OKLAHOMA
State Department
of Health

Delivery via email to: nursing@belfairseniorliving.com; Gsanders@belfairseniorliving.com

January 3, 2023

License Number: AL6304

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

Survey Event ID: M0YO11

Dear Ms. Sanders:

On **December 14, 2022, r**epresentatives 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 Analyst
Long Term Care
Protective Health Services

Enclosure

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Belfair of Shawnee**
Address: **1723 N Airport Drive**
City, State, Zip: **Shawnee, OK. 74804**
Facility ID #: **AL6304/ALC**
Complaint #: **OK00059429**
Investigation Date(s): **12/06/22, 12/13/22, and 12/14/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center failed to assess, monitor, and intervene for a change in condition related to excessive pain.	S

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

An unannounced on-site investigation was initiated on 12/06/2022 at 1:10 p.m.

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

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

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

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag 1505 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.

_____

Jennie Lewis LPN

Date report completed: 12/21/2022

OKLAHOMA
State Department
of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Belfair of Shawnee**
Address: **1723 N Airport Drive**
City, State, Zip: **Shawnee, OK 74804**
Provider #: **AL6304**
Complaint #: **OK00059771**
Investigation Date(s): **12/06/22, 12/13/22, and 12/14/22**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The center neglected to provide the necessary care and assistance required by the dependent resident.	**US**

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

An unannounced on-site investigation was initiated on 12/06/2022 at 1:10 p.m.

A sample of 4 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.

An investigation specific to the center neglecting to provide the necessary care and assistance required by the dependent resident was conducted.

Resident care observations were conducted throughout the survey. Call lights were observed being answered in a timely manner. Certified nursing assistants were observed to have provided and/or offered assistance to residents every one to two hours and as needed depending on the resident's level of care and/or plan of care. Residents were observed being provided with assistance with activities of daily living and were not observed to be unkempt or overly saturated with urine or feces. Residents' rooms were observed to be clean and tidy upon

inspection. There were no lingering odors of urine or feces. Hourly rounding logs for certified nursing assistants' documentation upon completion were observed at the nurse station.

The sampled residents stated they received necessary care and assistance from the staff in a timely manner. One of the sampled residents stated he had been left alone without staff assistance for one night which resulted in a fall with hip fracture. The staff stated all residents were to be monitored and provided with assistance if needed at least every two hours regardless of additional supervision provided by family/friends. The staff stated some residents were monitored and offered assistance on an hourly basis according to their level of care and/or plan of care. The DON stated an in-service was conducted in which staff were educated on abuse/neglect and the requirement to monitor/round on all residents at least every two hours and at least hourly on specific residents who resided in the center.

Policy and procedures, medical records, physician orders, care plans, incident reports, and in-service documentation was reviewed. Documentation of a state reportable incident report was reviewed. The state incident report documented an investigation completed by the center with substantiated findings related to lack of staff supervision for a resident which resulted in a fall with fracture. The report documented the Oklahoma Board of Nursing and Oklahoma State Department of Health Nurse Aide Registry were notified of the staff involved in the occurrence. In-service logs documented the staff were provided with education to monitor/round on all residents who resided within the center frequently regardless of additional supervision provided by family or friends. In-service logs documented the staff were educated over abuse and neglect after the occurrence.

At the time of the investigation, there was no deficient practice identified regarding the center failing to provide the necessary care and assistance required by the dependent resident.

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.

Alisha Conley

Clinical Health Facility Surveyor

Date report completed: 12/15/2022

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 12/14/2022

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 Complaint investigations (#OK00059429 and #OK00059771) were conducted on 12/06/22, 12/13/22, and 12/14/22. Listed below are abbreviations that will be used throughout this document: CNA- Certified Nurse aide c/o - complaint of cont - continues DON - Director of Nursing DM - diabetes mellitus d/t - due to HH - home health LE - left extremity LPN- License Practical Nurse Lt - left Res- resident ROM - range of motion SN - skilled nurse	C 000		
C1505 SS=E	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of	C1505		

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 12/14/2022

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
C1505	Continued From page 1 proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure residents received adequate care for three (#2, 3, and #4) of four residents sampled for medical care. The facility failed to: a. put interventions in place to help prevent falls and follow facility policy for documentation related to falls for Res #2 and #3. b. intervene in a timely manner for a resident with complaints of pain for Res #4. The "Daily Census" for 12/05/22 documented 29 residents resided at the facility.	C1505		

