

Delivery via email to: autumnketcher2021@gmail.com; autumnketcher813@gmail.com; missak4@live.com

October 14, 2024

License Number: RC0201
Survey Event ID: H9BQ11

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 **October 3, 2024**.

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:

- A statement of exactly how the facility has or intends to correct each deficiency.
- The method of correction. This includes who is responsible for the correction.
- 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.
- 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) 426-8200.

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) 426-8200 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
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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 10/03/2024
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 000	INITIAL COMMENTS A relicensure survey was conducted from 10/02/24 through 10/03/24. Facility Census: 37 Listed below are abbreviations that will be used throughout this document: CPR - cardiopulmonary resuscitation MAT - medication administration technician	R 000		
R 353 SS=F	310:680-7-4 (b) GARBAGE DISPOSAL - CONTAINERS/COVERS (b) All garbage waste containers shall have tight-fitting covers and shall be insect and rodent resistant. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure a garbage container in the kitchen had a lid. The assistant administrator identified 37 residents who resided in the facility. Findings: On 10/02/24 at 2:00 p.m., a garbage container in the kitchen by the back door was observed to be full of trash and without a lid. On 10/02/24 at 2:35 p.m., MAT #2 stated they did not have a lid for the garbage container. MAT #2 stated the garbage container with lid was moved to a different area of the facility. On 10/02/24 at 3:16 p.m., the assistant	R 353		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health
STATE FORM

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 10/03/2024
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R 510	Continued From page 2 (MAT #1) of ten sampled employees whose certifications were reviewed; and b. staff had first aide certification for ten (Administrator, Assistant Administrator, MAT #1, 2, 3, 4, 5, 6, 7 and #8) of ten sampled employees whose certifications were reviewed. The assistant administrator identified 37 residents who resided in the facility. Findings: MAT #1 did not have a current CPR certification in their employee file. The administrator, assistance administrator, MAT #1, 2, 3, 4, 5, 6, 7 and #8 did not have a current first aide certification in their employee file. On 10/03/24 at 9:24 a.m., the assistant administrator stated no one had their first aide certification. They stated they thought first aide was included in the CPR class, but it wasn't. On 10/03/24 at 9:38 a.m., the administrator stated MAT #1 did not have a current CPR certification. They stated they must have missed the certification class.	R 510		

Delivery via email to: autumnketcher2021@gmail.com; autumnketcher813@gmail.com

December 5, 2024

License Number: RC0201

Ms. Autumn Ketcher, Administrator
Sugar Mountain Retreat, Inc
25376 South Welling Road
Welling, OK 74471

RE: Survey Event H9BQ11

Dear Ms. Ketcher:

On **October 3, 2024**, a Licensure inspection was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. Our acceptance does not absolve the facility's responsibility for compliance should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **October 15, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health		(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: RC0201	A. BUILDING: _____ B. WING: _____	10/03/2024

NAME OF PROVIDER OR SUPPLIER SUGAR MOUNTAIN RETREAT, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 25376 SOUTH WELLING ROAD WELLING, OK 74471
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R 353 SS=F	310:680-7-4 (b) GARBAGE DISPOSAL - CONTAINERS/COVERS (b) All garbage waste containers shall have tight-fitting covers and shall be insect and rodent resistant. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure a garbage container in the kitchen had a lid. The assistant administrator identified 37 residents who resided in the facility. Findings: On 10/02/24 at 2:00 p.m., a garbage container in the kitchen by the back door was observed to be full of trash and without a lid. On 10/02/24 at 2:35 p.m., MAT #2 stated they did not have a lid for the garbage container. MAT #2 stated the garbage container with lid was moved to a different area of the facility. On 10/02/24 at 3:16 p.m., the assistant	R 353	R353 Staff will purchase a new trash can with secure lid. Assist. Admin. Will review and maintain a checklist to ensure that this requirement is met. Completed 10/15/24	

State Department of Health DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christina Ketcher</i>	TITLE Admin.	(X6) DATE 10-15-24
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PRINTED: 10/14/2024
FORM APPROVED

Department of Health

DEFICIENCIES
CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

RC0201

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: _____

B. WING: _____

(X3) DATE SURVEY
COMPLETED

10/03/2024

NAME OF PROVIDER OR SUPPLIER

SUGAR MOUNTAIN RETREAT, INC

STREET ADDRESS, CITY, STATE, ZIP CODE

25376 SOUTH WELLING ROAD
WELLING, OK 74471

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R 353	Continued From page 1 admininstrator stated there was no garbage container with lid for the kitchen..	R 353		
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. (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.	R 510	R510 Contact Rescue CPR will be scheduled for all staff. Assist. Admin. Will review cards to ensure all staff is trained. A checklist will be created and maintained by Assist. Admin to ensure that this requirement is met Completed 10/18/24	
This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure: a. staff had current CPR certification for one				

Oklahoma State Department of Health

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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		
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R 510	Continued From page 2 (MAT #1) of ten sampled employees whose certifications were reviewed; and b. staff had first aide certification for ten (Administrator, Assistant Administrator, MAT #1, 2, 3, 4, 5, 6, 7 and #8) of ten sampled employees whose certifications were reviewed. The assistant administrator identified 37 residents who resided in the facility. Findings: MAT #1 did not have a current CPR certification in their employee file. The administrator, assistance administrator, MAT #1, 2, 3, 4, 5, 6, 7 and #8 did not have a current first aide certification in their employee file. On 10/03/24 at 9:24 a.m., the assistant administrator stated no one had their first aide certification. They stated they thought first aide was included in the CPR class, but it wasn't. On 10/03/24 at 9:38 a.m., the administrator stated MAT #1 did not have a current CPR certification. They stated they must have missed the certification class.	R 510		

Delivery via email to: autumnketcher2021@gmail.com; autumnketcher813@gmail.com

December 11, 2024

License Number: RC0201
Survey Event ID: H9BQ12

Ms. Autumn Ketcher, Administrator
Sugar Mountain Retreat, Inc
25376 South Welling Road
Welling, OK 74471

Dear Ms. Ketcher:

On **December 10, 2024**, an offsite/paper revisit was conducted at your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Long Term Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **October 3, 2024**, have now been corrected and your facility is in compliance with licensure standards effective **October 18, 2024**.

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

Respectfully,

Clorissa Nubine

Clorissa Nubine, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

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 R 12/10/2024
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 000}	INITIAL COMMENTS An offsite/paper revisit was conducted on 12/10/24. The facility was in substantial compliance.	{R 000}		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE