



Oklahoma State Department of Health
Creating a State of Health

March 2, 2020

License Number: RC0201
Survey Event ID: BYC211

Ms. Autumn Ketcher, Administrator
Sugar Mountain Retreat
27753 South Welling Rd.
Welling, OK 74471

Dear Ms. Ketcher:

Enclosed is the Residential Care inspection deficiency report form, showing the summary of deficiencies noted during the survey at your facility on **February 20, 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 space 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.

Board of Health

Gary Cox, JD
Commissioner of Health

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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/kgs

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC0201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED 02/20/2020
NAME OF PROVIDER OR SUPPLIER SUGAR MOUNTAIN RETREAT, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 25376 SOUTH WELLING ROAD WELLING, OK 74471		
(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
N 000	Initial Comments A re-licensure survey was conducted on 02/19/20 and 02/20/20. Current census was 41. The following deficiency was cited.	N 000		
N1105 SS=E	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure two hours of in-service training supervised by a registered nurse was provided monthly for 4 (#1, 2, 8, and #9) of 4 employees who were long term care aides. This failed practice had the potential for more than minimal harm at a pattern. Findings: A review of the in-services documented a two hour in-service was conducted on 04/10/19 and a five hour in-service was conducted on 04/21/19,	N1105		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N1105	Continued From page 1 no other in-service records were provided. On 02/20/20 at 11:38 a.m., the administrator stated she could not find the monthly in-services.	N1105			
R 000	INITIAL COMMENTS A re-licensure survey was conducted on 02/19/20 and 02/20/20. Current census was 41. The following deficiencies were cited.	R 000			
R 205 SS=F	310:680-3-3 (e)(2) NURSE, DIETITIAN, AND REGISTERED PHARMACIST (e) The following items must be renewed annually: (2) Agreements with registered nurse, registered dietitian, and registered pharmacist, as required based on the needs of the residents. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure an agreement with a registered nurse was renewed annually. This failed practice had the widespread potential for more than minimal harm for all 41 residents who received physician ordered employee administered medications. Findings: On 02/19/19 at 4:02 p.m., a review of agreements was conducted with the administrator and there was no agreement with a registered nurse	R 205			

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R 205	Continued From page 2 available. The administrator stated she did not know why there was no current agreement with a registered nurse.	R 205			
R 213 SS=C	310:680-3-6 (a)(2) POSTING ADMINISTRATORS CERTIFICATE (a) Every residential care home shall conspicuously post in an area of its offices accessible to residents, employees and visitors, the following: (2) The name of the current administrator and their certificate shall be posted. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to have a current administrator's certificate conspicuously posted in an area accessible to residents, employees, and visitors. This failed practice had the widespread potential for minimal harm for all 41 residents. Findings: On 02/19/20 at 3:55 p.m., an administrator's expired license was posted on an information board in the living room by the main entrance. The license had an expiration date of 12/31/19. She stated did not know why her current administrator's certificate was not posted.	R 213			
R 221 SS=C	310:680-3-6 (b)(5) RETAINING A LIST OF PERSONNEL (b) Every residential care home shall retain the following for public inspection: (5) A list of personnel who are licensed,	R 221			

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R 221	Continued From page 3 certified, or registered and employed or retained by the residential care home, including area in which individual is credentialed. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to retain a list of personnel who were licensed, certified, registered, and employed or retained by the home. This failed practice had the widespread potential for minimal harm for all 41 residents. Finding: On 02/19/20 at 11:35 a.m., long term care aide/medication administration technician (LTCA/MAT)/employee #1 submitted a list of employees that she had just handwritten, due to she could not find a list to make a copy. At 1:20 p.m., information boards on both sides of the living room walls and the medication room walls were observed and no list of current personnel was found. LTCA/MAT/employee #1 was asked if a list of employed or retained personnel was available for inspection. She stated did not know if there was a list or where it was. On 02/20/20 at 3:48 p.m., the administrator stated she did not know why a list of personnel was not available.	R 221			
R 308 SS=E	310:680-5-1 (8) GENERAL CRITERIA - EQUIPMENT	R 308			

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R 308	Continued From page 4 Residential care homes must meet or exceed the following requirements: (8) Each residential care home shall maintain sufficient equipment and furnishings to provide for the needs of all residents. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to maintain chairs in good repair. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 02/19/20 at 12:57 p.m., the cottage common area had 11 ripped vinyl chairs with the padding showing through and the smoke shed had 10 ripped vinyl chairs with the padding showing through. On 02/20/20 at 4:05 p.m., the administrator stated she knew the chairs needed to be thrown out due to their condition.	R 308			
R 313 SS=E	310:680-5-2 (c) WATER HEATERS (c) Fuel-fire and water heaters must be vented to the outside and have adequate combustion air. They shall not be installed in habitable areas and must be enclosed. Water heaters must have pressure and temperature relief valves. Water heaters and surrounding areas must be kept clean.	R 313			

