Oklahoma State Department of Health
Creating a State of Health

December 5, 2019

License Number: AL6304

Ms. Genia Manion, Administrator
Belfair Of Shawnee
1723 N Airport Drive
Shawnee, OK 74804

RE: Survey Event ID: 1TNM11

Dear Ms. Manion:

On **November 14, 2019**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on November 14, 2019.

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;
(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,

for Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

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
	AL6304	A. BUILDING: _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 re-licensure survey was conducted on 11/13/19 and 11/14/19. Census was 46. Deficient practice was cited as follows.	C 000		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure: a) a 14 day admission assessment was completed on 2 (#2 and #8) of 8 sampled residents and; b) an annual comprehensive assessment was completed on 1 (#4) of 8 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #2 Resident #2 moved into the center on 08/21/19. The pre-admission assessment, dated 08/19/19, documented diagnoses to include dementia, behavioral disturbances, atrial fibrillation, type 2 diabetes mellitus, essential hypertension, major neuro-cognitive disorder, Alzheimer's, coronary	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 522	Continued From page 1 artery disease, and hyperlipidemia. On 11/14/19 at 4:25 p.m., the LPN stated there was no resident or resident representative signature on the comprehensive annual assessment dated 09/04/19 and the family representative meeting for the comprehensive annual assessment had not taken place. RESIDENT #8 Resident #8 moved into the center 10/11/19. The preadmission assessment, dated 10/09/19, documented diagnoses to include glaucoma, recent left hip fracture, bilateral rotator cuff repair, coronary artery disease, congestive heart failure, and a pacemaker. On 11/14/19 at 3:15 p.m. during the review of records no comprehensive annual assessment was found in the chart for resident #8. On 11/14/19 at 3:30 p.m., the LPN/DON stated the comprehensive annual assessment had not been completed for residents #8. RESIDENT #4 Resident #4 moved into the center on 12/19/13. The last comprehensive annual assessment, dated 07/11/18, documented diagnoses to include nephrolithiasis with an indwelling supra-pubic catheter, gastro-esophageal reflux disease, bipolar, anxiety, dementia, hypertension, glaucoma, coronary artery disease, and hyperlipidemia. On 11/14/19 at 4:25 p.m., the LPN stated the date of the comprehensive annual assessment was not current or completed within the 12 month time	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 522	Continued From page 2 period.	C 522		
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) had been provided to 7 (#12, 13, 14, 15, 16, 17 and #18) of 31 direct care employees; and b) First aid training had been provided to 7 (#12, 13, 14, 15, 16, 17 and #18) of 31 direct care employees. These failed practices resulted in the widespread potential for more than minimal harm for all 46 residents. Findings: On 11/13/19 at 2:20 p.m., a record review revealed the following direct care employees had not been provided CPR and first aid training: Long term care aid (LTCA)/employee #12 - hired 09/11/19, LTCA/employee #13 - hired 06/07/19, LTCA/employee #15 - hired 05/24/19, and; LTCA/employee #18 - hired 08/05/19. On 11/13/19 at 2:30 p.m., a review records	C 954		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 954	Continued From page 3 revealed the following direct care employees who were employed over one year did not have documentation showing CPR and first aid training: LTCA/employee #16 - hired 03/20/18, LTCA/Certified medication aide (CMA) employee #14 - hired 01/09/14, and; LTCA/CMA employee #17 - hired 04/10/14. On 11/14/19 at 4:30 p.m., the LPN/DON stated the direct care employees #12, through #18 had no documentation verifying CPR and first aid had been completed. The administrator stated it was time for a new CPR/first aid in-service certification class and they did not have the class scheduled at the time of survey.	C 954		
