Oklahoma State Department of Health
Creating a State of Health

USPS Tracking #9114 9011 5981 8322 2427 38

February 21, 2020

License Number: RC0101
Survey Event ID: DMX411

Ms. Autumn Ketcher, Administrator
Lake Francis Retirement Care Home, Llc
Lake Francis Retirement
P.O. Box 332
Watts, OK 74964

Dear Ms. Ketcher:

Enclosed is the summary of deficiencies from the complaint investigation conducted at your Residential Care facility on **February 7, 2020**.

The deficiencies cited resulted in deficiencies representing the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies.

Please note the items listed in the deficiency column of the report. Your plan of correction and anticipated date of completion must be typed in the spaces provided. If additional space is needed, a supplemental sheet may be attached.

The criteria for an acceptable plan of correction are:

(1) A statement of exactly how the facility has or intends to correct each deficiency.

(2) The method of correction. This includes who is responsible for the correction.

(3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

(4) A reasonable date of correction, which will normally be within 30 days of this notice.

NOTE: Please avoid naming individuals, business firms or brand names on the enclosed form since it is a public disclosure form.

Please sign, date and **return the completed form to this office within ten (10) days** of your receipt of this letter. **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 this completed form for your files.

In the event that we find your Plan of Correction unacceptable, you will be notified of the reason(s) it is not acceptable and we will request another Plan of Correction. If your plan of correction is acceptable, there will be no acknowledgement. We will conduct a revisit in accordance with your stated correction dates. If you have any questions concerning this letter, please contact me at (405) 271-6868.

In accordance with O.S. 63 830.1, 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 833-RC). 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 833RC and the Oklahoma IDR Process Residential Care Centers.

The IDR request must be submitted within 30 calendar days from receipt of the State Form deficiency statement. 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.

Sincerely,

Sue Davis, Enforcement Coordinator
Long Term Care
Protective Health Services

SD/ldc

Enclosure

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FROM:

Oklahoma State Dept. of Hea
Protective Health Services - I
1000 NE 10th St
Oklahoma City OK 73117-129

TO:

Ms. Autumn Ketcher, Administrat
Lake Francis Retirement Care Ho
Lake Francis Retirement
PO Box 332
Watts, OK 74964-0332

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Oklahoma State
Department of Health

INVESTIGATIVE REPORT
LICENSURE

Facility: **Lake Francis Retirement Care Home, LLC**
Address: **3rd and Cemetary Road**
City, State, Zip: **Watts, OK, 74964**
Provider #: **RC 0101**
Complaint #: **OK00054809**
Investigation Date(s): **02/07/2020**

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
1. The home failed to administer medications as ordered.	US
2. The home failed to provide a safe, clean environment.	S
3. The home failed to ensure safe food handling practices.	S
4. The home has failed to protect the residents' right to an orderly discharge and transfer process during the closure of the home.	S

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

An unannounced on-site investigation was initiated on Friday, February 7, 2020 at 10:30 a.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.

An investigation specific to medication administration and employee to resident verbal abuse was conducted.

Four sampled residents were interviewed regarding medication administration and all four stated they received their medications as prescribed by their physician. The further stated they had never been threatened by an

employee to call the police if the resident refused their medications. Two employees stated all of the residents had taken their correctly for a while and none had refused. Both employees stated they had not, nor had they heard any employee make threats to call the police on any resident for medication refusal.

A record review of all of the residents' January and February 2020 medication administration records revealed the residents had received their medications, except for two days, 02/01/20 and 02/06/20, where there were black daily blocks at 8:00 a.m. on one resident's records. That resident was interviewed about the empty blocks on her medication administration record and she adamantly denied that she had missed any medications, and had received all of her medications every day since she had returned back to the home.

Allegation #2: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R 356 for details.

However; there was no deficient practice related to the supporting details of a heater in the smoke shed or unlocked laundry, medication, and pantry rooms.

An outside ambient air temperature taken by the smoke shed door was 42 degrees Fahrenheit on the day of survey. An observation of an outdoor smoke shed revealed an electric heater mounted to a west wall in the smoke shed, approximately four feet from the floor of the shed. There was no open flame and the outside of the heater was not hot to touch. The door to the smoke shed was wide open.

