on 06/24/19, documented, "...Admissions Criteria...Belfair of McAlester, LLC, will not admit any person in need of skilled nursing care including those with...Stage 3-4 dermal ulcers...The following conditions are prohibited without a written exception: Stage 3-4 dermal ulcers..." No documentation was provided of a written exception. On 08/07/19 at 8:44 a.m., resident #1 was observed during toileting by the staff. The resident had two pink bordered dressings on her bottom area. On 08/08/19 at 2:30 p.m., the registered nurse/director of nurses (RN/DON) stated she was aware the resident should not have been admitted to the center after reviewing the contract.	C 341			

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NAME OF PROVIDER OR SUPPLIER

BELFAIR OF MCALESTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**802 WINDSONG WAY
MCALESTER, OK 74501**

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C 341	Continued From page 3 An undated director nursing job description documented, "...Evaluates current and potential residents and patients to ensure facility can provide appropriate level of care..."	C 341		
C 701 SS=F	Hot Water - Bathing - Appendix A GENERAL REQUIREMENTS (d) Each assisted living center shall comply with the hot water standards set forth in Appendix A. Hot Water available for resident use shall not exceed 115 degrees Fahrenheit (46 degrees C.) This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the center failed to ensure the hot water available for resident use did not exceed 115 degrees F (Fahrenheit). This failed practice had the widespread potential for more than minimal harm for the 15 residents who resided in the center. Findings: On 08/08/19 at 10:23 a.m., resident #2's bathroom hot water registered at 139.0 degrees F. She stated her water had gotten pretty hot. At 10:39 a.m., resident #5's bathroom hot water registered at 131.0 degrees F. She stated she had to jerk her finger away from the hot water when she adjusted the temperature or she would	C 701		

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C 701	Continued From page 4 have scalded her finger with the hot water. At 11:02 a.m., resident #9's bathroom hot water registered at 127.3 degrees F. She stated the water was plenty hot, it might be too hot. At 11:52 a.m. through 12:23 p.m., the following hot water temperatures were obtained in the residents' apartments with the assistance of maintenance director/employee #19: ASSISTED LIVING Resident #10 - 119.3 degrees F; Resident #9 - 123.2 degrees F; Resident #3 - 130.1 degrees F; and Resident #2 - 136.9 degrees F. MEMORY CARE Resident #1 - 134.5 degrees F; Resident #6 - 125.6 degrees F; and Resident #4 - 129.3 degrees F. Maintenance director/employee #19 stated the water temperatures were hotter in the apartments that were closer to the hot water tanks. He stated he had thought the water temperatures were a minimum of 120 degrees F.	C 701			
C 911 SS=G	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged:	C 911			

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C 911	Continued From page 5 (1) registered nurse supervision of skilled nursing interventions; This Rule is not met as evidenced by: Based on interview and record review, it was determined the registered nurse failed to assess, monitor and provide supervision for 1 (#1) of 1 sampled resident who had a stage III pressure ulcer and further developed a stage IV pressure ulcer. This resulted in isolated actual harm. Findings: Resident #1 was admitted to the center on 06/24/19 with diagnoses which included stage III pressure ulcer (full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough and/or eschar may be visible but does not obscure the depth of the tissue loss), arteriosclerotic heart disease, altered mental status, and chronic pain. A preadmission assessment, dated 06/24/19, and a 14-day assessment, dated 07/08/19, documented resident #1 was oriented to person and place, was forgetful and had good judgment, required one to two person assistance for transfers, toileting, and dressing, and had a stage III pressure ulcer to the sacrum with wound care orders. The skin assessment did not document measurements, description, or drainage to the pressure ulcer. A skin assessment, dated 06/24/19, documented resident #1 had reddened areas to the sacrum that remained after thirty minutes of pressure reduction to the sacrum and had open ulcer to the sacrum with treatment in place. The skin assessment did not document measurements,	C 911			