C5010 SS=E	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 the Home Care Act. D. The assisted living center shall monitor and	C5010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A BUILDING _____ B WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 4 assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to coordinate care with third party providers by ensuring correct documentation and treatments were rendered and monitored per home health and hospice plans of care (485) for 3 (#3, 4 and #8) of 5 sampled residents with third party provider care plans. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #3 Resident #3 moved into the center on 01/03/18. The last comprehensive annual assessment, dated 11/17/18, documented diagnoses to include Alzheimer's with behaviors, hypertension, hyperlipidemia, dysrithmia, and major neuro-cognitive disorder.	C5010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 5 On 11/14/19, at 4:05 p.m., a record review was performed and a current hospice certified plan of care detailing interventions for hypertensive heart disease and heart failure was not in the third party provider book or in the resident chart. On 11/14/19 at 4:15 p.m., the LPN/DON stated resident #3 was obtaining hospice care detailing hypertensive heart disease and heart failure. The LPN/DON stated there was no current hospice plan of care in the center for resident #3. RESIDENT #4 Resident #4 moved into the center on 12/19/13. The last comprehensive annual assessment, dated 07/11/18, documented diagnoses to include nephrolithiasis with an indwelling supra-pubic catheter, gastro-esophageal reflux disease, bipolar, anxiety, dementia, hypertension, glaucoma, coronary artery disease, and hyperlipidemia. On 11/14/19, at 4:07 p.m., a record review was performed and a current home health certified plan of care detailing interventions for supra-pubic catheter care for resident #4 was not in the third party provider book or in the resident chart. On 11/14/19 at 4:16 p.m., the LPN/DON stated resident #4 was obtaining home health care for supra-pubic catheter care. The LPN/DON stated there was no current home health plan of care in the center for resident #4. RESIDENT #8 Resident #8 moved into the center on 10/11/19.	C5010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 6 The preadmission assessment, dated 10/09/19, documented diagnoses to include glaucoma, recent left hip fracture, bilateral rotator cuff repair, coronary artery disease, congestive heart failure, and a pacemaker. On 11/14/19, at 4:10 p.m., a record review was performed and a current home health certified plan of care detailing interventions for hypertension and muscle weakness for resident #8 was not in the third party provider book or in the resident chart. On 11/14/19 at 4:17 p.m., the LPN/DON stated resident #8 was obtaining home health care for hypertension and muscle weakness. The LPN/DON stated there was no current home health plan of care in the center for resident #8. At the time of survey, no current hospice orders or home health 485 plans of care were in the center for resident #3, #4, and #8.	C5010		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
AL6304	BELFAIR OF SHAWNEE

