Oklahoma State Department of Health
Creating a State of Health

December 5, 2019

License Number: RC4101
Survey Event ID: CDFO11

Mr. Javon Cook, Administrator
3c Old Fashioned Boarding Home
P.O. Box 48
Prague, OK 74864

Dear Mr. Cook:

Enclosed is the Residential Care inspection deficiency report form, showing the summary of deficiencies noted during the survey at your facility on **November 5, 2019.**

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.

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

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
	RC4101	A BUILDING _____ B WING _____	11/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3C OLD FASHIONED BOARDING HOME	719 SOUTH JIM THORPE BLVD PRAGUE, OK 74864

(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 On 11/05/19 a re-licensure survey was conducted. The census was 20. The following deficient practice was cited.	R 000		
R 184 SS=F	63 O.S. 1-1950.1.C.2 CRIMINAL Every employer who is subject to the provisions of this section shall inform each applicant for employment, or each prospective contract provider, as applicable, that the employer is required to obtain a criminal arrest record before making an offer of permanent employment or contract to a nurses aide or other person described in subsection B of this section. This Rule is not met as evidenced by: Based on record review and interview, it was determined that the home failed to obtain a criminal arrest record before offering permanent employment for 1 (#2) of 7 employees. This failed practice resulted in the risk for serious harm to all 20 residents of the home. Findings: On 11/05/19 at 2:00 p.m., the staff records were reviewed with the owner. The owner was asked to submit OSBI (Oklahoma State Board of Investigations) background checks for all employees. A review of employee #2's record did not include a final letter sent by OSBI. Employee #2 was hired May 2019, and no final letter was available. The owner was asked to go online and provide the final letter, he stated the person who takes care of the OSBI is not in the office today and nobody else could provide the documentation for review.	R 184		

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R 244	Continued From page 1	R 244		
R 244 SS=F	310:680-3-8 (e) RESIDENTS' COUNCIL (e) Reports of the council meetings shall be maintained in the home. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain the reports of the resident council meetings in the home. Findings: On 11/05/19, the owner was asked for documentation of the resident council meetings for the past year. The owner said he was unable to locate the documentation at this time.	R 244		
R 343 SS=E	310:680-5-7 (j) RESIDENT ROOMS - FURNITURE (j) Each resident shall have a comfortable chair, a bedside table and a bureau or its equivalent for storing personal belongings. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure 3 resident rooms (#6, #8 and #10) of the 10 resident rooms had a bedside table in the room. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 11/05/19 at 11:00 p.m., a tour of resident rooms was conducted. There was no bed side table observed in resident room #6, #8 and #10. There were no residents who lived in these rooms available for an interview (at the mental health	R 343		

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R 343	Continued From page 2 facility). The owner was asked about the missing tables and he said some had been removed when they had the bed bug issue so they could exterminate behind them. Some bedside tables were built into the wall and had to be removed at that time. He said he would replace them.	R 343		
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. This Rule is not met as evidenced by:	R 510		

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R 510	Continued From page 3 Based on interview and record review, it was determined the home failed to ensure 2 (the administrator, and employee #2) of 7 employees were currently certified in first-aid and/or cardiopulmonary resuscitation (CPR) that was Red Cross or equivalent. This failed practice had the widespread potential for more than minimal harm for all 20 residents. Findings: On 11/05/19 at 1:45 p.m., the owner was asked if all the employees had gotten certified in first aid and CPR documentation. He was unable to provide documentation of first aid and CPR for the administrator and employee #2.	R 510		
R 513 SS=F	310:680-11-1 (3)(D) STAFF TRAINING - INITIAL/ANNUALLY 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. (D) All direct care staff shall begin eight (8) hours of inservice by the administrator of the home or other person designated by the administrator of the home within ninety (90) days of employment and completed within twelve (12) months of employment. Eight (8) hours of inservice shall be required annually thereafter. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure 1 (#2) of 3 direct care employee received 8 (eight) hours of in-service by the administrator annually. This failed practice had the widespread potential for more than minimal harm for all 20 residents.	R 513		