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R 313	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure a hot water heater and the surrounding area were kept clean. This failed practice had the potential for more than minimal harm for all 9 residents who lived in the Cottage building of the home at a pattern. Findings: On 02/19/20 at 2:10 p.m., an electric hot water heater, in an outdoor closet in the Cottage building, was observed and found to have dried brown leaves and sheetrock particles, blue lint, and dirt all over the floor. The top of the water heater tank was covered with a thick layer of light gray dust. Cob webs clung all around the top the door facing and connected to the hot water heater. On 02/20/20 at 2:40 p.m., the administrator was informed about the condition of the hot water closet and she stated she could not stay on top of keeping the hot water tank areas clean.	R 313			
R 329 SS=E	310:680-5-6 (g) BUILDING ELEMENTS - WATER TEMP (g) Hot water temperatures at faucets accessible to residents shall be maintained within a range of 100 degrees to 120 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure hot water temperatures at faucets accessible to the residents were maintained within a range of 100 degrees to 120 degrees Fahrenheit (F). This failed practice had the potential for more than	R 329			

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R 329	Continued From page 6 minimal harm for all 9 residents who resided in the Cottage building at a pattern. Findings: On 02/19/20 at 12:55 p.m., the hot water in the Cottage building registered at 97.9 degrees F. At 12:58 p.m., resident #7 stated the hot water in Cottage where she resided was not exactly warm. She also stated she had told the employees and it did not get real hot. At 1:02 p.m., long term care aide/medication administration technician (LTCA/MAT)/employee #2 stated the employees turn the hot water tank temperatures up and down and it was hard to get it to the correct temperature. At 2:06 p.m., the hot water in the Cottage building registered at 96.8 degrees F. On 02/20/20 at 3:05 p.m., residents #7 and #8 both stated the water was too cold in the Cottage to take comfortable showers.	R 329		
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 exterior of the home was kept safe, clean, and sanitary in regards to a littered yard and unclean/unsafe smoke shed. This failed practice	R 356		

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R 356	Continued From page 7 had the widespread potential for more than minimal harm for all 41 current residents. Findings: On 02/19/20 at 11:07 a.m., upon arrival to the home, Styrofoam cups, cigarette butts too numerous to count, empty aluminum cans, dead brown leaves and broken dead tree limbs were observed on the grounds on all sides of the home. At 1:03 p.m., empty Styrofoam cups, large quantity of cigarette butts and twenty-six empty aluminum cans were observed on the ground near the smoke shed, a rusted jagged edged kick-plate was observed on the bottom smoke shed east door, a wooden step was missing from the wooden stairs leading out of the door of the east side of the smoke shed, and the walls and ceilings of the smoke shed were covered with thick brown nicotine stains. The piles of dead brown leaves and tree limbs remained on the grounds. At 1:13 p.m. long term care aide (LTCA)/employee #2 stated the ceiling in the smoke shed was covered with nicotine and the residents threw their cigarette butts on the ground. On 02/20/20 at 2:22 p.m., LTCA/employee #9 stated no specific person cleaned the grounds and she she did not clean the grounds. At 2:25 p.m., the administrator stated the residents had been told not to throw their cigarette butts on the ground. She stated she was not aware of the smoke shed conditions and agreed the rusted kick-plate and missing board on the stairs were safety hazards. She stated the	R 356		

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R 356	Continued From page 8 employees were responsible for cleaning the grounds.	R 356		
R 505 SS=F	310:680-11-1 (1)(D) SUFFICIENT NUMBER - RN (1) Sufficient number of persons. (D) All residential care homes shall have a signed, written agreement with a registered nurse to act as a consultant. Documentation of the use of the nurse consultant shall be maintained in the home. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to have a signed agreement with a registered nurse consultant. This failed practice had the widespread potential for more than minimal harm for all 41 residents who received physician ordered employee administered medications. Findings: On 02/19/20 at 4:02 p.m., a review of agreements was conducted with the administrator and there was no agreement with a registered nurse available. The administrator stated she did not know why there was no current agreement with a registered nurse.	R 505		
R 510 SS=F	310:680-11-1 (3)(A) STAFF TRAINING - FIRST AID/CPR (3) In order to ensure all homes maintain a level of competency necessary to meet the needs of each individual served in the home, personnel must complete the following training requirements.	R 510		

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R 510	Continued From page 9 (A) All employees shall be currently certified in first-aid and cardiopulmonary resuscitation (Red Cross training or equivalent). Proof of certification and training shall be kept on file in the home. First-Aid and CPR certificates shall be renewed annually, or as required to be kept current. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure 2 (#7 and #9) of 10 employees were currently certified in first-aid and cardiopulmonary resuscitation (CPR) that was Red Cross or equivalent. This failed practice had the widespread potential for more than minimal harm for all 41 residents. Findings: On 02/20/20 at 11:00 a.m., the employees' files were reviewed there was no first-aid and CPR certifications in the file of the night watchman/employee #7 and long term care aide (LTCA)/medication administration technician (MAT)/employee #9. An employees' schedule documented night watchman/employee #7 was the only employee who worked from 10:00 p.m. to 6:00 a.m. on	R 510		