Two employees stated a maintenance man had remounted the heater after a resident had pulled it off the wall. Two of four interviewed residents stated they did not go in the smoke shed, but the other two stated the heater was there to warm the shed. They also added the residents would not shut the smoke shed door for the heater to keep the room warm.

Upon entrance to the home, the laundry room was open, but no chemicals were visible. Another door inside the laundry was locked. An employee stated she just had come out of the laundry and only one resident was in the home, and she was sick in bed at that time. The laundry door was locked the throughout the rest of the survey. The medication room and pantry doors were locked each time they were checked. All four residents interviewed stated the medication room, laundry, and pantry doors were kept locked. They stated the employees would unlock the laundry room door at certain times for the residents to pick up their clean and folded laundry.

Allegation #3: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R 411 for details.

Allegation #4: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag R 253 for details.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #2, 3, and #4. 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. 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.

Marie Remer, RN, CHFS IV

Date report completed: 02/11/2020

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
	RC0101	A. BUILDING: _____ B. WING _____	C 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FRANCIS RETIREMENT CARE HOME, LI	3RD AND CEMETARY ROAD WATTS, OK 74964

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R 000	INITIAL COMMENTS An abbreviated survey was conducted on 02/07/20 to investigate complaint #OK00054809. Current census was 15. The following deficiencies were cited.	R 000		
R 182 SS=F	63 O.S. 1-1950.1.B.1 CRIMINAL ARREST Except as otherwise provided by subsection C of this section, before any employer makes an offer to employ or to contract with a nurses aide or other person to provide nursing care, health-related services or supportive assistance to any individual except as provided by paragraph 4 of this subsection, the employer shall provide for a criminal arrest check to be made on the nurses aide or other person pursuant to the provisions of this section. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure employees had a finger-print based background check (OK-Screen) performed within 72 hours of	R 182		

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R 182	Continued From page 1 employment for 1 (#1) of 1 sampled employee who had returned to work. This failed practice had the widespread potential for more than minimal harm. Findings: On 02/07/20 at 11:00 a.m., residential care aide/medication administration (RCA/MAT)/employee #1 stated she returned to work in the home in the middle of November 2019. At 4:56 p.m., RCA/MAT/employee #1 stated she had a two year break in service with the home when she returned to work in November 2019. She stated she did not think an OK Screen background check had been completed. No documentation of an OK Screen background was available or submitted.	R 182		
R 253 SS=F	310:680-3-12 (a)(b)(c) VOLUNTARY CLOSING (a) Any owner of a residential care home shall give ninety (90) days' notice to the residents and the Department prior to voluntarily closing a home or closing any part of a home if the closing will require the transfer or discharge of more than ten percent (10%) of the residents. The notice shall include the proposed date of closing and the reason for closing. (b) The home shall offer to assist the resident in securing alternate placement. (c) The Department shall be notified if there is need for relocation assistance.	R 253		

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R 253	Continued From page 2 This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to notify the residents and the Oklahoma State Department of Health (OSDH) 90 days prior to voluntarily closure. This failed practice had the widespread potential for more than minimal harm for all 15 residents who remained in the home, after the transfer of 15 residents to a sister residential care home. Findings: On 01/28/20 at 4:01 p.m., the home sent a facsimile notice of closure to the OSDH that documented, "...Majority Of Residents Are Already Transferd (sic) to Sugar Mtn (Mountain) And The Few That Are Left Are Waiting For The New Remodels Apartments For Indepenant (sic) Living Are Completed We Expect That Those Residents Will Moved In By The 1st of February 2020 or Maybe At The Very Latest Feb (February) 7th..." On 02/07/20 at 10:38 a.m., the owner stated the home would probably be closed by the end of February 2020. At 10:42 a.m., a list of 15 residents and room numbers was submitted. At 2:03 p.m., resident #4 stated that she had been verbally told after Thanksgiving (2019) and that she would move into one of the remodeled apartment by the day treatment center. She stated she had not been given a written notice, told the reasons, or when she would move. At 2:45 p.m., resident #3 stated he had not received a written notice about the home's closure, but had been told by one of the	R 253		