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 12/14/2022

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
C1505	Continued From page 2 Findings: An undated facility policy titled, "Fall Risk Assessment and Prevention," read in parts, "...post non-injury fall management...Assess for any injury...Obtain vital signs...Obtain neuro checks if there was a head injury...Assess for change in range of motion...Monitor resident as condition warrants per policy...Document in chart...Report the fall to the physician...Modify the care plan as patient condition warrants...Notify the family...Provide additional resident/family education...Place resident in 72-hour charting book...Residents are to be reassessed with any status change by the nurse...The Interdisciplinary Fall Risk Assessment Tool will be updated at that time..." 1. Res #2 was admitted with diagnoses which included unspecified dementia, myoneural disorders, depressive episodes, and hypertension. A care plan, dated 02/16/22, documented Res #2 was dependent with mobility, occasionally incontinent, and had moderate impairment in mental status. A fall risk assessment tool, dated 06/07/22, documented Res #2 at high risk for falls. An incident report, dated 08/25/22, documented the resident fell to right side while trying to ambulate without assistance in the dining room. The report documented no injury sustained with fall. There was no documentation of a fall risk assessment tool, 72-hour charting book, or care plan modification for the 08/25/22 fall.	C1505		

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 12/14/2022

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
C1505	Continued From page 3 Incident reports dated, 09/05/22, 09/21/22, and 10/27/22, documented Res #2 had fell without major injury. There was no documentation of 72-hour charting or that the care plan had been modified with a new intervention that had not already been enacted after a fall at an earlier date for the 09/05/22, 09/21/22, and 10/27/22 falls. An annual resident assessment form, dated 10/25/22, documented Res #2 was alert, forgetful, and had poor judgement. The assessment documented the resident was incontinent of bowel and bladder, had poor mobility, strength, gait, and required one person assistance with ambulation and activities of daily living. Incident reports dated, 11/13/22, 11/24/22, and 11/30/22, documented Res #2 had fell without major injury. There was no documentation of a fall risk assessment tool or 72-hour charting for the 11/13/22, 11/24/22, and 11/30/22 falls. On 12/13/22 at 1:30 p.m., Res #2 was observed sitting in a high-back wheelchair beside the nurse's station. The resident stated he had fell a couple of times lately due to losing his balance but denied injury or discomfort. On 12/14/22 at 9:30 a.m., the DON stated the care plan for Res #2 was not updated after the 08/25/22 fall but should have been according to policy. The DON stated fall risk assessments for the falls that occurred on 08/25/22, 11/13/22, 11/24/22, and 11/30/22 could not be found and were not completed. She stated 72-hour post fall	C1505		

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 12/14/2022

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
C1505	Continued From page 4	C1505		

charting had not been completed for any resident after a fall. The DON stated new fall interventions had not been documented on Res #2's care plan after the falls that occurred on 09/05/22, 09/21/22, and 10/27/22.
2. Res #3 was admitted with diagnoses of Alzheimer's disease, bradycardia, and diabetes mellitus.

A care plan, dated 10/04/22, documented resident #3 was independent with mobility inside the facility, was incontinent, and had heavy impairment in mental status.

A fall risk assessment tool, dated 10/04/22, documented the resident was at high risk for falls.

There was no documentation of incident reports for falls on 9/23/22 and 10/16/22.

There was no documentation of risk assessments for falls on 10/06/22, 10/10/22, 10/16/22, and 10/17/22.

There was no revision to the care plan for falls on 09/24/22 and 09/25/22.

The falling star form was not documented for falls on 09/24/22, 09/25/22, and 10/06/22.

On 12/14/22 at 9:35 a.m., the DON stated new interventions needed to be added to help prevent falls and documentation needed to be completed according to policy.

3. Res #4 was admitted on 06/26/18 with diagnoses of age related cognitive decline, other malaise, and hypertension.

A nurse's note, dated 07/29/22, documented the

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 12/14/2022

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
C1505	Continued From page 5	C1505		

resident fell in the common area. The nurse's note documented the resident complained of pain to her left knee and right lower extremity. The nurse's note documented x-rays were ordered for both knees and both tibia/fibulas with negative results for fractures.

A "Resident Shower/Skin Observation Report," dated 07/30/22, documented a handwritten note, "Bad fall yesterday, sponge bath, red raw rash under breast, really sore on Lt hip- barely move & it hurts her a lot." The report was signed by the CNA, LPN, and DON.

A nurse note, dated 07/30/22, documented the resident complained of pain when transferring to left extremity.