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R 510	Continued From page 10 Fridays, Saturdays, and Sundays. At 11:55 a.m., the administrator stated she could not find employee #7 and employee #9's first aid/CPR card. She further stated the employee #7 worked alone on the night shift on the weekends.	R 510			
R 512 SS=F	310:680-11-1 (3)(C) STAFF TRAINING - MEDICATION - 8 HRS 3) In order to ensure all homes maintain a level of competency necessary to meet the needs of each individual served in the home, personnel must complete the following training requirements. (C) Direct care staff who are responsible for administering or monitoring medication shall annually be required to receive at least eight (8) hours of training by the administrator of the home in patient reporting and observation, record keeping, independent or daily living skills, leisure skills and recreation, human relations and such other training relevant to residential care program and operation. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure the administrator provided eight (8) hours of training relevant to the residential care program and operation annually to 7 (#1 through #4 and 6 through #9) of 7 direct care employees who were responsible for administering medication. This	R 512			

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R 512	Continued From page 11 failed practice had the widespread potential for more than minimal harm to all 41 residents who received employee administered medications. Findings: On 02/20/20 at 11:00 a.m., the in-service training documented the following in-services had been provided: 04/10/19 - 2 hour training on medications; and 04/21/19 - 5 hour training on resident rights, abuse, behavior management, policies and procedures for five hours. Long term care aide (LTCA)/medication administration technician (MAT)/employee #8 had not attended the in-service. No other in-services covering the following topics as required were found in the home: patient reporting and observation, record keeping, independent or daily living skills, leisure skills and recreation, human relations. At 11:38 a.m., the administrator stated she could not find any other documentation of in-services provided to the employees who were responsible for medication administration.	R 512		

STATE WORKLOAD REPORT

 Provider/Supplier Number
 RC0201

 Provider/Supplier Name
 SUGAR MOUNTAIN RETREAT, INC

Type of Survey (select all that apply)

2				
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- | | | |
|---------------------------|-------------------------|---------------------|
| A Complaint Investigation | E Initial Certification | I Recertification |
| B Dumping Investigation | F Inspection of Care | J Sanctions/Hearing |
| C Federal Monitoring | G Validation | K State License |
| D Follow-up Visit | H Life Safety Code | L CHOW |
| M Other | | |

Extent of Survey (select all that apply)

A				
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- 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. <i>mm</i> 25837	02/19/2020	02/20/2020	0.50	0.00	12.50	0.00	6.25	3.00
2. <i>pb</i> 36191	02/19/2020	02/20/2020	1.00	0.00	12.50	0.00	8.00	5.00
3.								
4.								
5.								
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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

 MAR 03 2020 *jm*



OKLAHOMA
State Department
of Health

via email delivery:tenkillerhealthassistant.violet@gmail.com &
ashleyarriaga.hnh@outlook.com

July 30, 2020

License Number: RC0201
Survey Event ID: BYC211

Ms. Autumn Ketcher, Administrator
Sugar Mountain Retreat
27753 South Welling Rd.
Welling, OK 74471

Dear Ms. Ketcher:

On February 20, 2020, agents from our office completed an investigation at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **R-205 does not include who or how monitoring/evaluation will be conducted.**
- **R221 does not include who will monitor and be responsible to keep the personnel list updated.**
- **R308 does not include monitoring/evaluation of the corrective measures.**
- **R356 does not include monitoring/evaluation of the corrective measures.**
- **R505 does not include monitoring/evaluation of the corrective measures.**
- **R510 does not include how often monitoring/evaluation will be conducted**

An amended plan of correction is due within 10 days of receipt of this notice.

Sincerely,

Users, V. Sue Davis
Digitally signed by Users, V. Sue Davis
Date: 2020.07.30 15:31:19 -05'00'

Sue Davis, Enforcement Coordinator
Long Term Care
Oklahoma State Department of Health

SD/

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC0201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2020
NAME OF PROVIDER OR SUPPLIER SUGAR MOUNTAIN RETREAT, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 25376 SOUTH WELLING ROAD WELLING, OK 74471		
(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
N 000	Initial Comments A re-licensure survey was conducted on 02/19/20 and 02/20/20. Current census was 41. The following deficiency was cited.	N 000		
N1105 SS=E	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of Inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long-term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure two hours of in-service training supervised by a registered nurse was provided monthly for 4 (#1, 2, 8, and #9) of 4 employees who were long term care aides. This failed practice had the potential for more than minimal harm at a pattern. Findings: A review of the in-services documented a two- hour in-service was conducted on 04/10/19 and a five-hour in-service was conducted on 04/21/19,	N1105	N1105 – Admin #1 Found All Current and Past 12 months of 2 hour Staff In-Service after Inspectors Left. Admin #1 will have them Ready and Available for review for surveyors when they come back out.	3/1/2020