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C 911	Continued From page 6 description, or drainage to the pressure ulcer. A care plan, dated 06/24/19, documented resident #1 had a stage III pressure ulcer to the sacrum with treatment orders in place. The care plan did not document interventions or goals for the pressure ulcer. A physician's order for resident #1, dated 06/27/19, documented, "...Wound to coccyx wound care as follows: Using aseptic technique SN (skilled nurse) to cleanse wound with SNS (sterile normal saline), pat dry with 4 x 4 gauze, apply gentamicin oint (ointment) and cover with dry protective dressing. Wound care to be done 3 x (three times) daily. HHS SN (home health skilled nurse) to see patient 3 x weekly monitor wound condition, measure weekly..." The order documented it was a verbal telephone order and it was read back to the physician. A hospital discharge summary for resident #1, dated 07/14/19, documented, "...infection of sacral decubitus wound...She was found to have hypertensive urgency and an infected sacral decubitus ulcer and was admitted to the medical floor for management...Discharge Assessment...Stage IV ulcer (Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed.) of sacrum inferiorly and a stage III superiorly..." On 08/06/19 at 1:19 p.m., the registered nurse/director of nursing (RN/DON) stated resident #1 was admitted with one pressure ulcer. She also stated she had not assessed the pressure ulcers.	C 911		

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C 911	Continued From page 7 On 08/07/19 at 10:10 a.m., resident #1's home health records and physician's orders were reviewed with the RN/DON and she stated the wound care was not supposed to be done three times a day. She stated that was a documentation error. The RN/DON stated home health was to do all the wound care; they did not come out three times a day, nor did the center's nurses perform the wound care. Resident #1's record did not document the center assessed the stage III pressure ulcer or the partial thickness wound. No documentation was submitted which indicated the center had assessed the pressure ulcers.	C 911		
C 951 SS=F	310:663-9-5(a) - USE 6000 STAFF QUALIFICATIONS (a) All of the assisted living center's employees shall be subject to the requirements for criminal arrest checks applicable to nurses aides under 63 O.S. Supp. 1997, Section 1-1950.1. 63-1-1950.1(B) 1. Except as otherwise provided by subsection C of this section, before any employer makes an offer to employ or to contract with a nurse aide or other person to provide nursing care, health-related services or supportive assistance to any individual except as provided by paragraph 4 of this subsection, the employer shall provide for a criminal history background check to be made on the nurse aide or other person pursuant to the provisions of this section. If the employer is a facility home or institution which is part of a larger complex of buildings, the requirement of a criminal history background check shall apply	C 951		

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C 951	Continued From page 8 only to an offer of employment or contract made to a person who will work primarily in the immediate boundaries of the facility, home or institution. 2. Except as otherwise specified by subsection D of this section, an employer is authorized to obtain any criminal history background records maintained by the Oklahoma State Bureau of Investigation which the employer is required or authorized to request by the provisions of this section. 3. The employer shall request the Bureau to conduct a criminal history background check on the person and shall provide to the Bureau any relevant information required by the Bureau to conduct the check. The employer shall pay a fee of Fifteen Dollars (\$15.00) to the Bureau for each criminal history background check that is conducted pursuant to such a request. 4. The requirement of a criminal history background check shall not apply to an offer of employment made to: a. a nursing home administrator licensed pursuant to the provisions of Section 330.53 of this title, b. any person who is the holder of a current license or certificate issued pursuant to the laws of this state authorizing such person to practice the healing arts, c. a registered nurse or practical nurse licensed pursuant to the Oklahoma Nursing Practice Act, d. a physical therapist registered pursuant to the Physical Therapy Practice Act, e. a physical therapist assistant licensed pursuant to the Physical Therapy Practice Act,	C 951		

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C 951	Continued From page 9 f. a social worker licensed pursuant to the provisions of the Social Worker's Licensing Act, g. a speech pathologist or audiologist licensed pursuant to the Speech-Language Pathology and Audiology Licensing Act, h. a dietitian licensed pursuant to the provisions of the Licensed Dietitian Act, i. an occupational therapist licensed pursuant to the Occupational Therapy Practice Act, or j. an individual who is to be employed by a nursing service conducted by and for the adherents of any religious denomination, the tenets of which include reliance on spiritual means through prayer alone for healing. 5. At the request of the employer, the Bureau shall conduct a criminal history background check on any person employed by the employer, including the persons specified in paragraph 4 of this subsection at any time during the period of employment of such person. 63-1-1950.1(C) 1. An employer may make an offer of temporary employment to a nurse aide or other person pending the results of the criminal history background check on the person. The employer in such instance shall provide to the Bureau the name and relevant information relating to the person within seventy-two (72) hours after the date the person accepts temporary employment. The employer shall not hire or contract with a person on a permanent basis until the results of the criminal history background check are received. 2. An employer may accept a criminal history background report less than one (1) year old of a	C 951		