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R 513	Continued From page 4 Findings: On 11/05/19 at 2:30 p.m., employee #2's file was reviewed with the assistance of the owner. Documentation for new employee #2 orientation/in-service was not completed. The owner said he was unable to provide documentation of completed in-service hours for employee #2.	R 513		
R 716 SS=F	310:680-15-2 (4) PROTECTION OF RESIDENT'S FUNDS To protect each resident's funds, the residential care home: (4) Shall maintain and allow each resident and responsible party access to a written record of all financial arrangements and transactions involving the individual resident's funds. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to maintain a written, accurate record of resident funds for 20 (#1 - #20) of 20 sampled residents. This failed practice had the wide spread potential for harm for all residents in the center. Findings: On 11/05/19 at 2:00 p.m., the owner was asked to provide bank documentation of funds the center received as a payee for residents and any financial bookkeeping for observation. The owner said he could not locate the ledger/documentation of funds. The person	R 716		

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R 716	Continued From page 5 responsible for the documentation was out of the office at this time for personal reasons.	R 716		

FORM APPROVED

STATE WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
RC4101	3C OLD FASHIONED BOARDING HOME

Type of Survey (select all that apply)

2				

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				

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. 32[illegible]8	11/05/2019	11/05/2019	0.50	0.00	4.50	0.00	3.50	5.50
2. 1[illegible]3	11/05/2019	11/05/2019	0.50	0.00	4.50	0.00	2.50	1.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
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**

DEC 09 2019

Oklahoma State Department of Health
Creating a State of Health

December 10, 2019

License Number: RC4101
Survey Event ID: CDFO11

Mr. Javon Cook, Administrator
3c Old Fashioned Boarding Home
P.O. Box 48
Prague, OK 74864

Dear Mr. Cook:

On November 5, 2019, a State Licensure survey was conducted at your Residential Care Facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

You have alleged that the deficiencies cited on that survey will be corrected and you will be in substantial compliance by **December 31, 2019**.

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) 271-6868.

Sincerely,

Lisa Calvin
Long Term Care Enforcement Reviewer
Oklahoma State Department of Health

LC/ks

Oklahoma State Department of Health

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R 000	INITIAL COMMENTS On 11/05/19 a re-licensure survey was conducted. The census was 20. The following deficient practice was cited.	R 000		
R 184 SS=F	63 O.S. 1-1950.1.C.2 CRIMINAL Every employer who is subject to the provisions of this section shall inform each applicant for employment, or each prospective contract provider, as applicable, that the employer is required to obtain a criminal arrest record before making an offer of permanent employment or contract to a nurses aide or other person described in subsection B of this section. This Rule is not met as evidenced by: Based on record review and interview, it was determined that the home failed to obtain a criminal arrest record before offering permanent employment for 1 (#2) of 7 employees. This failed practice resulted in the risk for serious harm to all 20 residents of the home. Findings: On 11/05/19 at 2:00 p.m., the staff records were reviewed with the owner. The owner was asked to submit OSBI (Oklahoma State Board of Investigations) background checks for all employees. A review of employee #2's record did not include a final letter sent by OSBI. Employee #2 was hired May 2019, and no final letter was available. The owner was asked to go online and provide the final letter, he stated the person who takes care of the OSBI is not in the office today and nobody else could provide the documentation for review.	R 184	To correct this deficiencie employee #2 no longer works at 3C since 9-10-19.	12-9-1

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

Oklahoma State Department of Health

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R 244 SS=F	310:680-3-8 (e) RESIDENTS' COUNCIL (e) Reports of the council meetings shall be maintained in the home. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain the reports of the resident council meetings in the home. Findings: On 11/05/19, the owner was asked for documentation of the resident council meetings for the past year. The owner said he was unable to locate the documentation at this time.	R 244	To correct this deficiencie the residental Council book was found.	12-31-19
R 343 SS=E	310:680-5-7 (j) RESIDENT ROOMS - FURNITURE (j) Each resident shall have a comfortable chair, a bedside table and a bureau or its equivalent for storing personal belongings. This Rule is not met as evidenced by: Based on observation and interview, it was determined the home failed to ensure 3 resident rooms (#6, #8 and #10) of 10 resident rooms had a bedside table in the room. This failed practice had the potential for more than minimal harm at a pattern. Findings: On 11/05/19 at 11:00 p.m., a tour of resident rooms was conducted. There was no bed side table observed in resident room #6, #8 and #10. There were no residents who lived in these rooms available for an interview (at the mental health facility).	R 343	To correct this deficiencie the residents elected not to have one. Amendment 310:680-5-7 j.	12-31-19