If continuation sheet 2 of 12

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R 221	Continued From page 3 certified, or registered and employed or retained by the residential care home, including area in which individual is credentialed. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to retain a list of personnel who were licensed, certified, registered, and employed or retained by the home. This failed practice had the widespread potential for minimal harm for all 41 residents. Finding: On 02/19/20 at 11:35 a.m., long term care aide/medication administration technician (LTCA/MAT)/employee #1 submitted a list of employees that she had just handwritten, because she could not find a list to make a copy. At 1:20 p.m., information boards on both sides of the living room walls and the medication room walls were observed, and no list of current personnel was found. LTCA/MAT/employee #1 was asked if a list of employed or retained personnel was available for inspection. She stated did not know if there was a list or where it was. On 02/20/20 at 3:48 p.m., the administrator stated she did not know why a list of personnel was not available.	R 221	Admin #1 Shall have a personal Roster of Current Employees and Their credentials posted in the Lobby.	3/1/2020	
R 308 SS=E	310:680-5-1 (8) GENERAL CRITERIA - EQUIPMENT	R 308			

Oklahoma State Department of Health

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R 308	Continued From page 4 Residential care homes must meet or exceed the following requirements: (8) Each residential care home shall maintain sufficient equipment and furnishings to provide for the needs of all residents. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to maintain chairs in good repair. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 02/19/20 at 12:57 p.m., the cottage common area had 11 ripped vinyl chairs with the padding showing through and the smoke shed had 10 ripped vinyl chairs with the padding showing through. On 02/20/20 at 4:05 p.m., the administrator stated she knew the chairs needed to be thrown out due to their condition.	R 308	Administration shall have only furniture that's in good condition at the Home. Admin #1 Had all Chairs removed from the Facility.	3/1/2020
R 313 SS=E	310:680-5-2 (c) WATER HEATERS (c) Fuel-fire and water heaters must be vented to the outside and have adequate combustion air. They shall not be installed in habitable areas and must be enclosed. Water heaters must have pressure and temperature relief valves. Water heaters and surrounding areas must be kept clean.	R 313	WATER HEATERS. Admin #1 Will monitor the Hot Water Heaters and their Surroundings periodically to Ensure it is kept free and Clean of any Debris or dust in that Area to Ensure Safety of Residents and potential fires from starting	3/10/2020

Oklahoma State Department of Health

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R 313	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure a hot water heater and the surrounding area were kept clean. This failed practice had the potential for more than minimal harm for all 9 residents who lived in the Cottage building of the home at a pattern. Findings: On 02/19/20 at 2:10 p.m., an electric hot water heater, in an outdoor closet in the Cottage building, was observed and found to have dried brown leaves and sheetrock particles, blue lint, and dirt all over the floor. The top of the water heater tank was covered with a thick layer of light gray dust. Cobwebs clung all around the top the door facing and connected to the hot water heater. On 02/20/20 at 2:40 p.m., the administrator was informed about the condition of the hot water closet and she stated she could not stay on top of keeping the hot water tank areas clean.	R 313		
R 329 SS=E	310:680-5-6 (g) BUILDING ELEMENTS - WATER TEMP (g) Hot water temperatures at faucets accessible to residents shall be maintained within a range of 100 degrees to 120 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure hot water temperatures at faucets accessible to the residents were maintained within a range of 100 degrees to 120 degrees Fahrenheit (F). This failed practice had the potential for more than	R 329	As of 2/24/2020 the hot water heater temp. dial was turned up and retested, it registered at 117.4.	

Oklahoma State Department of Health

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R 329	Continued From page 6 minimal harm for all 9 residents who resided in the Cottage building at a pattern. Findings: On 02/19/20 at 12:55 p.m., the hot water in the Cottage building registered at 97.9 degrees F. At 12:58 p.m., resident #7 stated the hot water in Cottage where she resided was not exactly warm. She also stated she had told the employees and it did not get really hot. At 1:02 p.m., long term care aide/medication administration technician (LTCA/MAT)/employee #2 stated the employees turn the hot water tank temperatures up and down and it was hard to get it to the correct temperature. At 2:06 p.m., the hot water in the Cottage building registered at 96.8 degrees F. On 02/20/20 at 3:05 p.m., residents #7 and #8 both stated the water was too cold in the Cottage to take comfortable showers.	R 329	Admin#1 Will conduct a staff In-Service consisting of frequent monitoring the hot water temperature on weekly basis, if the temperature ever drops below 100 or above 120 they are to notify the Administrator immediately and the Administrator is to readjust the Water temp. to ensure it stays between 100-120.	2/27/2020
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 exterior of the home was kept safe, clean, and sanitary in regards to a littered yard and unclean/unsafe smoke shed. This failed practice	R 356		