A nurse note, dated 08/01/22, documented the resident transferred from the bed to the recliner and stated did not want to get up because it hurt everywhere.

A nurse note, dated 08/04/22, documented the resident continued to voice pain during transfers.

A nurse note, dated 08/09/22, documented "SN approached by family with concerns about Res pain and 0 recoup from fall. Offered family repeat x-ray d/t decrease swelling and possible HH for therapy. SN in to assess res. Res present with cont. decrease ROM to Left LE. C/O in thigh when performing ROM exercise. Res also cont. with decrease in appetite. Res remained in bed for meals this shift. Spoke with family about x-ray to left hip and femur. Res cont. to express pain during routine are as well as fear of falling x-ray obtain awaiting results. Pain meds given per ordered. Will continue to monitor."

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 12/14/2022

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
C1505	Continued From page 6 A nurse note, dated 08/10/22, documented The Res continued with complaints of pain with movement to left leg. Results received of x-ray showing acute subcapital fracture of left hip. On 08/11/22, the resident was transferred to the hospital for frature. On 12/13/22 at 3:17 p.m., the CNA #1 was asked if they had reported the resident's complaint of left hip pain to the charge nurse. The CNA stated, "Yes." On 12/13/22 at 3:25 p.m., LPN #1 was asked if she signed off on the shower forms right after the shower was completed. She stated, "Yes." The LPN was asked if the resident had complained of left hip pain. The LPN stated according to her CNA, she had. The LPN was asked if the resident's complaint of left hip pain had been addressed. The LPN stated, "No, because she did not complain of pain in her hip when I did my assessment." On 12/13/22 at 4:48 p.m., the DON was shown the shower form, dated 07/30/22, and asked if the resident's complaint of left hip pain should have been addressed immediately. The DON stated, "Yes."	C1505		

OKLAHOMA
State Department
of Health

Delivery via email to: TEllis@belfairseniorliving.com

January 23, 2023

License Number: AL6304

Ms. Teri Ellis, Executive Director
Belfair Of Shawnee
1723 N Airport Drive
Shawnee, OK 74804

Survey Event ID: M0YO11

Dear Ms. Ellis:

On **December 14, 2022,** 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 have been corrected and you were in substantial compliance by **January 17, 2023**.

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: 2023.01.23 13:19:13 -06'00'

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

enc

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 1/10/2023** **Facility Name:** Belfair Senior LIving **License Number:** AL6304 **Survey Event ID:** M0YO11 **Date Survey Completed: 12/14/2022**

SUMMARY OF DEFICIENCY CITED BY OSDH	
ID Prefix Tag: C1505	Based on: Record review,observation and interview, the center failed to ensure residents received adequate care for three (#2, #3 and #4) of four residents sampled for medical care. The facility failed to : a. put interventions in place to help prevent falls and follow facility policy for documentation related to falls for Res #2 and #3. B. intervene in a timely manner for a resident with complaints of pain for res #4.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments:

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?	#2 DON/Desigee will update the care plan and Fall risk. #3, #4 are deceased.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	After each incident the nurse will review the Fall Tracker to updated
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?	Fall policies will be revised. Interventions will not be repeated for 14 days. DON or designee will inservice nurses on fall risk, pain and incident report forms, and Point Click Care. Don or designee will audit Falling star program after each incident. Falling star book will be update every quarter or as needed The ED / DON or designee will review incident reports the next business day or as warranted. All nursing staff will be inserviced on the Falling star book.
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.	The quality assurance team will review huddle sheets, falling star book and inservices for all staff and nurses. The huddle book to be kept in the ED office.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	1/17/2023
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Teri Ellis	**Date 1/10/2023**

OAC 310:663-25-4(F)			
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

Delivery via email to: TEllis@belfairseniorliving.com

February 16, 2023

License Number: AL6304

Ms. Teri Ellis, Administrator
Shawnee Memory Care
1723 N Airport Drive
Shawnee, OK 74804

Survey Event ID: M0YO12

Dear Ms. Ellis:

On **February 10, 2023,** a complaint revisit was conducted at your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **December 14, 2022,** have now been corrected effective **January 17, 2023.**

If you have any questions concerning the information in this letter, please contact me at (405) 426-8200.

Sincerely,

Katie Stagner

Katie Stagner, 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
	AL6304	A. BUILDING: _____ B. WING _____	R 02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE MEMORY CARE	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 revisit was conducted on 02/10/23. All deficiencies from the 12/14/22 survey were cleared.	{C 000}		

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