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C 951	Continued From page 10 person to whom such employer makes an offer of employment or employment contract. The report shall be obtained from the previous employer or contractor of such person and shall only be obtained upon the written consent of such person.	C 951		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/08/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELFAIR OF MCALESTER

**802 WINDSONG WAY
MCALESTER, OK 74501**

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C 951	Continued From page 11 This LEVEL A is not met as evidenced by: Based on interview and record review, it was determined the center failed to provide a fingerprint-based national background check/OK Screen for 19 (registered nurse (RN), licensed practical nurses (LPN) #2 through #6, #2, #3, #6 through #13, and #15 through #17) of 33 recently hired employees. This failed practice had the widespread potential for more than minimal harm for all 15 residents. Findings: On 08/06/19 at 11:05 a.m., a review of the employees' files revealed the following employees had not received eligibility determination from the fingerprint-based national background check: RN - hired 07/22/19; LPN #2 - hired 05/06/19; LPN #3 - hired 05/06/19; LPN #4 - hired 05/06/19; LPN #5 - hired 05/06/19; LPN #6 - hired 08/03/19; Long term care aide (LTCA)/employee #2 - hired 05/20/19; Activities director/employee #3 - hired 04/22/19; Sales director/employee #6 - 06/11/19; Human Resources director/employee #7 - hired 01/14/19; Activities assistant/employee #8 - hired 05/02/19; Certified medication aide (CMA)/employee #9 - hired 05/11/19; CMA/employee #10 - hired 05/02/19; CMA/employee #11 - hired 05/02/19; LTCA/employee #12 - hired 05/06/19; LTCA/employee #13 - hired 07/11/19; LTCA/employee #15 - hired 05/30/19; CMA/employee #16 - hired 05/06/19; and	C 951		

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C 951	Continued From page 12 Cook employee #17 - hired 05/02/19. At 1:25 p.m., Human Resources director/employee #7 stated the center had not completed the OK Screen application for the above employees.	C 951		
C 954 SS=F	310:663-9-5(d) STAFF QUALIFICATIONS (d) Assisted living center direct care staff shall be trained in first aid and cardiopulmonary resuscitation. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure: a) Cardiopulmonary resuscitation (CPR) and first aid training had been provided to 3 (#13, 14, and #15) of 11 direct care employees; and b) First aid training had been provided to 2 (#2 and #9) of 11 direct care employees. These failed practices resulted in the widespread potential for more than minimal harm for all 15 residents. Findings: On 08/06/19 at 12:21 p.m., a review of the employees' records revealed the following direct care employees had not been provided CPR and/or first aid training: CPR and FIRST AID	C 954		

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C 954	Continued From page 13 Long term care aid (LTCA)/employee #13 - hired 07/11/19; LTCA/employee #14 - hired 07/13/19; and LTCA/employee #15 - hired 05/30/19. FIRST AID LTCA/employee #2 - hired 05/20/19; and Certified medication aide/employee #9 - hired 05/11/19. At 1:47 p.m., the registered nurse stated the direct care employees hired after 05/06/19 had not been certified/trained in CPR and/or first aid. POLICY An undated policy titled 'First Aid Certification' documented, "...All employees are required to be certified in First Aid by a recognized provider (i.e. The Red Cross)..."	C 954		
C 961 SS=E	310:663-9-6(a) MINIMUM STAFF FOR SERVICES (a) The right number of trained staff shall be on duty, awake, and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents and to carry out all the processes listed in the continuum of care facility's, or assisted living center's, written emergency and disaster preparedness plan for fires and other natural disasters.	C 961		

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C 961	Continued From page 14 This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure appropriately trained staff were on duty and present in the center at all times to meet the needs of 6 (#2, 3, and #7 through #10) of 10 sampled residents who had physician ordered as needed (PRN) medications. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: On 08/06/19 at 5:33 a.m., long term care aid (LTCA)/employee #2 stated residents #10 and #11 might request a PRN medication during the 10:00 p.m. to 6:00 a.m. shift. On 08/07/19 at 10:32 a.m., a review of the employees' electronic time sheets documented the following employees clocked in for the 10:00 p.m. to 6:00 a.m. shift: 06/05/19 - LTCA/employee #2 and LTCA/employee #18; and 06/06/19 - LTCA/employee #1 and LTCA/employee #2. At 10:55 a.m., the administrator stated the former director of nurses had not scheduled a medication administration aide on 06/05/19 and 06/06/18 for the 10:00 p.m. to 6:00 a.m. shift because none of the residents had any physician ordered routine medications to be administered. He further stated a certified medication aide had not been available on 06/05/19 or 06/06/19, if any of the residents had requested a PRN medication during the 10:00 p.m. to 6:00 a.m. shift.	C 961		