Type of Survey (select all that apply)

2				

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

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 42023	11/13/2019	11/14/2019	0.50	0.00	22.00	0.00	4.00	1.50
2.								
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**

DEC 09 2019

Oklahoma State Department of Health
Creating a State of Health

December 18, 2019

License Number: AL6304

Ms. Genia Manion, Administrator
Belfair Of Shawnee
1723 N Airport Drive
Shawnee, OK 74804

RE: Survey Event 1TNM11

Dear Ms. Manion:

On November 14, 2019, a Licensure 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 will be corrected and you will be in substantial compliance by **February 3, 2020**.

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,

Sue Davis
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

SD/jt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 re-licensure survey was conducted on 11/13/19 and 11/14/19. Census was 46. Deficient practice was cited as follows.	C 000		
C 522 SS=E	310:663-5-2(b) ASSESSMENT TIMEFRAMES (b) The assisted living center shall complete the comprehensive assessment in accordance with the following: (1) within fourteen (14) days after admission of the resident; (2) once every twelve (12) months thereafter; and (3) promptly after a significant change in the resident's condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure: a) a 14 day admission assessment was completed on 2 (#2 and #8) of 8 sampled residents and; b) an annual comprehensive assessment was completed on 1 (#4) of 8 sampled residents. This failed practice resulted in the potential for more than minimal harm at a pattern. Findings: RESIDENT #2 Resident #2 moved into the center on 08/21/19. The pre-admission assessment, dated 08/19/19, documented diagnoses to include dementia, behavioral disturbances, atrial fibrillation, type 2 diabetes mellitus, essential hypertension, major neuro-cognitive disorder, Alzheimer's, coronary	C 522	The facility will ensure that all sampled residents have current and accurate assessments completed. Residents identified from survey have been reviewed and now compliant on all assessments. A review of at least 20% of current residents will be completed monthly by the Director of Nursing Services to ensure compliance. Any deficient areas noted will be corrected immediately. This process will be overseen by the Executive Director to ensure continual compliance. The audit will be presented to the QA committee each month for review of any needed process or policy changes. This will be done for a period of 90 days. The QA committee will then review quarterly for 6 months or until such a time as full compliance has been achieved and current systems and processes are effective for a period of at least 3 months.	2/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 522	Continued From page 1 artery disease, and hyperlipidemia. On 11/14/19 at 4:25 p.m., the LPN stated there was no resident or resident representative signature on the comprehensive annual assessment dated 09/04/19 and the family representative meeting for the comprehensive annual assessment had not taken place. RESIDENT #8 Resident #8 moved into the center 10/11/19. The preadmission assessment, dated 10/09/19, documented diagnoses to include glaucoma, recent left hip fracture, bilateral rotator cuff repair, coronary artery disease, congestive heart failure, and a pacemaker. On 11/14/19 at 3:15 p.m. during the review of records no comprehensive annual assessment was found in the chart for resident #8. On 11/14/19 at 3:30 p.m., the LPN/DON stated the comprehensive annual assessment had not been completed for residents #8. RESIDENT #4 Resident #4 moved into the center on 12/19/13. The last comprehensive annual assessment, dated 07/11/18, documented diagnoses to include nephrolithiasis with an indwelling supra-pubic catheter, gastro-esophageal reflux disease, bipolar, anxiety, dementia, hypertension, glaucoma, coronary artery disease, and hyperlipidemia. On 11/14/19 at 4:25 p.m., the LPN stated the date of the comprehensive annual assessment was not current or completed within the 12 month time	C 522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 522	Continued From page 2 period.	C 522		
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) had been provided to 7 (#12, 13, 14, 15, 16, 17 and #18) of 31 direct care employees; and b) First aid training had been provided to 7 (#12, 13, 14, 15, 16, 17 and #18) of 31 direct care employees. These failed practices resulted in the widespread potential for more than minimal harm for all 46 residents. Findings: On 11/13/19 at 2:20 p.m., a record review revealed the following direct care employees had not been provided CPR and first aid training: Long term care aid (LTCA)/employee #12 - hired 09/11/19, LTCA/employee #13 - hired 06/07/19, LTCA/employee #15 - hired 05/24/19, and; LTCA/employee #18 - hired 08/05/19. On 11/13/19 at 2:30 p.m., a review records	C 954	The facility will ensure that all direct care staff have been trained in first aid and cardiopulmonary resuscitation. The staff that were noted has been non-compliant during this survey have now completed training on first aide and cardiopulmonary resuscitation. The facility will continue to provide this training two times annually and will also add this training into the general orientation process upon hire. The Human Resources staff will complete a new hire checklist for each employee upon hire. This checklist will include first aide and cardiopulmonary resuscitation training. Proof of this training will be maintained in the employee records. The Human Resources staff will complete a monthly audit sheet of all direct care staff to ensure compliance with CPR & First aide. This audit will be provided to the Executive Director for review by the 5th day of each month for the prior month. This audit will then be presented to the QA committee monthly for 90 days and then will be provided quarterly after the 90 days or until such a time as the committee feels that the current process is effective in maintaining continual compliance in this deficient practice.	2/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 954	Continued From page 3 revealed the following direct care employees who were employed over one year did not have documentation showing CPR and first aid training: LTCA/employee #16 - hired 03/20/18, LTCA/Certified medication aide (CMA) employee #14 - hired 01/09/14, and; LTCA/CMA employee #17 - hired 04/10/14. On 11/14/19 at 4:30 p.m., the LPN/DON stated the direct care employees #12, through #18 had no documentation verifying CPR and first aid had been completed. The administrator stated it was time for a new CPR/first aid in-service certification class and they did not have the class scheduled at the time of survey.	C 954		