Oklahoma State Department of Health

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R 356	Continued From page 7 had the widespread potential for more than minimal harm for all 41 current residents. Findings: On 02/19/20 at 11:07 a.m., upon arrival to the home, Styrofoam cups, cigarette butts too numerous to count, empty aluminum cans, dead brown leaves and broken dead tree limbs were observed on the grounds on all sides of the home. At 1:03 p.m., empty Styrofoam cups, large quantity of cigarette butts and twenty-six empty aluminum cans were observed on the ground near the smoke shed, a rusted jagged edged kick-plate was observed on the bottom smoke shed east door, a wooden step was missing from the wooden stairs leading out of the door of the east side of the smoke shed, and the walls and ceilings of the smoke shed were covered with thick brown nicotine stains. The piles of dead brown leaves and tree limbs remained on the grounds. At 1:13 p.m. long term care aide (LTCA)/employee #2 stated the ceiling in the smoke shed was covered with nicotine and the residents threw their cigarette butts on the ground. On 02/20/20 at 2:22 p.m., LTCA/employee #9 stated no specific person cleaned the grounds and she did not clean the grounds. At 2:25 p.m., the administrator stated the residents had been told not to throw their cigarette butts on the ground. She stated she was not aware of the smoke shed conditions and agreed the rusted kick-plate and missing board on the stairs were safety hazards. She stated the	R 356	The home has hired a groundkeeper to maintain debris and other trash off the premises on a routine basis to ensure a clean and sanitary environment. To pick up Cigarette Butts, Aluminum cans, Styrofoam cups, dead leaves and twigs as of 3/18/2020 all the above has been completed. The Administrator will hold an in service with residents and staff regarding cigarette receptacles and redirection as of 03/20/2020	3/16/2020

Oklahoma State Department of Health

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R 356	Continued From page 8 employees were responsible for cleaning the grounds.	R 356			
R 505 SS=F	310:680-11-1 (1)(D) SUFFICIENT NUMBER - RN (1) Sufficient number of persons. (D) All residential care homes shall have a signed, written agreement with a registered nurse to act as a consultant. Documentation of the use of the nurse consultant shall be maintained in the home. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to have a signed agreement with a registered nurse consultant. This failed practice had the widespread potential for more than minimal harm for all 41 residents who received physician ordered employee administered medications. Findings: On 02/19/20 at 4:02 p.m., a review of agreements was conducted with the administrator and there was no agreement with a registered nurse available. The administrator stated she did not know why there was no current agreement with a registered nurse.	R 505	Agreements Between the Home and the RN was retained and Admin #1 will monitor all agreements on a routine basis.		3/5/2020
R 510 SS=F	310:680-11-1 (3)(A) STAFF TRAINING - FIRST AID/CPR (3) In order to ensure all homes, maintain a level of competency necessary to meet the needs of each individual served in the home, personnel must complete the following training requirements.	R 510			3/19/2020

Oklahoma State Department of Health

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R 510	Continued From page 9 (A) All employees shall be currently certified in first aid and cardiopulmonary resuscitation (Red Cross training or equivalent). Proof of certification and training shall be kept on file in the home. First-Aid and CPR certificates shall be renewed annually, or as required to be kept current. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure 2 (#7 and #9) of 10 employees were currently certified in first-aid and cardiopulmonary resuscitation (CPR) that was Red Cross or equivalent. This failed practice had the widespread potential for more than minimal harm for all 41 residents. Findings: On 02/20/20 at 11:00 a.m., the employees' files were reviewed there was no first-aid and CPR certifications in the file of the night watchman/employee #7 and long-term care aide (LTCA)/medication administration technician (MAT)/employee #9. An employees' schedule documented night watchman/employee #7 was the only employee who worked from 10:00 p.m. to 6:00 a.m. on	R 510	Employee #7 and #9 will be certified in First Aid and CPR. Admin #1 will monitor to ensure all employees are kept up to date. Admin with have documentation ready & Available for Surveyors on next follow-up.		

Oklahoma State Department of Health

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R 510	Continued From page 10 Fridays, Saturdays, and Sundays. At 11:55 a.m., the administrator stated she could not find employee #7 and employee #9's first aid/CPR card. She further stated the employee #7 worked alone on the night shift on the weekends.	R 510		
R 512 SS=F	310:680-11-1 (3)(C) STAFF TRAINING - MEDICATION - 8 HRS 3) In order to ensure all homes, maintain a level of competency necessary to meet the needs of each individual served in the home, personnel must complete the following training requirements. (C) Direct care staff who are responsible for administering or monitoring medication shall annually be required to receive at least eight (8) hours of training by the administrator of the home in patient reporting and observation, record keeping, independent or daily living skills, leisure skills and recreation, human relations and such other training relevant to residential care program and operation. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure the administrator provided eight (8) hours of training relevant to the residential care program and operation annually to 7 (#1 through #4 and 6 through #9) of 7 direct care employees who were responsible for administering medication. This	R 512	Admin shall Review all employees' credentials and All Certifications on a quarterly basis to ensure that all staff are kept up to date on all certifications. Admin #1 will have the RN do an 8-hour class with all staff for a continued education on MAT	3/20/2020