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C 961	Continued From page 15 At 11:33 a.m., a review of residents' admission dates documented there had been 10 residents who resided in the assisted living or the memory care on 06/01/2019. Six of 10 residents had physician ordered as needed medications. The following residents had PRN medications administered on the 10:00 p.m. to 6:00 a.m. shift prior to 06/05/19: Resident #8 - 06/02/19 at 12:48 a.m. - pain medication; 06/03/19 at 12:45 a.m. - pain medication; 06/03/19 at 5:01 a.m. - pain medication; Resident #10 - 06/01/19 at 3:42 a.m. - pain medication; and 06/03/19 at 4:47 - pain medication and nausea medication. None of the sampled residents had been able to remember if they had requested any PRN medications on 06/05/19 or 06/06/19, when there had not been appropriate staffing available for medication administration.	C 961		
C1301 SS=F	310:663-13-1(a) RESIDENT SERVICE CONTRACT (a) Each assisted living center shall furnish to each resident a complete and understandable copy of the resident service contract. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure a complete and understandable copy of the resident service	C1301		

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C1301	Continued From page 16 contract was available and given for 10 (#1 through #10) of 10 sampled residents. This failed practice resulted in the widespread potential for more than minimal harm. Findings: On 08/08/19 at 2:23 p.m., after the administrator reviewed the service contract, he stated the contracts had not contained the provision which stated the residents received a complete and understandable copy of their service contract.	C1301		
C1330 SS=F	310:663-13-2(10) CONTENTS OF CONTRACT Each resident service contract shall contain a clear statement of the following: (10) a provision in the event that a resident's condition merits transfer, the transfer shall be initiated within five (5) working days and progress on the transfers shall be noted in the resident's record. This Rule is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure 10 (#1 through #10) of 10 sampled residents service contracts contained a provision for the event that a resident's conditions merits transfer, the transfer shall be initiated within five (5) working days and progress on the transfers shall be noted in the resident's record. This failed practice resulted in the widespread potential for more than minimal harm. Findings: On 08/08/19 at 2:23 p.m., after the administrator and Human Resources director/employee #7 reviewed the service contracts, they stated the contracts had not contained the required five (5) working day transfer provision.	C1330		

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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 interview and record review, it was determined the center failed to maintain organized and accurate records for 1 (#1) of 1 sampled resident. This failed practice had the potential for more than minimal harm at a pattern. Findings: Resident #1 was admitted to the center on 06/24/19 with diagnoses that included stage III pressure ulcer. A physician's order doe resident #1, dated 06/27/19, documented, "...Wound to coccyx wound care as follows: Using aseptic technique SN (skilled nurse) to cleanse wound with SNS (sterile normal saline), pat dry with 4 x 4 gauze, apply gentamicin oint (ointment) and cover with dry protective dressing. Wound care to be done 3 x (three times) daily. HHS SN (home health skilled nurse) to see patient 3 x weekly monitor wound condition, measure weekly..." The order documented it was a verbal telephone order and it was read back to the physician. A treatment administration record for resident #1, dated 07/2019, documented the above wound care was to be done three times a day with a start date of 06/28/19 and a stop date of 07/28/19.	C1951		

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C1951	Continued From page 18 An order clarification for resident #1, dated 08/07/19, documented late entry discontinue wound care order of three times daily written on 06/27/19. Home health to manage the wound care three times weekly. This order clarification was not in the resident's record and was written at the time of survey. On 08/07/19 at 10:10 a.m., resident #1's home health records were reviewed with the RN/DON. She stated the wound care was not supposed to be done three times a day. She stated that was a documentation error. The RN/DON stated home health was to do all the wound care. An undated director nursing job description documented, "...Ensures all required records are maintained and submitted, as appropriate, in an accurate and timely manner..."	C1951			
C5010 SS=G	63 O.S. 1-890.8(A-D) Care and Services - Coordination of Care A. Residents of an assisted living center may receive home care services and intermittent, periodic, or recurrent nursing care through a home care agency under the provisions of the Home Care Act. B. Residents of an assisted living center may receive hospice home services under the provisions of the Oklahoma Hospice Licensing Act. C. Nothing in the foregoing provisions shall be construed to prohibit any resident of an assisted living center from receiving such services from any person who is exempt from the provisions of	C5010			