C5010 SS=E	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 the Home Care Act. D. The assisted living center shall monitor and	C5010	The facility will continue to ensure that the coordination of care with third party providers is documented and present in the current plan of care. All sampled residents that were noted has being deficient has been reviewed and the current plan of care is now present and correct. Residents who are receiving hospice and home health services will have a monthly audit completed by the Director of Nursing. Any deficient areas noted will be addressed immediately by the Director of Nursing. This audit will be presented to the facility Executive Director for review. This audit will then be provided to the QA committee team for review and to ensure that the current processes and procedures are effective. This audit will be completed monthly for the next 90 days and then will be completed quarterly until such a time as the team feels that the current processes are effective and continual compliance has been achieved.	2/03/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 4 assure the delivery of those services. All nursing services shall be in accordance with the written orders of the personal or attending physician of the resident. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the center failed to coordinate care with third party providers by ensuring correct documentation and treatments were rendered and monitored per home health and hospice plans of care (485) for 3 (#3, 4 and #8) of 5 sampled residents with third party provider care plans. This failed practice had the potential for more than minimal harm at a pattern. Findings: RESIDENT #3 Resident #3 moved into the center on 01/03/18. The last comprehensive annual assessment, dated 11/17/18, documented diagnoses to include Alzheimer's with behaviors, hypertension, hyperlipidemia, dysrithmia, and major neuro-cognitive disorder.	C5010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 5 On 11/14/19, at 4:05 p.m., a record review was performed and a current hospice certified plan of care detailing interventions for hypertensive heart disease and heart failure was not in the third party provider book or in the resident chart. On 11/14/19 at 4:15 p.m., the LPN/DON stated resident #3 was obtaining hospice care detailing hypertensive heart disease and heart failure. The LPN/DON stated there was no current hospice plan of care in the center for resident #3. RESIDENT #4 Resident #4 moved into the center on 12/19/13. The last comprehensive annual assessment, dated 07/11/18, documented diagnoses to include nephrolithiasis with an indwelling supra-pubic catheter, gastro-esophageal reflux disease, bipolar, anxiety, dementia, hypertension, glaucoma, coronary artery disease, and hyperlipidemia. On 11/14/19, at 4:07 p.m., a record review was performed and a current home health certified plan of care detailing interventions for supra-pubic catheter care for resident #4 was not in the third party provider book or in the resident chart. On 11/14/19 at 4:16 p.m., the LPN/DON stated resident #4 was obtaining home health care for supra-pubic catheter care. The LPN/DON stated there was no current home health plan of care in the center for resident #4. RESIDENT #8 Resident #8 moved into the center on 10/11/19.	C5010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL6304	A. BUILDING: _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(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 6 The preadmission assessment, dated 10/09/19, documented diagnoses to include glaucoma, recent left hip fracture, bilateral rotator cuff repair, coronary artery disease, congestive heart failure, and a pacemaker. On 11/14/19, at 4:10 p.m., a record review was performed and a current home health certified plan of care detailing interventions for hypertension and muscle weakness for resident #8 was not in the third party provider book or in the resident chart. On 11/14/19 at 4:17 p.m., the LPN/DON stated resident #8 was obtaining home health care for hypertension and muscle weakness. The LPN/DON stated there was no current home health plan of care in the center for resident #8. At the time of survey, no current hospice orders or home health 485 plans of care were in the center for resident #3, #4, and #8.	C5010		

OKLAHOMA
State Department
of Health

Delivery via email to: gmanion@belfairseniorliving.com

November 17, 2020

License Number: AL6304

Genia Manion, Administrator
Belfair Of Shawnee
1723 N Airport Drive
Shawnee, OK 74804

RE: Survey Event 1TNM12

Dear Ms. Manion:

On **November 12, 2020,** a desk audit/paper revisit was conducted with your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **November 14, 2019,** have now been corrected effective **February 3, 2020.**

If you have any questions concerning the information in this letter, please contact an Enforcement worker at (405) 271-6868.

Sincerely,

Users, Lisa D Calvin
Digitally signed by Users, Lisa D Calvin
Date: 2020.11.17 12:40:03 -06'00'

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

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
	AL6304	A. BUILDING: _____ B. WING _____	R 11/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELFAIR OF SHAWNEE	1723 N AIRPORT DRIVE SHAWNEE, OK 74804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS An offsite/paper revisit was completed on 11/12/20. Credible evidence of correction was submitted for all defficiencies from 11/14/19. An offsite/paper revisit was completed on 11/12/20. Credible evidence of correction was submitted for all defficiencies from 11/14/19.	{C 000}		

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