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R 253	Continued From page 3 councilors at the day treatment. He did not know when the home would close, but he had made plans to move to another city to be nearer his mother. At 2:57 p.m., resident #2 stated the residents were told at day treatment of the plans to close the home. He stated that the residents did not get anything in writing or told when the home would close. He added that he was told none of the residents would be homeless and that he would be moved into an independent living apartment with his girlfriend. At 3:14 p.m., resident #1 stated one of the day treatment councilors told the residents before Christmas that the home would soon close. She stated she did not receive a written notice, but thought she would be moved to an independent living apartment in the next two weeks.	R 253		
R 351 SS=F	310:680-7-3 INSECT AND RODENT CONTROL Methods shall be employed to prevent the entrance and harborage of insects, spiders, and rodents. Homes shall be kept free of insects, and rodents. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to have an effective pest control to keep the home free of rodents. This failed practice resulted in the widespread potential for more than minimal harm for all 15 residents. Findings:	R 351		

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R 351	Continued From page 4 On 02/07/20 at 11:40 a.m., a small gray mouse wiggled on a sticky pad that was on the floor just left of a silver refrigerator in the kitchen. Residential care aide/medication administration technician/employee #1 stated she had placed the sticky pad there on the floor on the previous day (02/06/20). She further stated she had caught another mouse in the women's hallway bathroom two nights previously (02/05/20). At 2:03 p.m., resident #3 stated he had seen mice walking around in the home. He stated he last saw a live mouse in his room on the previous night, and he did not like mice. At 2:57 p.m., resident #2 stated there were 'a bunch' of mice in the home, and they were 'terrible.' At 4:08 p.m., resident #1 stated the home was 'infested' with mice. She added that she last saw a live mouse in the living room of home on the previous day. At 4:15 p.m., a medium size striped dark gray/blackish cat was observed outside on a living room window sill near the main entrance. At 5:05 p.m., resident #4 stated there were mice in the home and she had last seen one on the previous morning in the dining room when she and the other residents were at breakfast. She also stated a cat was in the house then, and she saw that cat catch three mice. At 5:28 p.m., the same gray/blackish cat was meowing and tried to get in the main entrance door each time someone went in or out of the home.	R 351		

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R 356	Continued From page 5	R 356		
R 356 SS=F	310:680-7-5 (a) HOUSEKEEPING (a) The interior and exterior of the home shall be safe, clean and sanitary. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure the interior and exterior of the home was kept safe, clean, and sanitary in regards to sagging ceiling tiles, littered yard, unclean smoke shed, dog feces, unclean floor, missing weather stripping under men's hallway door, and dried spills on living room floor. This failed practice had the widespread potential for more than minimal harm for all 15 current residents. Findings: On 02/07/20 from 10:30 a.m. until 5:28 p.m., observations were conducted throughout the survey and the following issues were identified: A water stained and sagging ceiling tile in the women's hallway by room 12; Resident room 15 with clothes, food products and trash on floor, and overfull trash can, stacked and piled personal items on the floor and wooden wardrobe closet; A twin size black box springs leaned against the north hall wall by room 16; A large pile of brown dog feces on the ground just outside the women's hallway exit door; Other piles of dog feces scattered randomly around the back and north side yard of the home; Large amounts of fallen leaves piled up in the yard and against the home;	R 356		

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R 356	Continued From page 6 Large amounts of tan and white cigarette butts scattered and piled on the yard all around the home, on the wooden patio, and cement sidewalk up to the main entrance door, with the majority of butts near and around both back hallway entrance/exit doors; Smoke shed floor covered with tan and white cigarette butts, paper and plastic trash on wooden floor and wooden bench; Paper, Styrofoam, aluminum cans, and plastic trash littered all over the yard and parking area; A tan cracked mattress on the ground near the men's hallway entrance/exit door; 10 long slender pieces of Polyvinyl chloride (PVC) pipe on top of the ground on south yard; Weather stripping completely missing across the bottom of men's hallway entrance/exit door; Sticky dried fluid spills on the blue tiles in the living room; and Women's bathroom laundry hamper and trash containers over-flowed, and paper trash on the floor near the toilet stool. The four sampled residents interviewed stated they had seen the sagging ceiling tiles, some had been replaced recently by the maintenance man, and it was from the rains that caused them to leak. The residents stated many of the residents threw cigarette butts down everywhere, they were too lazy to use the butt cans, and occasionally butts got tracked into the home on shoes. Residential care aide/medication administration technician (RCA/MAT)/employee #1 stated she did not know about all the trash, cigarette butts, mattress, and missing weather stripping. She stated the dried spills on the blue living room tiles were from residents spilling their morning coffee. She stated the resident in room 15 had a 'melt down' that morning and 'destroyed her room.'	R 356		