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STATE FORM

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C5010	Continued From page 20 progressed to a stage IV and required hospitalization for wound infection and debridement. This deficient practice resulted in isolated actual harm. Findings: Resident #1 was admitted to the center on 06/24/19 with diagnoses which included stage III pressure ulcer (full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough and/or eschar may be visible but does not obscure the depth of the tissue loss.), arteriosclerotic heart disease, altered mental status, and chronic pain. The resident's care and service agreement, signed by the resident's responsible party on 06/24/19, documented, "...Admissions Criteria...Belfair of McAlester, LLC, will not admit any person in need of skilled nursing care including those with...Stage 3-4 dermal ulcers...The following conditions are prohibited without a written exception: Stage 3-4 dermal ulcers..." No documentation was provided of a written exception. A preadmission assessment, dated 06/24/19, and a 14-day assessment, dated 07/08/19, documented resident #1 was oriented to person and place, was forgetful and had good judgment, required one to two person assistance for transfers, toileting, and dressing, and had a stage III pressure ulcer to the sacrum with wound care orders. A skin assessment, dated 06/24/19, documented resident #1 had reddened areas to the sacrum that remained after thirty minutes of pressure reduction to the sacrum and had open ulcer to the sacrum with treatment in place. The skin	C5010		

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C5010	Continued From page 21 assessment did not document measurements, description, or drainage to the pressure ulcer. A care plan, dated 06/24/19, documented resident #1 had a stage III pressure ulcer to the sacrum with treatment orders in place. The care plan did not document interventions or goals for the pressure ulcer. A shower/skin observation report, dated 06/25/19, documented resident #1 had a stage three pressure ulcer. The report did not document a description of the pressure ulcer. A home health plan of care for resident #1, dated 06/28/19, documented the patient/caregiver will verbalize understanding of dietary measures to support wound healing. The resident did not have any documentation in the record to indicate a dietician had seen the resident. A home health skilled nurse clinical note for resident #1, dated 06/28/19, documented, the resident had a stage III pressure ulcer to the coccyx with 25 % serosanguinous drainage on the dressing, it documented the periwound to be red and excoriated and was 1.5 cm in length (L) x 1 cm in width (W) x 0.5 cm in depth (D). The home health note documented the care giver was taught the wound care and verbalized understanding. A physician's order for resident #1, dated 06/27/19, documented, "...Wound to coccyx wound care as follows: Using aseptic technique SN (skilled nurse) to cleanse wound with SNS (sterile normal saline), pat dry with 4 x 4 gauze, apply gentamicin oint (ointment) and cover with dry protective dressing. Wound care to be done 3 x (three times) daily. HHS SN (home health	C5010		

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C5010	Continued From page 22 skilled nurse) to see patient 3 x weekly monitor wound condition, measure weekly..." The order documented it was a verbal telephone order and it was read back to the physician. A home health skilled nurse visit note addendum, dated 07/01/19, documented the wound was free from signs and symptoms of infection. A home health skilled nurse clinical note, dated 07/03/19, documented the resident had one stage III pressure ulcer on the coccyx with less than 25% of saturated serosanguinous drainage on the dressing, with periwound pink and excoriated with size 1.5 cm (L) x 1 cm (W) x 0.3 cm (D). The home health note documented the following wound care orders: "...Wound care to pressure ulcer at coccyx as follows: 1. Using aseptic technique, SN (skilled nurse) to cleanse wound with SNS (sterile normal saline) 2. Pat dry with 4 x 4 gauze 3. Apply Gentamycin ointment & cover with dry protective dressing. Wound care to be done 3 times daily. SN to see patient 3 x weekly to monitor wound condition and measure wound weekly...Wound care taught to CG/facility nurse and demonstrated understanding..." A home health skilled clinical note, dated 07/05/19, documented the above wound care was performed and was to be continued. The skilled note documented, "...PT/SO (patient/significant other) independent in wound care procedures & have knowledge of s/sx (signs and symptoms) of infection- Caregiver able to perform wound care as ordered...Partial..." A home care skilled nurse clinical note, dated 07/05/19, documented, resident #1 had a stage III pressure ulcer to the coccyx with less than 25 %	C5010		

