OKLAHOMA
State Department
of Health

Delivery via email to: asfranklin@mrhcok.com

March 10, 2022

License Number: AL6102

Ms. Anna Franklin, Administrator
Belfair Of McAlester
802 Windsong Way
McAlester, OK 74501

Survey Event ID: P0YF11

Dear Ms. Franklin:

On **February 28, 2022,** representatives from the Oklahoma State Department of Health (OSDH) concluded 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

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Belfair of McAlester**
Address: **802 Windsong Way**
City, State, Zip: **McAlester, OK, 74501**
Provider #: **AL6102**
Complaint #: **OK00058394**
Investigation Date(s): **02/25/22 and 02/28/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center does not have an administrator as required by state regulation.	**US**
2. The center failed to have safe hot water temperatures.	**S**
3. The center failed to submit incident reports as required by state licensure and as required by abuse protocol.	**US**
4. The center failed to do assessments to update care plans as required by state licensure	**US**
5. The center failed to follow proper infection control procedures to prevent the spread of COVID.	**US**

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

An unannounced on-site investigation was initiated on 02/25/2022 at 12:12 p.m.

A sample of four residents, including any identified residents, was 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 unsubstantiated related to this allegation.

An investigation specific to the center's administrator was conducted.

A tour was conducted on entry. The center's administrator was present in the facility on entry and throughout the survey.

The administrator was interviewed and reported they had been hired to serve full time at the center on 02/01/22.

The administrator provided a copy of their licensure as an administrator.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, C0701 for details.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to the submission of incident reports in relation to abuse was conducted.

Tours were conducted on entry to the center and throughout the survey. Residents and staff interactions were observed to be cordial and respectful. Staff members in the memory care unit were observed to actively supervise and redirect residents as needed. Residents were observed to be calm and engaged in activities, watching television, conversing with other residents, or napping.

Staff members were interviewed and reported an understanding of the center's abuse protocol and who to report allegations. The staff members reported they were unaware of any reports of resident to resident abuse. Residents who were able to be interviewed reported they were happy with the care they received at the facility and had no concerns. The director of nursing reported the center had not had incidents of resident to resident abuse. The director of nursing reported if any abuse occurred it would be reported immediately to OSDH. The administrator reported any incident of abuse would have been reported to OSDH as required and interventions to protect residents would be initiated immediately.

Policy and procedures were reviewed. Education plans were reviewed. Skills check off for staff members were reviewed. Incident reports, including state reportable incidents reports were reviewed.

Allegation #4: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to required assessments and care plans was conducted.

Residents were observed at meals, during activities, in their rooms, and in the common area. Staff members were observed assisting residents to ambulate, with activities, cleaning their rooms, and providing ADL assistance as required.

Residents were interviewed and reported the center staff members met their needs and they were satisfied with the care they received at the center. Family members were interviewed and reported they were satisfied with the care their loved ones received at the center. Staff members were interviewed and reported assessments and care plans were updated as required and residents and/or resident representative were involved in the care plan process.

A sample of resident records were reviewed including assessments and care plans were reviewed and were current and applicable to the residents. Policies and procedures were reviewed.

Allegation #5: Deficient practice was unsubstantiated related to this allegation.

An investigation specific to infection control practices was conducted. On entry to the facility, signage was observed related to COVID-19 infection control along with a COVID-19 questionnaire and a thermometer. Alcohol based hand sanitizer was observed at the desk as well as in a dispenser. Masks were observed to be available for staff and visitor use. Alcohol based hand sanitizer dispensers were observed throughout the Assisted Living Center and was available for use in the Memory Care center. Staff members on both units were observed to perform hand hygiene as appropriate. ADL care was observed on the Memory Care unit and hand hygiene and infection control practices were observed to be performed by the staff at appropriate times.

Staff members were interviewed and reported an understanding of infection control practices. The staff members reported they had recent in-services related to infection control and COVID-19. Residents were interviewed and reported the staff wore masks and performed hand hygiene frequently and masks were available for resident use as well. The director of nursing reported the facility did not have any active cases of COVID-19 in residents or staff in over four weeks.

Policy and procedures were reviewed. Incident reports, including state reportable incidents, were reviewed. Infection control annual and update training were reviewed.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2. 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.

Deficient practice was unsubstantiated for allegation #1, #3, #4, and #5. No further action is required.

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

Thank you for bringing these concerns to our attention.