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R 356	Continued From page 7 RCA/MAT/employee #1 stated the women's hall had probably not been cleaned that day. She also stated many of the ceiling tiles had to be replaced by the maintenance man after heavy rains hit the home, and she had not seen the sagging tile in the women's hallway.	R 356		
R 364 SS=F	310:680-7-6 (a) (1-4) RESIDENTIAL AND VISITING PETS (a) Each home that allows residential or visiting animals shall adopt and comply with policies that meet or exceed 310:680-7-6(a) and 310:680-7-6(b). The facility's policies shall describe the schedule of animal care and zoonotic infection control for the respective facility. The facility shall not allow any animal to reside in the facility until all of the following requirements are met: (1) The animal is a dog, cat, fish, bird, rabbit, or guinea pig. If a home desires to include other types of animals in their program, the home shall submit a supplemental request accompanied by its policies, procedures, and guidelines to the Department and receive written approval from the Department prior to implementation. (2) For residential pets, excluding fish, the number of animals in a home shall be limited to no more than one dog per 50 residents; 1 cat, rabbit, or guinea pig per 30 residents; or 1 bird per 20 residents, unless the home has received the Department's prior approval of a greater number of pets through a supplemental request pursuant to 310:675-7-19(a)(1). (3) The home adopts policies ensuring non-disruption of the home.	R 364		

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R 364	Continued From page 8 (4) All pets are housed and controlled in a manner that ensures that neither the pet nor the residents are in danger. A pet cage or container must not obstruct an exit or encroach on the required corridor width. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to follow their pet policy to ensure pets, to include 2 dogs and 1 cat, did not live at the home on a permanent basis. This failed practice resulted in the widespread potential for more than minimal harm to all 15 residents. Findings: On 02/07/20 at 12:04 p.m., a large pile of brown dog feces was on the ground just outside the women's hallway exit door. A small black and white female dog was in the back yard and growled and barked, then ran under the smoke shed. At 12:06 p.m., there was another unseen dog under the smoke shed that growled and barked. At 12:17 p.m., residential care aide/medication administration technician (RCA/MAT)/employee #1 stated those were two stray dogs outside and had been at the home off and on for about a month.	R 364		

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R 364	Continued From page 9 At 12:21 p.m., a small reddish short haired dog and the black and white dog were running around the parked cars in the front of the home. Both barked and growled loudly when approached. At 2:03 p.m., resident #4 stated the dogs would not leave because they liked it at the home. She stated one of the male residents fed the dogs and they had puppies under the smoke shed. At 2:45 p.m., resident #3 stated he liked to pet the stray dogs, and they did not have anybody (to care for them). He further stated sometimes the residents fed the dogs and they lived under the smoke shed. At 2:57 p.m., resident #2 stated the stray dogs had lived at the home as long as he had been there (10/09/19), and they chased off other dogs. At 3:14 p.m., resident #1 stated the dogs had been at the home since before she moved in on 11/30/19. At 3:34 p.m., MAT/cook/employee #3 stated the two stray dogs were not anyone's pet and they just stayed outside the home. She added that one of the male residents buys dog food and feeds them. She then stated the dogs had been there at the home for a long time. At 4:15 p.m., a medium sized striped dark gray/blackish cat was observed on a living room window sill near the main entrance. At 5:05 p.m., resident #4 stated there were mice in the home and she had last seen one on the previous morning in the dining room when she and the residents were at breakfast. She also stated a cat was in the house the previous	R 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC0101	A. BUILDING: _____ B. WING _____	C 02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R 364	Continued From page 10 morning, and she saw it catch three mice. At 5:16 p.m., RCA/MAT/employee #1 stated MAT/employee #4 had let the cat in the home on the previous morning because she thought it was cold outside. At 5:28 p.m., the same cat was meowing and tried to get in the main entrance door each time someone went in or out of the home. No policy was located during this survey, but the following policy was provided by the home on a previous survey, 09/05/19, and it documented: POLICY An undated pet policy documented, "...It shall be the policy of Lake Francis R.C.F. (residential care facility) to not allow residents to bring any type of pet to the facility to live on a permanent basis...)	R 364		
R 411 SS=F	310:680-9-1(j) FOOD SERVICE - Chapter 257 A residential care home shall be in compliance with Chapter 257 of this Title, regarding storage, preparation, and serving of food (including milk and ice). A residential care home may use residential equipment provided that the equipment must maintain hot and cold temperatures as required in OAC 310:257. This Rule is not met as evidenced by:	R 411		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC0101	A. BUILDING: _____ B. WING _____	C 02/07/2020