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C5010	Continued From page 23 serosanguinous drainage to the dressing, periwound flesh excoriated with 25% granulation tissue to the wound bed and was 0.5 cm (L) x 0.5 cm (W) x 0.2 cm (D). A home health skilled nurse clinical note, dated 07/08/19, documented resident #1 now had two (2) wounds. The note documented wound #1 was a stage III pressure ulcer on the coccyx with less than 25% drainage and periwound flesh was intact. The note documented wound #2 was a partial thickness wound (Stage 2 pressure ulcer partial-thickness skin loss with exposed dermis.) to the left medial buttock with bloody drainage with the periwound pink and excoriated and measured 0.6 cm (L) x 0.5 cm (W) x 0.1 cm (D). The note documented the following wound care orders: "...Wound care to partial thickness wound on left butt cheek, towards midline: SN or CG to cleanse wound with SNS, pat dry with 4 x 4 gauze, apply Gentamycin ointment and cover with sacral optifoam. To be performed three times a week (MWF) and as needed...New wound care orders received...today..." A shower/skin observation report, dated 07/08/19, documented the resident had two areas marked one area of swelling and another area was documented as abnormal skin, swollen, decubitus (pressure ulcer) with drainage. A nurses progress note, dated 07/09/19 at 9:42 p.m., documented resident #1 complained of increased pain. The note did not document home health or the physician was notified of the resident's complaints of increased pain. A nurses progress note, dated 07/11/19 at 10:07 p.m., documented the resident stated she did not feel well and had "slight paleness to the face."	C5010		

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C5010	Continued From page 24 A nurses progress note, dated 07/12/19 at 9:56 a.m., documented the resident woke up this morning complained of pain to her sacral region related to the wound, was tired and did not want to eat. The note documented the home health nurse advised to send the resident to the emergency room. A hospital discharge summary for resident #1, dated 07/14/19, documented, "...infection of sacral decubitus wound...She was found to have hypertensive urgency and an infected sacral decubitus ulcer and was admitted to the medical floor for management...She was started on IVF (intravenous fluid) and Bactrim and the wound was mechanically debrided with significant improvement with decreased erythema...wound culture preliminary staph species...Discharge Assessment...Stage IV ulcer (Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed.) of sacrum inferiorly and a stage III superiorly..." A patient information sheet from the hospital, dated 07/14/19, documented, "...Chief Complaint from Patient: Sacral Ulcer and Pain...Wound clinic referral as soon as possible..." A home health skilled nurse clinical note, dated 07/15/19, documented resident #1 had two wounds, one stage III to the coccyx and one unstageable pressure ulcer with MRSA to the left buttock. The skilled nurses note documented the resident was on a low air loss mattress and the assisted living staff was to provide a house meal supplement 2-3 times daily between meals. The resident was observed to not have a low air loss	C5010		

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C5010	Continued From page 24 A nurses progress note, dated 07/12/19 at 9:56 a.m., documented the resident woke up this morning complained of pain to her sacral region related to the wound, was tired and did not want to eat. The note documented the home health nurse advised to send the resident to the emergency room. A hospital discharge summary for resident #1, dated 07/14/19, documented, "...infection of sacral decubitus wound...She was found to have hypertensive urgency and an infected sacral decubitus ulcer and was admitted to the medical floor for management...She was started on IVF (intravenous fluid) and Bactrim and the wound was mechanically debrided with significant improvement with decreased erythema...wound culture preliminary staph species...Discharge Assessment...Stage IV ulcer (Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed.) of sacrum inferiorly and a stage III superiorly..." A patient information sheet from the hospital, dated 07/14/19, documented, "...Chief Complaint from Patient: Sacral Ulcer and Pain...Wound clinic referral as soon as possible..." A home health skilled nurse clinical note, dated 07/15/19, documented resident #1 had two wounds, one stage III to the coccyx and one unstageable pressure ulcer with MRSA to the left buttock. The skilled nurses note documented the resident was on a low air loss mattress and the assisted living staff was to provide a house meal supplement 2-3 times daily between meals. The resident was observed to not have a low air loss	C5010		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/08/2019
NAME OF PROVIDER OR SUPPLIER BELFAIR OF MCALESTER			STREET ADDRESS, CITY, STATE, ZIP CODE 802 WINDSONG WAY MCALESTER, OK 74501		
(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	
C5010	Continued From page 25 mattress in place; the resident had a memory foam mattress on her bed, which was purchased by her family member. Additionally, resident #1 did not have an order for house meal supplements, and according to the treatment administration record did not receive house meal supplements until 07/28/19. A verbal physician's order, dated 07/28/19, documented an Ensure supplement was to be provided to resident #1 three times a day between meals. On 08/06/19 at 1:19 p.m., the registered nurse/director of nursing (RN/DON) stated resident #1 was admitted with one pressure ulcer. She stated she thought it was looking good and it "broke open and started weeping." She also stated she had not assessed the pressure ulcers. On 08/07/19 at 8:07 a.m., resident #1 stated her wounds on her bottom use to hurt more. She stated she was going to the doctor's office now to have it treated. She stated she did not remember going to the hospital. At 8:31 a.m., licensed practical nurse (LPN) #2 stated the resident went to the hospital in July 2019 due to the pressure ulcer and when she returned she was on isolation for Methicillin-resistant Staphylococcus Aureus (MRSA) (Gram-positive bacteria that are genetically distinct from other strains of staphylococcus aureus and are responsible for difficult to treat infections) in the pressure ulcer. She stated home health was responsible for wound care and she did not perform wound care to the resident's pressure ulcer. At 8:44 a.m., resident #1 was observed during	C5010			