G. Rose Dosch RN

G. Rose Dosch RN

Date report completed: 03/01/2022

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	AL6102	A. BUILDING: _____ B. WING _____	C 02/28/2022

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 000	INITIAL COMMENTS A complaint investigation (#OK00058394) was conducted on 02/25/22 and 02/28/22. Listed below are abbreviations that will be used throughout this document. AL - Assisted Living CNA - Certified Nursing Aide DON - Director of Nursing F - Fahrenheit Res - Resident	C 000		
C 701 SS=D	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, the facility failed to ensure the water temperature of the assisted living (AL) Spa Room whirlpool did not exceed 115 degrees Fahrenheit (F) for three (#1, 2, and #3) of three residents identified by the facility as residents who utilized the whirlpool. The director of nursing (DON) reported 22	C 701		

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C 701	Continued From page 1	C 701		

residents resided in the AL.

Findings:

On 02/25/22 at 12:26 p.m., the following AL Spa Room water temperatures were obtained:
shower hot water - 117 degrees F,
hand washing sink - 62 degrees F, and
whirlpool - 126 degrees F.

On 02/25/22 at 12:29 p.m., Resident (Res) # 2 was observed participating in an activity in the hall near the AL Spa Room. Res #2 stated the water temperature in the Spa Room was always comfortable but the room temperature was sometimes cold.

Maintenance requests were reviewed from 01/26/21 through 02/25/22. Several maintenance requests were present for the AL Spa room, including one for 02/25/22, and were found to be related to room air temperature however none were documented as concerns for water temperatures greater than 115 degrees F.

On 02/25/22 at 1:27 p.m., the water temperature in the AL Spa Room was rechecked, with the administrator, and was found to be under 107 degrees F.

On 02/25/22 at 2:10 p.m., CNA #1 stated she checked water temperatures prior to assisting a resident into the whirlpool by using a thermometer and would keep the temperature at a comfortable level around 100 degrees.

On 02/25/22 at 3:20 p.m., Maintenance man #1 was observed in the AL Spa Room to conduct repairs related to the room air temperature. At that time Maintenance man #1 stated the center's

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April 5, 2022

License Number: AL6102

Anna Franklin, Administrator
Belfair Of McAlester
802 Windsong Way
McAlester, OK 74501

Survey Event ID: P0YF11

Dear Ms. Franklin:

On **February 28, 2022**, agents from our office completed a complaint investigation at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C 701**- The survey exit date was 02/28/22. The date of corrective action is documented as 02/28/22. There is not adequate time for monitoring to achieve compliance. The plan of correction date is not acceptable.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

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MAR 22 2022
Long Term Care

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amos Franklin — TITLE: Administrator — (X6) DATE: 3/15/22

Oklahoma State Department of Health

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Oklahoma State Department of Health

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April 13, 2022

License Number: AL6102

Ms. Anna Franklin, Administrator
Belfair Of McAlester
802 Windsong Way
McAlester, OK 74501

Survey Event ID: P0YF11

Dear Ms. Franklin:

On **February 28, 2022,** a complaint investigation was conducted at your Assisted Living Center. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. Your amended 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 **March 30, 2022**.

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.

Respectfully,

Tempal Killman Digitally signed by Tempal Killman
Date: 2022.04.13 12:03:01 -05'00'

