OKLAHOMA
State Department
of Health

Delivery via email to: Gsanders@belfairseniorliving.com

June 1, 2022

License Number: AL6304

Ms. Gay Sanders, Administrator
Belfair Of Shawnee
1723 N Airport Drive
Shawnee, OK 74804

Survey Event ID: K4LQ11

Dear Ms. Sanders:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **May 25, 2022**. No deficiencies were cited. Oklahoma Statutes require that this report be made available for public inspection within the facility for the next three years.

If you have any questions concerning this report, please call me at (405) 426-8200.

Sincerely,

Lisa Calvin

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

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Belfair of Shawnee**
Address: **1723 N Airport Drive**
City, State, Zip: **Shawnee, OK, 74804, Pottawatomie**
Provider #: **AL6304**
Complaint #: **#OK00055344**
Investigation Date(s): **05/24/2022 – 05/25/2022**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure the resident's right to privacy	**US**

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

An unannounced on-site investigation was initiated on 05/24/2022 at 1:00 p.m.

A sample of four residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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.

There were no privacy concerns upon entry to the facility. Staff providing care in resident rooms had the proper privacy barriers in place. Did not observe staff using their cell phones at any time during the investigation.

Administrative staff were not employed at the time the incident being investigated occurred.

Reviewed the employee file and disciplinary write up and termination record for the employee involved in the incident being investigated. No concerns noted.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegation #1. No further action is required.

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

Thank you for bringing these concerns to our attention.

Audra Smith Digitally signed by Audra Smith
Date: 2022.05.25 16:55:14 -05'00'

Audra Smith, LPN

Date report completed: 05/25/2022

Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Belfair of Shawnee**
Address: **1723 N Airport Drive**
City, State, Zip: **Shawnee, OK, 74804, Pottawatomie**
Provider #: **AL6304**
Complaint #: **#OK00058858**
Investigation Date(s): **05/24/2022 – 05/25/2022**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The facility failed to ensure residents were free from abuse.	**US**
2. The facility failed to put interventions in place to prevent falls.	**US**
3. The facility failed to ensure staff were qualified to care for residents.	**US**

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

An unannounced on-site investigation was initiated on 05/24/2022 at 1:00 p.m.

A sample of four residents including any identified resident(s), was selected for the investigation based on the concerns relevant to the allegation(s).

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

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

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

On entry to the facility several residents were in the dining room finishing their noon meal. Other residents were ambulating throughout the facility without assistance or ambulating in their wheelchairs. Residents were alert, responding appropriately and did not appear to be sedated.

All four sampled residents were alert but not able to be interviewed due to their cognitive status. Spoke with each residents' family via phone. Family members reported they were satisfied with the care their loved ones were receiving at the facility. They did not feel the residents were over medicated. Several family members

reported being informed of medication orders and when those medications were changed or discontinued. They felt the staff have been meeting their needs.

Staff were interviewed and reported that they did not feel the residents were overmedicated.

Reviewed the Medication Administration Record for the four sampled residents. Medications were administered per physician's orders.

Reviewed progress notes, incident reports, physician's orders, resident assessments, grievances and no concerns were identified.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

On entry to the facility several residents were in the dining room finishing their noon meal. Other residents were ambulating throughout the facility without assistance or ambulating in their wheelchairs. No safety hazards noted.

Family members were interviewed for the four sampled residents They reported that the residents had falls at home and that the falls in the facility were expected and not unusual for the resident. They expressed being pleased with the care that the residents were receiving.

Staff were interviewed and reported that falls were being tracked to look for trends and that they are trying to involved home health, therapy and activities as an intervention regarding falls.

Reviewed progress notes, incident reports, physician's orders, resident assessments, grievances and no concerns were identified.

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

On entry to the facility staff were assisting residents in the dining room with their noon meal or out on the floor assisting residents.

Staff were interviewed and reported having the proper certifications and/or licenses.

A review of six employees filed was conducted. Individual licenses, certifications and trainings were reviewed and no concerns were identified.

Determination Summary and Follow-Up Action:

Deficient practice was unsubstantiated for allegations #1, 2 and #3. 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.

Audra Smith Digitally signed by Audra Smith
Date: 2022.05.25 16:39:15 -05'00'

Audra Smith, LPN

Date report completed: 05/25/2022

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 _____	C 05/25/2022

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 Abbreviated survey was conducted on 05/24/22 to 05/25/22 for an investigation complaint (#OK00055344 and #OK00058858). No deficiencies were cited.	C 000		

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