Oklahoma State Department of Health

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R 512	Continued From page 11 failed practice had the widespread potential for more than minimal harm to all 41 residents who received employee administered medications. Findings: On 02/20/20 at 11:00 a.m., the in-service training documented the following in-services had been provided: 04/10/19 - 2-hour training on medications; and 04/21/19 - 5-hour training on resident rights, abuse, behavior management, policies and procedures for five hours. Long term care aide (LTCA)/medication administration technician (MAT)/employee #8 had not attended the in-service. No other in-services covering the following topics as required were found in the home: patient reporting and observation, record keeping, independent or daily living skills, leisure skills and recreation, human relations. At 11:38 a.m., the administrator stated she could not find any other documentation of in-services provided to the employees who were responsible for medication administration.	R 512	All In-Services were found the day of the exit interview and the home shall have it ready and av available for O.S.D.H. next visit. Administration shall record, keep and organize better to ensure all documents are kept in a specific area to avoid misplacement on all paperwork daily.	3/20/2020	



Delivery Via Email: davetta_mcintosh@hotmail.com

September 17, 2020

License Number: RC0201
Survey Event ID: BYC211

Ms. Autumn Ketcher, Administrator
Sugar Mountain Retreat
27753 South Welling Rd.
Welling, OK 74471

Dear Ms. Ketcher:

On **February 20, 2020**, agents from our office completed an re-licensure survey at your Residential Care Facility. Deficiencies were identified and we have received your amended plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- N1105 & R0213 - The Plan of Correction does not specify who is responsible for monitoring.
- R0313 - The Plan of Correction does not specify who will be responsible for cleaning, if there will be a schedule for cleaning the area, if any education was provided, and who will be responsible for monitoring to ensure the cleaning is being done.
- R0329 - There was no Plan of Correction.
- Most monitoring, per submitted POC, states the administrator will complete the monitoring. Specify on the deficiencies who will be the contingent to monitor if the administrator is unavailable. Please specify who will be responsible to monitor that continued education is provided and note how the Quality Assurance is involved with each deficiency.

An amended plan of correction is due within 10 days of receipt of this notice.

Sincerely,

Katie
Stagner

Digitally signed by Katie Stagner
DN: cn=Katie Stagner,
o=Oklahoma State Department of
Health, ou=Long Term Care,
email=katies@health.ok.gov, c=US
Date: 2020.09.17 14:27:30 -05'00'

Katie Stagner, Enforcement Analyst
Long Term Care
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

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N 000	Initial Comments A re-licensure survey was conducted on 02/19/20 and 02/20/20. Current census was 41. The following deficiency was cited.	N 000		
N1105 SS=E	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the center failed to ensure two hours of in-service training supervised by a registered nurse was provided monthly for 4 (#1, 2, 8, and #9) of 4 employees who were long term care aides. This failed practice had the potential for more than minimal harm at a pattern. Findings: A review of the in-services documented a two- hour in-service was conducted on 04/10/19 and a five hour in-service was conducted on 04/21/19,	N1105	N1105 – Admin #1 Found All Current and Past 12 months of 2 hour Staff In-Service after Inspectors Left. Admin #1 will have them Ready and Available for review for surveyors when they come back out.	3/1/2020

Oklahoma State Department of Health

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N1105	Continued From page 1 no other in- service records were provided.	N1105			
R 000	On 02/20/20 at 11:38 a.m., the administrator stated she could not find the monthly in-services. INITIAL COMMENTS A re-licensure survey was conducted on 02/19/20 and 02/20/20. Current census was 41. The following deficiencies were cited.	R 000			
R 205 SS=F	310:680-3-3 (e)(2) NURSE, DIETITIAN, AND REGISTERED PHARMACIST (e) The following items must be renewed annually: (2) Agreements with registered nurse, registered dietitian, and registered pharmacist, as required based on the needs of the residents. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure an agreement with a registered nurse was renewed annually. This failed practice had the widespread potential for more than minimal harm for all 41 residents who received physician ordered employee administered medications. Findings: On 02/19/19 at 4:02 p.m., a review of agreements was conducted with the administrator and there was no agreement with a registered nurse	R 205	Admin will have a current agreement completed on 3/8/20 Admin will observe quarterly to ensure all agreements are completed on an annual basis or before agreement dates has expired	3/8/2020 9/15/2020	