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6102	(X2) MULTIPLE CONSTRUCTION A. BUILDING. _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/08/2019
NAME OF PROVIDER OR SUPPLIER BELFAIR OF MCALESTER		STREET ADDRESS, CITY, STATE, ZIP CODE 802 WINDSONG WAY MCALESTER, OK 74501		
(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
C5010	Continued From page 26 toileting and had two approximately 2 inch x 2 inch pink bordered dressings on her bottom area. At 8:47 a.m., long term care aide (LTCA)/employee #12 stated the resident was in pain when the wound was "red and oozing." At 10:10 a.m., resident #1's home health records were reviewed with the RN/DON. She stated the wound care was not supposed to be done three times a day. She stated that was a documentation error. The RN/DON stated home health was to do all the wound care; they did not come out three times a day, nor did the center's nurses perform the wound care. The RN/DON was asked how she would know if the home health was doing the correct wound care if the correct physician's orders were not in the record. She stated she would not know. At 11:29 a.m., LPN/sales director/employee #6 director stated the physician from the long term care facility the resident transferred from agreed to manage the pressure ulcer until the resident could be seen at the wound care clinic. At 2:44 p.m., the long term care physician stated he gave a verbal order for a wound care clinic consult to LPN/sales director/employee #6 while the home health nurse was on the phone. Resident #1's record did not document the verbal physician's order for the wound care clinic consult. The resident's record did not document the verbal order had been followed up on with the home health service. On 08/08/19 at 11:41 a.m., the RN/DON stated the resident had her first appointment with the wound care clinic on 08/01/19. She stated the dietician had not done a dietary consult for	C5010		

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/08/2019
NAME OF PROVIDER OR SUPPLIER BELFAIR OF MCALESTER			STREET ADDRESS, CITY, STATE, ZIP CODE 802 WINDSONG WAY MCALESTER, OK 74501		
(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	
C5010	Continued From page 27 resident #1. The RN/DON observed the mattress on the resident's bed and stated it was a memory foam mattress. Resident #1's record did not document the center assessed the stage III pressure ulcer or the partial thickness wound. No documentation was submitted which indicated the center had assessed the pressure ulcers. No documentation was submitted the dietician had been notified to assess the resident's dietary needs related to wound healing.	C5010			

STATE WORKLOAD REPORT

Provider/Supplier Number AL6102	Provider/Supplier Name BELFAIR OF MCALESTER
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Type of Survey (select all that apply)

1	3			
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- 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. <i>W</i> 36191	08/06/2019	08/08/2019	1.25	4.75	19.75	0.00	5.75	10.75
2. <i>W</i> 35195	08/06/2019	08/08/2019	0.75	4.75	19.75	0.00	8.25	10.00
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

AUG 27 2019 *jm*



Oklahoma State Department of Health
Creating a State of Health

September 9, 2019

License Number: AL6102

Mr. Robert Samples, Administrator
Belfair Of McAlester
802 Windsong Way
McAlester, OK 74501

Survey Event ID: K9VH11

Dear Mr. Samples:

On August 8, 2019, a complaint investigation was 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 **September 16, 2019**.

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) 271-6868.