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R 411	Continued From page 11 Based on observation and interview, it was determined the home failed to ensure compliance with Chapter 257 Food Service Establishment Regulations, in regards to food storage. This failed practice had the widespread potential for more than minimal harm for all 15 residents who received their nutrition from the kitchen. Findings: On 02/07/20 at 11:38 a.m., the following food items were observed stored stacked and piled in a single door stainless refrigerator: A large clear plastic container with a red lid that was labeled and contained egg salad, but was not dated; A medium clear square plastic container with a blue lid with a thick brown substance in it, no label or date; A medium clear rectangle plastic storage container with a blue lid with thick white substance, no label or date; A medium square clear plastic container with a blue lid of unlabeled/undated cooked cabbage; A medium square clear plastic container with a blue lid of unlabeled/undated sliced peaches; A large clear plastic storage container with a red lid with 'chef salad', no label or date; A medium clear rectangle plastic storage container with a blue lid with green beans, no label or date; A large clear plastic container with a red lid that contained mixed vegetables, no label or date; A gallon plastic storage bag full of 'pizza pockets', no label or date; A small plastic storage bag with a cut one-half cucumber, no label or date; A small plastic storage bag with a cut one-fourth head of lettuce, no label or date; A small plastic storage bag with a cut one-half	R 411		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC0101	A. BUILDING. _____ B. WING _____	C 02/07/2020

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R 411	Continued From page 12 green bell pepper, no label or date; A large plastic storage bag with eight long wieners/franks, no label or date; An opened 16 ounce package smoked turkey lunch meat, not sealed or dated; Two slices of American cheese, not labeled or dated, loose on a shelf; and An undated opened 32 ounce bag of shredded mild cheddar cheese, not dated. Residential care aide/medication administration technician/employee #1 stated she did not know when any of the unlabeled or undated food products had been open, prepared, or served.	R 411		
R 631 SS=D	310:680-13-1 (2)(C) ADMINISTRATION OF MEDICATIONS (2) Administration of Medications. (C) The person administering the medication shall maintain an accurate written record of medications administered. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure medication administration records (MAR) were documented accurately to reflect employee administered medications for 1 (#1) of 1 sampled resident who received employee administered medications. This failed practiced had the isolated potential for more than minimal harm. Findings: On 02/07/20 at 2:15 p.m., resident #1's February	R 631		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 631	Continued From page 13 2020 MAR had blank daily blocks on 02/01/20 and 02/06/20 at the 8:00 a.m. doses on the following medications: Norgestimate/Ethinyl Estradiol (used to prevent pregnancy) tablets; Escitalopram (used to treat depression and anxiety) 20 milligrams (MG); and Alprazolam (used to treat anxiety and panic disorders) 2 MG. At 3:14 p.m., resident #1 stated she had not refused any of her medications since she returned to the home and she knew she had received and taken all of her prescribed medications every day. At 4:17 p.m., residential care aide/medication administration technician/employee #1 stated there was an employee that did not know how to sign medications out and then shook her head.	R 631		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
RC0101	LAKE FRANCIS RETIREMENT CARE HOME, LLC

Type of Survey (select all that apply)

3				

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 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)
1. 25837	02/07/2020	02/07/2020	1.00	0.00	6.50	0.00	2.50	8.00
2.								
3.								
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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**

FEB 2 1 2020