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R 343	Continued From page 2 The owner was asked about the missing tables he said some had been removed when they had the bed bug issue, so they could exterminate behind them. Some bedside tables were built into the wall and had to be removed at that time. He said he would replace them.	R 343		
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	To correct this defici 12-31-P encie the administrator cpr and First aid was found. Employee #2 is enrolled and waiting for date on course.	
	This Rule is not met as evidenced by: Based on interview and record review, it was			

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R 510	Continued From page 3 determined the home failed to ensure 2 (the administrator, and employee #2) of 7 employees were currently certified in first-aid and/or cardiopulmonary resuscitation (CPR) that was Red Cross or equivalent. This failed practice had the widespread potential for more than minimal harm for all 20 residents. Findings: On 11/05/19 at 1:45 p.m., the owner was asked if all the employees had gotten certified in first aid and CPR documentation. He was unable to provide documentation of first aid and CPR for the administrator and employee #2.	R 510		
R 513 SS=F	310:680-11-1 (3)(D) STAFF TRAINING - INITIAL/ANNUALLY 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. (D) All direct care staff shall begin eight (8) hours of inservice by the administrator of the home or other person designated by the administrator of the home within ninety (90) days of employment and completed within twelve (12) months of employment. Eight (8) hours of inservice shall be required annually thereafter. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to ensure 1 (#2) of 3 direct care employee received 8 (eight) hours of in-service by the administrator annually. This failed practice had the widespread potential for more than minimal harm for all 20 residents. Findings:	R 513	To correct this deficiencie 12-31-19 the Staff Trainning book was found.	

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R 513	Continued From page 4 On 11/05/19 at 2:30 p.m., employee #2's file was reviewed with the assistance of the owner. Documentation for new employee #2 orientation/in-service was not completed. The owner said he was unable to provide documentation of completed in-service hours for employee #2.	R 513		
R 716 SS=F	310:680-15-2 (4) PROTECTION OF RESIDENT'S FUNDS To protect each resident's funds, the residential care home: (4) Shall maintain and allow each resident and responsible party access to a written record of all financial arrangements and transactions involving the individual resident's funds. This Rule is not met as evidenced by: Based on interview and record review, it was determined the home failed to maintain a written, accurate record of resident funds for 20 (#1 - #20) of 20 sampled residents. This failed practice had the wide spread potential for harm for all residents in the center. Findings: On 11/05/19 at 2:00 p.m., the owner was asked to provide bank documentation of funds the center received as a payee for residents and any financial bookkeeping for observation. The owner said he could not locate the ledger/documentation of funds. The person responsible for the documentation was out of the	R 716	To correct this deficiencie the needed financial book was found. 12-31-19	

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R 716	Continued From page 5 office at this time for personal reasons.	R 716		

OKLAHOMA
State Department
of Health

Delivery via email to: melodie_waddell@yahoo.com

November 25, 2020

License Number: RC4101
Survey Event ID: CDFO12

Ms. Melodie Waddell, Administrator
3c Old Fashioned Boarding Home
719 South Jim Thorpe Blvd
Prague, OK 74864

Dear Ms. Waddell:

On **November 19, 2020**, an offsite/paper revisit was conducted with your facility by this agency to verify that the facility had achieved substantial compliance with the requirements for licensure as a Residential Care Facility. The findings of that visit indicate that the deficiencies cited during your survey on **November 5, 2019,** have now been corrected and your facility is in compliance with licensure standards effective **November 19, 2020**.

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

Sincerely,

Users, Lisa D Calvin

Digitally signed by Users, Lisa D Calvin
Date: 2020.11.25 12:36:20 -06'00'

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

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
	RC4101	A. BUILDING: _____ B. WING _____	R 11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
3C OLD FASHIONED BOARDING HOME	719 SOUTH JIM THORPE BLVD PRAGUE, OK 74864

(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 off-site/paper revisit was conducted on 11/19/2020. Credible evidence of correction was submitted for all deficiencies.	{R 000}		

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