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

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C 000	INITIAL COMMENTS A complaint investigation (#OK00058394) was conducted on 02/25/22 and 02/28/22. Listed below are abbreviations that will be used throughout this document. AL - Assisted Living CNA - Certified Nursing Aide DON - Director of Nursing F - Fahrenheit Res - Resident	C 000		
C 701 SS=D	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, the facility failed to ensure the water temperature of the assisted living (AL) Spa Room whirlpool did not exceed 115 degrees Fahrenheit (F) for three (#1, 2, and #3) of three residents identified by the facility as residents who utilized the whirlpool. The director of nursing (DON) reported 22	C 701	To determine appropriate water temperatures not greater than 115 degrees Fahrenheit in the resident spa room whirlpool. Environmental Services staff will monitor temperature of water from the spout monthly and record in appropriate log binder. The Administrator will be notified immediately of any temperatures recorded over 115 degrees Fahrenheit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6102	A. BUILDING: _____ B. WING _____	C 02/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF MCALESTER	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
C 701	Continued From page 1 residents resided in the AL. Findings: On 02/25/22 at 12:26 p.m., the following AL Spa Room water temperatures were obtained: shower hot water - 117 degrees F, hand washing sink - 62 degrees F, and whirlpool - 126 degrees F. On 02/25/22 at 12:29 p.m., Resident (Res) # 2 was observed participating in an activity in the hall near the AL Spa Room. Res #2 stated the water temperature in the Spa Room was always comfortable but the room temperature was sometimes cold. Maintenance requests were reviewed from 01/26/21 through 02/25/22. Several maintenance requests were present for the AL Spa room, including one for 02/25/22, and were found to be related to room air temperature however none were documented as concerns for water temperatures greater than 115 degrees F. On 02/25/22 at 1:27 p.m., the water temperature in the AL Spa Room was rechecked, with the administrator, and was found to be under 107 degrees F. On 02/25/22 at 2:10 p.m., CNA #1 stated she checked water temperatures prior to assisting a resident into the whirlpool by using a thermometer and would keep the temperature at a comfortable level around 100 degrees. On 02/25/22 at 3:20 p.m., Maintenance man #1 was observed in the AL Spa Room to conduct repairs related to the room air temperature. At that time Maintenance man #1 stated the center's	C 701	To protect all residents who utilize the spa room whirlpools; temperatures of the water will be tested prior to a resident entering the unit by running hot water thoroughly, filling a cup with the hot water, and testing the temperature with a liquid thermometer which is attached to the whirlpool water knob. Staff is to log the recorded temperature and immediately notify the Administrator if the water temperature is over 115 degrees F. If a water temperature is ever recorded above 115 degrees F, the resident will not utilize the whirlpool, the spa will be closed, and proper signage utilized to indicate the closure until the issue is safely resolved and proper water temperatures are achieved. Affected Residents: To date, there have been zero reported, recorded or known incidents of injury due to water temperatures in the spa whirlpools at Belfair of McAlester. Potentially affected residents: Anyone in the population with access to the spa. Date of corrective action began immediately on 2/28/22: A log was developed and implemented, thermometers were put in place, in-service training occurred, and all of the above communicated with surveyor prior to her exiting the community and concluding the survey. Corrective action is ongoing via the water temperature log and enforcement of proper procedure to ensure temperatures are tested, recorded monthly, and kept at an appropriate temperature under 115 degrees F. To today's date, monitoring has occurred on Feb 28, 2022 and March 30th, 2022. Scheduled again for April 29th to continue with the corrective action plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6102	A. BUILDING: _____ B. WING _____	C 02/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF MCALESTER	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
C 701	Continued From page 2 plumber was off during that day, but to his knowledge there had been no reports of water which was too hot. Maintenance man #1 stated the hot water boiler was usually set at 140 degrees F. The water temperature was retaken with the administrator and maintenance man #1 present and the hot water at the level of the faucet in the whirlpool was 142 degrees F. The administrator reported no residents would be allowed to use the AL spa room until the hot water was below 115 degrees F. On 02/28/22 at 9:39 a.m., the maintenance supervisor reported there had been no previous reports of excessively high water temperatures in the AL Spa Room and the hot water had been set to 115 degrees F Friday. He stated the facility would further monitor to ensure safe water temperatures for the residents. On 02/28/22 at 9:39 a.m., the administrator reported no knowledge of any resident sustaining a burn from using the AL Spa Room. On 02/28/22 at 11:20 a.m., Res #3 reported he had used the AL Spa Room whirlpool in the past but had not used it recently. Res #3 reported he had not experienced water that was too hot and could adjust the water temperature if needed.	C 701		

OKLAHOMA
State Department
of Health

Delivery via email to: asfranklin@mrhcok.com

January 4, 2023

License Number: AL6102

Anna Franklin, Administrator
Belfair Of McAlester
802 Windsong Way
McAlester, OK 74501

RE: Survey Event P0YF12

Dear Ms. Franklin:

Enclosed is the Assisted Living Center Licensure inspection deficiency report form, showing the summary of deficiencies noted during the revisit at your facility on **December 29, 2022**. These deficiencies remain uncorrected since your survey of **February 28, 2022**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written 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;
(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) 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 Analyst
Long Term Care
Protective Health Services

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6102	A. BUILDING: _____ B. WING _____	R-C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF MCALESTER	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
{C 000}	INITIAL COMMENTS A revisit was conducted on 12/29/22.	{C 000}		
{C 701} SS=D	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 record review, observation, and interview the facility failed to document spa water temperatures in the AL spa room. The administrator documented a census of 55. On 12/29/22 at 2:28 p.m., there were no temperature logs to document water temperatures in the spa. On 12/29/22 at 2:30 p.m., the administrator reported the spa room temperatures were not documented. The administrator reported the spa room temperatures should have been documented as part of the facilities plan of correction.	{C 701}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

OKLAHOMA
State Department
of Health

Delivery via email to: asfranklin@mrhcok.com

January 17, 2023

License Number: AL6102

Ms. Anna Franklin, Administrator
Belfair Of McAlester
802 Windsong Way
McAlester, OK 74501

RE: Survey Event P0YF12

Dear Ms. Franklin:

On **December 29, 2022**, a Licensure follow-up inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

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

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **December 30, 2022**.