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NAME OF PROVIDER OR SUPPLIER SUGAR MOUNTAIN RETREAT, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 25376 SOUTH WELLING ROAD WELLING, OK 74471			
(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	
R 205	Continued From page 2 available. The administrator stated she did not know why there was no current agreement with a registered nurse.	R 205		2/19/2020	
R 213 SS=C	310:680-3-6 (a)(2) POSTING ADMINISTRATORS CERTIFICATE (a) Every residential care home shall conspicuously post in an area of its offices accessible to residents, employees and visitors, the following: (2) The name of the current administrator and their certificate shall be posted. This Rule is not met as evidenced by: Based on observation, interview, and record review, it was determined the home failed to have a current administrator's certificate conspicuously posted in an area accessible to residents, employees, and visitors. This failed practice had the widespread potential for minimal harm for all 41 residents. Findings: On 02/19/20 at 3:55 p.m., an administrator's expired license was posted on an information board in the living room by the main entrance. The license had an expiration date of 12/31/19. She stated did not know why her current administrator's certificate was not posted.	R 213	Admin #1 Shall keep a copy of License Posted up at all times in all areas of the home. Admin #1 posted a copy of License up.		
R 221 SS=C	310:680-3-6 (b)(5) RETAINING A LIST OF PERSONNEL (b) Every residential care home shall retain the following for public inspection: (5) A list of personnel who are licensed,	R 221			

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R 308	Continued From page 4 Residential care homes must meet or exceed the following requirements: (8) Each residential care home shall maintain sufficient equipment and furnishings to provide for the needs of all residents. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to maintain chairs in good repair. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 02/19/20 at 12:57 p.m., the cottage common area had 11 ripped vinyl chairs with the padding showing through and the smoke shed had 10 ripped vinyl chairs with the padding showing through. On 02/20/20 at 4:05 p.m., the administrator stated she knew the chairs needed to be thrown out due to their condition.	R 308	Administration shall have only furniture that's is in good condition at the Home. Admin #1 Had all Chairs removed from the Facility. Admin will monitor 1x weekly for furniture that is broken to ensure all furniture is in good repair.	3/1/2020 9/15/2020	
R 313 SS=E	310:680-5-2 (c) WATER HEATERS (c) Fuel-fire and water heaters must be vented to the outside and have adequate combustion air. They shall not be installed in habitable areas and must be enclosed. Water heaters must have pressure and temperature relief valves. Water heaters and surrounding areas must be kept clean.	R 313			

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R 313	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure a hot water heater and the surrounding area were kept clean. This failed practice had the potential for more than minimal harm for all 9 residents who lived in the Cottage building of the home at a pattern. Findings: On 02/19/20 at 2:10 p.m., an electric hot water heater, in an outdoor closet in the Cottage building, was observed and found to have dried brown leaves and sheetrock particles, blue lint, and dirt all over the floor. The top of the water heater tank was covered with a thick layer of light gray dust. Cobwebs clung all around the top the door facing and connected to the hot water heater. On 02/20/20 at 2:40 p.m., the administrator was informed about the condition of the hot water closet and she stated she could not stay on top of keeping the hot water tank areas clean.	R 313			3/10/2020
R 329 SS=E	310:680-5-6 (g) BUILDING ELEMENTS - WATER TEMP (g) Hot water temperatures at faucets accessible to residents shall be maintained within a range of 100 degrees to 120 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure hot water temperatures at faucets accessible to the residents were maintained within a range of 100 degrees to 120 degrees Fahrenheit (F). This failed practice had the potential for more than	R 329	WATER HEATERS. Admin #1 Will monitor the Hot Water Heaters and their Surroundings periodically to Ensure it is kept free and Clean of any Debris or dust in that Area to Ensure Safety of Residents and potential fires from starting.		

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R 329	Continued From page 6 minimal harm for all 9 residents who resided in the Cottage building at a pattern. Findings: On 02/19/20 at 12:55 p.m., the hot water in the Cottage building registered at 97.9 degrees F. At 12:58 p.m., resident #7 stated the hot water in Cottage where she resided was not exactly warm. She also stated she had told the employees and it did not get really hot. At 1:02 p.m., long term care aide/medication administration technician (LTCA/MAT)/employee #2 stated the employees turn the hot water tank temperatures up and down and it was hard to get it to the correct temperature. At 2:06 p.m., the hot water in the Cottage building registered at 96.8 degrees F. On 02/20/20 at 3:05 p.m., residents #7 and #8 both stated the water was too cold in the Cottage to take comfortable showers.	R 329			
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 exterior of the home was kept safe, clean, and sanitary in regards to a littered yard and unclean/unsafe smoke shed. This failed practice	R 356			