Sincerely,

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

LC/KS

Board of Health

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 Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	OPTIONAL PLAN OF CORRECTION TEMPLATE		
	Current Date: 8/26/2019		
	Facility Name: Belfair of McAlester		
	License Number: AL 6102		
	Survey Event ID: K9VH11		
			Date Survey Completed: 8/8/2019
SUMMARY OF DEFICIENCY CITED BY OSDH			
ID Prefix Tag: C341		Based on: observation, interview, and record review, it was determined the center failed to deny admission to 1 of 1 resident who did not meet the center's admission criteria as outlined in the resident care service agreement.	
ASSISTED LIVING CENTER'S PLAN OF CORRECTION			
Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).			
REQUIRED ELEMENTS OF A PLAN		ASSISTED LIVING CENTER'S PLAN ELEMENTS	
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?		The individual resident affected by this has had a plan of accommodation created which laid out the coordination of care with the home health, wound care center and Belfair of McAlester.	
OSDH Response: Element accepted: Yes ☐ No ☐			
2. How will other residents having the potential to be affected by the same deficient practice be identified?		Staff who participate in the admission process have been in-serviced on the admission criteria for Belfair of McAlester.	
OSDH Response: Element accepted: Yes ☐ No ☐			
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?		The admission process has been streamlined so that only the Director of Nursing and/or the Administrator approves admissions into Belfair of McAlester.	
OSDH Response: Element accepted: Yes ☐ No ☐			
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:		The Administrator and/or the Director of Nursing will review all admissions monthly to ensure admission meet the center's admission criteria.	
a. How the correction will be evaluated for effectiveness;		The Quality Assurance Committee will monitor the plan for effectiveness	
b. How the correction will be incorporated into the center's quality assurance system; and		Monthly audit records performed by the Administrator and/or Director of Nursing will be kept in the Initial Survey and corrective action plan book.	
c. How monitoring records will be kept to evidence the correction.			
OSDH Response: Element accepted: Yes ☐ No ☐			
5. On what date will corrective action be completed?		9/13/2019	
OSDH Response: Element accepted: Yes ☐ No ☐			
Administrator's Signature Robert Samples OAC 310:663-25-4(F)			Date 9/6/2019
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			

Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.



Oklahoma State
Department of Health
Creating a State of Health

Protective Health Services
Long Term Care Service

OPTIONAL PLAN OF CORRECTION TEMPLATE

Current Date: 8/26/2019

Facility Name: Belfair of McAlester

License Number: AL 6102

Survey Event ID: K9VH11

Date Survey Completed: 8/8/2019

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C701

Based on: observation, interview and record review, it was determined the center failed to ensure the hot water available for resident use did not exceed 115 degrees.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

REQUIRED ELEMENTS OF A PLAN

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

OSDH Response: Element accepted Yes ☐ No ☐

2. How will other residents having the potential to be affected by the same deficient practice be identified?

OSDH Response: Element accepted Yes ☐ No ☐

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

OSDH Response: Element accepted Yes ☐ No ☐

4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include:

- How the correction will be evaluated for effectiveness;
- How the correction will be incorporated into the center's quality assurance system; and
- How monitoring records will be kept to evidence the correction.

OSDH Response: Element accepted Yes ☐ No ☐

5. On what date will corrective action be completed?

OSDH Response: Element accepted Yes ☐ No ☐

ASSISTED LIVING CENTER'S PLAN ELEMENTS

The maintenance Director has been in-serviced on appropriate water temperatures per OSDH regulations.

Weekly random audits will be performed by the Director of Maintenance and/or his designee and logs kept of the temperatures. Any adjustments will be made at the time of the weekly random audit.

Weekly random audits will be performed by the Director of Maintenance and/or his designee and logs kept of the temperatures. Any adjustments will be made at the time of the weekly random audit.

The maintenance Director has been in-serviced on appropriate water temperatures per OSDH regulations. Weekly random audits will be performed by the Director of Maintenance and/or his designee and logs kept of the temperatures. Any adjustments will be made at the time of the weekly random audit.

The Administrator will monitor weekly to ensure the audits are being performed.

The Quality Assurance Committee will monitor the plan for effectiveness.

9/13/2019

Administrator's Signature Robert Samples

OAC 310:663-25-4(F)

Date 9/6/2019

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.

Addendum Date	Enter a date of addendum.	Submitted by	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text.			
Facility in Compliance by: Click here to enter a date.			