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.

Respectfully,

Tempal Killman

Digitally signed by Tempal Killman
Date: 2023.01.17 14:08:39 -06'00'

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

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Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6102	A. BUILDING: _____ B. WING _____	R-C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF MCALESTER	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
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Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Jamie Franklin TITLE Administrator (X6) DATE 1/3/23

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/3/2023** **Facility Name:** Belfair of McAlester, LLC **License Number:** AL6102 **Survey Event ID:** P0YF12 **Date Survey Completed: 12/29/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C 701	Based on: Based on record review, observation, and interview the facility failed to document spa water temperatures in the AL Spa Room.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Upon reinspection of the exact verbiage used in the original POC, it was determined that in addition to the monthly water temperature check log, a log for each individual use was to have been constructed and maintained. This step was overlooked and the log was not in place at the time of revisit.

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?	On 12/29/22 the administrator constructed a log and housed it in the AL Spa room for immediate implimenation and maintaining. In-service was conducted with staff on-site and mass instruction sent to all staff. No residents had been adversely affected by the log not being present, because monthly inspections had been maintained and logged appropriately. Copies of the monthly water temperature inspection log was provided to the surveyor upon request. The corrective action plan of creating the log not found in place was completed upon departure of the surveyor 12/29/2022 & in full effect 12/30/2022. The logs will remain in place for one year, over the duration of four QA periods, to satisfy a consistent & acceptable amount of time ensuring the initial problem has been resolved. 12/29/2023
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	In addition to monthly water temperature checks being maintained, the spa has been out-of-order for resident use due to the HVAC system needing maintananced. A work order was sent to MRHC for repair on 10/19/2022. No spa use has occurred since that date. The HVAC repairs have now been contracted out due to the inability of MRHC's maintenance department to provide the repair service as quickly as desired. Those repairs are expected to be made within the next 30 days. Spa usage is optional, as every resident has a personal shower located in their room. There is no certainty a resident will utilize the spa tub or shower. However, the log is in place now, and any resident utilizing the spa will be identified by room number, date, time, and the water temperature documented by staff (initialed).
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic	The usage & temp log will be housed in the spa room and

changes made to ensure that the deficient practice will not recur?	maintained with each spa use. During the monthly inspection (currently being maintainted) the staff member completing the logging of temps will insure the logs are in place and daily accounts being reported in the log.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	Enter methods to ensure corrections are sustained: Effectiveness is evaluated by consistency of logging. The monthly temp logs should continue to validate the effectiveness of the daily temp checks. The initial correction, which decreased the temperature of the water being distributed by the hot water tank, addressed the initial problem of the water being above 115*f. The logs will continue to validate the correcting of the water temp from the source. The monthly check will evaluate the daily logs, continuously. The daily log maintenance will be implemented into Belfair's quarterly QA program. The daily use log is the monitoring record. And that daily log will be monitored by the monthly log.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	12/30/2022
OSDH Response: Element accepted Yes ☐ No ☐	
Administrator's Signature OAC 310:663-25-4(F) Administrator signature required.	**Date** Enter a date of signature. 1/3/23
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** A
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

Delivery via email to: asfranklin@mrhcok.com

FINAL DETERMINATION NOTICE
Tracking # 7021 2720 0002 0354 1402

March 8, 2023

License Number: AL6102

Anna Franklin, Administrator
Belfair Of McAlester
802 Windsong Way
McAlester, OK 74501

Survey Event ID: P0YF13

Dear Ms. Franklin:

A revisit conducted **February 28, 2023**, revealed that your facility corrected deficiencies effective **December 30, 2022**.

We will notify you of any enforcement actions being taken. If you have any questions, please contact me 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

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Analyst
Long Term Care
Protective Health Services

Enclosure:

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6102	A. BUILDING: _____ B. WING _____	R-C 02/28/2023

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 000}	INITIAL COMMENTS A revisit was conducted on 02/28/23. All deficiencies from the 02/28/22 survey were cleared.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE