OKLAHOMA
State Department
of Health

Delivery via email to: rbarby@baptistvillage.org

January 2, 2024

License Number: NH240801

Ms. Robin Barby, Administrator
Baptist Village Of Enid
5801 North Oakwood Road
Enid, OK 73703

Survey Event ID: 4Q2811

Dear Ms. Barby:

Enclosed is a report of the complaint investigation conducted at your Assisted Living facility on **December 21, 2023**. 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.

Respectfully,

Tempal Killman

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

Enclosure

OKLAHOMA
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of Health

INVESTIGATIVE REPORT

Facility: **Baptist Village of Enid**
Address: **5801 North Oakwood Road**
City, State, Zip: **Enid, OK 73703**
Provider #: **NH240802**
Complaint #: **OK00061984**
Investigation Date(s): **12/18/23 through 12/21/23**

ALLEGATION(S)

The facility failed to ensure residents were not physically, verbally, or psychosocially abused and failed to assess, monitor, and intervene for a change in condition.
The facility failed to report abuse to the State Agency (OSDH).

An unannounced on-site investigation was initiated 12/18/2023 at 2:20 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 Summary of Complaint Investigation:

Upon entry and throughout the survey, resident and staff interactions were observed. Residents were observed for cleanliness, and response to requests made to staff, and personal needs for assistance with activities of daily living.

Reviews were conducted for medical records, incident reports, state reportable events, monitoring tools, facility policy and procedures, and hospital records.

Residents were asked if there had been any event that made them feel fearful of other residents, staff, or visitors, or if there had been a time that someone had made them feel bad about themselves or needed assistance. Residents were asked if they could report concerns or areas that needed to be addressed or corrected without fear of retaliation. Residents were asked who they would report an occurrence to. Residents were asked if they are ill, or fallen, does the staff check on them more often to ensure they do not need additional medical treatment.

Staff were asked if they had been provided with education regarding abuse, and neglect. Staff were asked what the facility protocol was for reporting potential abuse or neglect. Staff were asked if they

were aware of any event of abuse or neglect. Staff were asked when and to whom an allegation of abuse would be reported. Staff were asked how a resident is provided monitoring after any event that standards of practice would warrant a resident to be monitored for further injuries, or additional medical interventions.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 12/27/2023

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
	NH240801	A. BUILDING: _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST VILLAGE OF ENID	5801 NORTH OAKWOOD ROAD ENID, OK 73703

(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 complaint investigation (#OK00061984) was conducted from 12/18/23 through 12/21/23. No deficiencies were cited. Facility Census: 28	C 000		

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