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R 356	Continued From page 7 had the widespread potential for more than minimal harm for all 41 current residents. Findings: On 02/19/20 at 11:07 a.m., upon arrival to the home, Styrofoam cups, cigarette butts too numerous to count, empty aluminum cans, dead brown leaves and broken dead tree limbs were observed on the grounds on all sides of the home. At 1:03 p.m., empty Styrofoam cups, large quantity of cigarette butts and twenty-six empty aluminum cans were observed on the ground near the smoke shed, a rusted jagged edged kick-plate was observed on the bottom smoke shed east door, a wooden step was missing from the wooden stairs leading out of the door of the east side of the smoke shed, and the walls and ceilings of the smoke shed were covered with thick brown nicotine stains. The piles of dead brown leaves and tree limbs remained on the grounds. At 1:13 p.m. long term care aide (LTCA)/employee #2 stated the ceiling in the smoke shed was covered with nicotine and the residents threw their cigarette butts on the ground. On 02/20/20 at 2:22 p.m., LTCA/employee #9 stated no specific person cleaned the grounds and she did not clean the grounds. At 2:25 p.m., the administrator stated the residents had been told not to throw their cigarette butts on the ground. She stated she was not aware of the smoke shed conditions and agreed the rusted kick-plate and missing board on the stairs were safety hazards. She stated the	R 356	The home has hired a groundkeeper to maintain debris and other trash off the premises on a routine basis to ensure a clean and sanitary environment. To pick up Cigarette Butts, Aluminum cans, Styrofoam cups, dead leaves and twigs. The Administrator will hold an in service with residents and staff regarding cigarette receptacles and redirection. Groundskeeper and staff will monitor the RCF grounds 2x monthly to ensure the debris and trash are picked up and free from limbs and leaves to ensure a safe living environment.	9/15/2020	

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R 356	Continued From page 8 employees were responsible for cleaning the grounds.	R 356		
R 505 SS=F	310:680-11-1 (1)(D) SUFFICIENT NUMBER - RN (1) Sufficient number of persons. (D) All residential care homes shall have a signed, written agreement with a registered nurse to act as a consultant. Documentation of the use of the nurse consultant shall be maintained in the home. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to have a signed agreement with a registered nurse consultant. This failed practice had the widespread potential for more than minimal harm for all 41 residents who received physician ordered employee administered medications. Findings: On 02/19/20 at 4:02 p.m., a review of agreements was conducted with the administrator and there was no agreement with a registered nurse available. The administrator stated she did not know why there was no current agreement with a registered nurse.	R 505	Agreements Between the Home and the RN was retained and Admin #1 will monitor all agreements on a routine basis.	3/5/2020
R 510 SS=F	310:680-11-1 (3)(A) STAFF TRAINING - FIRST AID/CPR (3) In order to ensure all homes, maintain a level of competency necessary to meet the needs of each individual served in the home, personnel must complete the following training requirements.	R 510		3/19/2020

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R 510	Continued From page 9 (A) All employees shall be currently certified in first aid and cardiopulmonary resuscitation (Red Cross training or equivalent). Proof of certification and training shall be kept on file in the home. First-Aid and CPR certificates shall be renewed annually, or as required to be kept current. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure 2 (#7 and #9) of 10 employees were currently certified in first-aid and cardiopulmonary resuscitation (CPR) that was Red Cross or equivalent. This failed practice had the widespread potential for more than minimal harm for all 41 residents. Findings: On 02/20/20 at 11:00 a.m., the employees' files were reviewed there was no first-aid and CPR certifications in the file of the night watchman/employee #7 and long-term care aide (LTCA)/medication administration technician (MAT)/employee #9. An employees' schedule documented night watchman/employee #7 was the only employee who worked from 10:00 p.m. to 6:00 a.m. on	R 510	Employee #7 and #9 will be certified in First Aid and CPR. Admin #1 will monitor to ensure all employees are kept up to date. Admin with have documentation ready & Available for Surveyors on next follow-up. #7 and #9 employees no longer work at RCF. However Admin has had all current employees certified for 1st aid and CPR. Admin will monitor certification dates quarterly to ensure they are all kept up to date.	09/15/2020

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R 510	Continued From page 10 Fridays, Saturdays, and Sundays. At 11:55 a.m., the administrator stated she could not find employee #7 and employee #9's first aid/CPR card. She further stated the employee #7 worked alone on the night shift on the weekends.	R 510		
R 512 SS=F	310:680-11-1 (3)(C) STAFF TRAINING - MEDICATION - 8 HRS 3) In order to ensure all homes, maintain a level of competency necessary to meet the needs of each individual served in the home, personnel must complete the following training requirements. (C) Direct care staff who are responsible for administering or monitoring medication shall annually be required to receive at least eight (8) hours of training by the administrator of the home in patient reporting and observation, record keeping, independent or daily living skills, leisure skills and recreation, human relations and such other training relevant to residential care program and operation. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure the administrator provided eight (8) hours of training relevant to the residential care program and operation annually to 7 (#1 through #4 and 6 through #9) of 7 direct care employees who were responsible for administering medication. This	R 512	Admin shall Review all employees' credentials and All Certifications on a quarterly basis to ensure that all staff are kept up to date on all certifications. Admin #1 will have the RN do an 8-hour class with all staff for a continued education on MAT	3/20/2020